Positive practice environments for professional nurses working in selected psychiatric institutions in South Africa: a practice theory

MM Lekgetho
10899286

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Promoter Prof. H C Klopper
Co-promoter Prof. P Bester
Assistant promoter Prof. S K Coetzee

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DECLARATION

I, Mangena M Lekgetho, student number 10899286, hereby declare that the following is my own work.

I further declare that:

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________________________
M.M Lekgetho
ABSTRACT

Key words: positive practice environments, nurse manager, professional nurses, psychiatric hospitals, improved staff outcomes, motivation.

This research evaluated the practice environments of professional nurses working at selected psychiatric institutions in South Africa. Thus far, no theoretical knowledge has been used to inform the scientific development of a practice theory. Professional nurses working at psychiatric institutions experience their work environment as stressful because of unfavourable working conditions. These unfavourable working conditions result in professional nurses resigning, thereby increasing the workload of the remaining professional nurses. The purpose of the research was to evaluate the current practice environment of professional nurses who work at selected psychiatric institutions and to identify strategies to improve their practice environments.

The study followed a quantitative, descriptive, contextual and theory construction research design. The objectives were to explore and describe the status of the practice environment of psychiatric institutions (Phase I); to measure the prevalence of burnout among professional nurses working at psychiatric institutions (Phase II); and to construct a conceptual framework for a practice theory for professional nurses working at psychiatric institutions (Phase III). The main aim of the study was to develop a practice theory that can be used to improve the practice environment of professional nurses working in psychiatric institutions. Psychiatric hospitals in North West and Gauteng and professional nurses working at these hospitals were selected. Data was collected from participants by means of a questionnaire (Practice Environment Scale for Nurse Work Index [PESNWI]) that was contextualised for the psychiatric nursing context. The quantitative results were analysed using SPSS, resulting in the emergence of main and sub-themes. The Maslach Burnout Inventory (MBI) was used to measure the level of burnout among professional nurses at psychiatric institutions, and the results were used as a basis for theory construction through a deductive reasoning process or conclusive statements.

A process of theory construction was followed, including concept synthesis, statement synthesis and theory synthesis. Furthermore, a literature review was done and concepts were identified from empirical data and integrated with the conceptual framework. Concept classification was done according to the survey list of Dickoff, James and Wiedenbach (1968) to ensure systematic ordering of concepts. From the six categories, 35 conclusive statements made it possible for the construction of the practice theory.
The dynamic of the theory is motivation. Professional nurses working at psychiatric institutions can provide quality patient care to mental health users if they are motivated to work in a psychiatric environment. It should be noted that not all professional nurses are comfortable or enjoy working at a psychiatric institution for personal reasons. Yet, the quantitative results indicated that professional nurses are positive which might be satisfaction to work in a psychiatric institution as opposed to general hospitals. The results generally demonstrate that the work environment is positive and professional nurses experience less burnout while working at psychiatric institutions.

Evaluators knowledgeable and experienced in practice theory construction and quantitative research evaluated the theory according to the criteria from Chinn and Kramer (1991; 2011). This practice theory adds value to nursing science, nursing practice and nursing research. Recommendations were formulated for nursing practice, education and research.
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Make your travels through time worthwhile
Choose the roads that allow you opportunities to grow and change
Look for adventures that challenge your abilities and find mysteries in life
that excite your sense of wonder
Search for the truths that you believe in and discover as many secrets about life as you can
It is up to you to create your life
Your unique spirit needs to explore the world
And be an active part of every day
Don’t be so concerned about finding
The easiest roads to travel
But follow the roads that lead you toward
Being the person you really want to be
Remember, the important things in life
Are the things that you believe are important.
(Deanna Beisser)
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LIST OF ABBREVIATIONS

AACN: American Association of Colleges of Nursing
ANA: American Nurses Association
APNA: American Psychiatric Nurses Association
CEO: Chief Executive Officer
CFI: Comparative fit index
CHSRF: Canadian Health Service Research Foundation
CNS: Clinical nurse specialist
CPD: Continuous professional development
DoH: Department of Health
DP: Depersonalisation
DSM: Diagnostic and Statistical Manual
ED: Emergency department
EE: Emotional exhaustion
EAP: Employee assistance program
ICN: International Council of Nurses
IQ: Intelligence quotient
ISPN: International Society of Psychiatric-Mental Health Nurses
JS: Job satisfaction
KMO: Kaizer-Meyer-Olkin
HIPAA: Health Insurance Portability and Accountability Act
HPCSA: Health Professions Council of South Africa
LOS: Length of stay
MBI: Maslach Burnout Inventory
MDG: Millennium Development Goals
MHCA: Mental Health Care Act
NHI: National Health Insurance
NIMH: National Institute for Mental Health
NWI: Nurse Work Index
NWU: North-West University
PA: Personal accomplishment
PES-NWI: Practice Environment Scale of the Nursing Work Index
PHC: Primary health care
PPE: Positive practice environment
PTCA: Plan-to-check-act
RMSEA: Root Mean Square Error of Approximation
RN4CAST: Registered Nurses Forecast
RNAO: Registered Nurses Association of Ontario
SADC: Southern African Development Community
SANC: South African Nursing Council
SAMHSA: Substance Abuse and Mental Health Service Administration
SASH: South African Stress and Health
SDG: Sustainable Development Goals
SPSS: Statistical Package for the Social Sciences
UK: United Kingdom
UN: United Nations
USA: United States of America
WHO: World Health Organisation
WMH: World Mental Health
WMSD: Work-related Musculoskeletal Disorders
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PREFACE

As a professional nurse with knowledge and experience in psychiatric nursing, a question that came to my mind was “What is the status of the practice environment of professional nurses working in psychiatric institutions? This concern prompted me to undertake a study in the psychiatric setting to evaluate the practice environment and the level of burnout experienced by professional nurses at psychiatric institutions. People generally experience certain challenges and a certain degree of dissatisfaction with their work environment. This dissatisfaction can be caused by various factors, be it known or unknown factors. It is through research that one will have scientific knowledge about the real practice environment of professional nurses in psychiatric institutions.

The study offers a glimpse into the practice environment of professional nurses in psychiatric institutions and suggests interventions for the identified challenges to improve the nursing practice.

Remember, the proof of the pudding is in the eating, meaning one cannot form an opinion until one has tried something, nothing ventured, nothing gained.

Mangena Lekgetho
Klerksdorp
November 2016
CHAPTER 1: OVERVIEW OF THE RESEARCH STUDY

1.1 INTRODUCTION

Chapter 1 gives the reader an overview of the research. The chapter starts with the background, followed by the problem statement and consequent research questions, aim and objectives. These discussions extend the underlying rationale for this research. Thereafter the leading concepts of psychiatric nursing, positive practice environment and burnout/stress are explored. The researcher’s philosophical assumptions and the ethical considerations and rigour in this research are formulated. The chapter concludes with an outline of the structure of this thesis.

1.2 BACKGROUND AND RATIONALE FOR THE STUDY

Health systems worldwide are increasingly challenged by and faced with a growing range of health needs and financial constraints that limit service providers’ potential to strengthen health sector infrastructure and workforces. There is a global nursing workforce crisis, one marked by a critical shortage of nurses (Dambino, 2010:2532). The reasons for the shortages are varied and complex, but key among them are toxic work environments that weaken performance or alienate nurses and, too often, drive them away from specific work settings or from the nursing profession itself (Duffield et al., 2010:24). Yet there are environments that do just the opposite, that support excellence and have the power to attract and keep nurses. They are called positive practice environments (Roche & Duffield, 2010:195). These settings support excellence and decent work. In particular, a positive practice environment is geared to ensure the health, safety and personal well-being of staff, support quality patient care and improve the motivation, productivity and performance of individuals and the organization, International Council of Nurses(ICN, 2008; Ditomassi, 2012:266).

The beneficial effect of a positive work environment on everything from nurse satisfaction, to patient outcomes, to innovation is documented by a substantial body of evidence. Still, much work is needed to make positive practice environments the norm. The nurse’s job is particularly stressful and emotionally draining (Aiken et al., 2012:1). Psychiatric nursing staff has been found to exhibit more of the consequences of job-related stress than do other professional groups such as social workers, psychologists and occupational therapists (Leka et al., 2012:123). Nursing staff play a central role in the management of and administration of care to psychiatric hospital patients, and have the most direct one-to-one contact with these patients of all the hospital staff.

One question that is often raised when nurses talk about the healthcare environment is whether psychiatric nurses are vulnerable to being replaced as expensive and out-dated providers or whether they are valued as competent clinicians who can function in a world of changing needs,
processes and structures. Potential areas of vulnerability that have been identified include that fewer nurses are attracted to psychiatric nursing as compared with other specialty areas. They often experience verbal abuse (i.e., use of degrading comments and insults, yelling, cursing and inappropriate joking) in the workplace. This is a problem worldwide. Registered nurses report physicians to be one of the main sources of verbal abuse (Chapman et al., 2010). In a national survey conducted in the United States, of 1 000 staff nurses and 1 000 nurse managers, it was found that 82% of staff nurses and 77% of nurse managers reported experiencing verbal abuse, with physicians as the most common source of abuse. Nurses reported on average five verbal abuse events per month (Brewer et al., 2013:408). Verbal abuse not only affects professional nurses’ turnover and their intentions to leave their employer or the profession, but it may also have an impact on patients’ clinical outcomes and quality of care (Rosenstein, 2009). A question may be asked: Does verbal abuse cause low job satisfaction causing professional nurses to leave their work place, and does the poor work environment increase the level of burnout? According to Lake (2002), a practice environment is defined as the organizational characteristics of a work setting that facilitate or constrain professional nursing practice.

A favourable practice environment facilitates professional nursing practice and has structured policies, procedures and systems in place where nurses play a participatory role and are valued for their contributions. In such an environment nursing foundations for quality care are emphasized, the nurse manager is viewed as playing a critical role and expected to have good leadership and management skills, there is adequate staff and resources to provide quality care and there are positive working relationships between the nurses and physicians (Coetzee et al., 2012:163).

The shortage of professional nurses in South Africa is another worrying factor and is confirmed by the statistics as revealed by the South African Nursing Council (SANC). It shows that the ratio of the population per registered nurse is 469:1 in the North West and 363:1 in Gauteng (SANC, 2014b).

Toxic practice environments are a feature of many health systems around the world. Such environments weaken an employers’ ability to meet the organization’s performance targets and make it more difficult to attract, motivate and retain staff. Unrealistic workloads, poorly equipped facilities, unsafe working conditions, lack of commitment, poor leadership and unfair compensation feature among the many factors affecting the work life and performance of today’s healthcare professionals and healthcare workers (International Council of Nurses [ICN], 2008, Duffield et al., 2011:24).

Establishing positive practice environments across health sectors worldwide is of paramount importance to guarantee patient safety and health workers’ wellbeing. All health sector
stakeholders, be they employer or employee, private or public, governmental or non-governmental, have their respective and specific roles and responsibilities to foster a positive practice environment (Duffield et al., 2010:25). They must work in concert to achieve positive practice environment for quality care. The literature reveals that professional nurses working in psychiatric institutions are subjected to challenging practice environments, which require some attention.

1.3 PROBLEM STATEMENT

Psychiatric institutions are experiencing a high turnover of professional nurses because of toxic practice environments, among other reasons. There are various factors that cause professional nurses to leave these institutions, for example the imbalance in the nurse-patient ratio and unrealistic workload (Duffield et al., 2011:246). Another factor that plays a role is the verbal abuse of nurses by other health professionals such as physicians, which could result in more nurses leaving the institution (Roche & Daffield, 2010:197). There is a serious shortage of professional nurses in various health establishments, with few nurses being attracted to psychiatric nursing practice (Tran et al., 2010:149; Hinno et al., 2011:133). This shortage of professional nurses and resources could have a negative impact on the quality of care provided to patients. The toxic practice environment can also result in burnout among the nursing personnel, and later stress that can manifest itself either physically, socially or psychologically (Aiken et al., 2011:358). It is clear from the problem statement that a practice environment is a complex phenomenon and needs further investigation, especially within psychiatric institutions.

1.4 RESEARCH QUESTIONS

From the above problem statement, the researcher formulated specific research questions to address this problem as the work environments of professional nurses in psychiatric institutions, particularly in South Africa, have not been investigated in any depth. The following central question emerges:

- How can a practice theory for positive practice environments for professional nurses in psychiatric institutions be constructed?

- In order to answer this question, the following sub-questions have to be addressed:
  - What is the status of the psychiatric practice environment in South Africa?
  - What is the prevalence or level of burnout among professional nurses working in psychiatric institutions?
  - What are the concepts and the relationship between these concepts (in other words,
statements) that would be involved in constructing a theory of practice environments for professional nurses in psychiatric institutions?

1.5 AIM AND OBJECTIVES

The overall aim of this study is to construct a practice theory for positive practice environments for professional nurses in selected psychiatric institutions in South Africa. To achieve this aim, the following objectives are stipulated:

- To explore and describe the status of the practice environment in psychiatric institutions.
- To measure the prevalence of burnout among professional nurses working in psychiatric institutions.
- To describe a conceptual framework for the practice theory.

1.6 CENTRAL THEORETICAL ARGUMENT

The researcher will collect data using a quantitative method to construct a practice theory for professional nurses working in psychiatric institutions. The theory is intended to explore and describe the status of the practice environment in psychiatric institutions and to discuss the prevalence of burnout among professional nurses working in psychiatric institutions. This will form the basis to identify the concepts and statements to describe a practice theory.

1.7 RESEARCHER’S ASSUMPTIONS

Assumptions are the basic principles that we accept on faith, or assume to be true without proof or verification (Polit et al, 2000; Polit & Beck, 2014:374). They determine the nature of concepts, definitions, purposes and relationships. They are the basic underlying truths from which theoretic reasoning proceeds (Brink, 2009:25). In this study, as a researcher I have a Christian view. According to the Christian view, a human being consists of the body and a spirit or soul. For the human being to live on earth, the body and the spirit must be together. Should the two be separated, the human being will cease to exist (die) and the spirit will go back to its owner (God). The spirit never dies, but lives forever.

In this study, the following assumptions are discussed:

1.7.1 Meta-theoretical assumptions

The researcher’s meta-theoretical assumptions originate from the following views and philosophies that are congruent with the researcher’s personal philosophy. According to Botes (1995:9), the meta-theoretical assumptions are based on the researcher’s view of the world and society (Klopper, 2008). As indicated earlier on, my assumptions are argued from the Christian
point of view. These assumptions may not have any significant value, but are merely a reflection of how I view the world and the society. I believe that professional nurses are human beings who have chosen nursing as a career and provide quality nursing care by using the holistic approach. Based on this approach, they take care of patients in a health establishment, keeping in mind the fact that the patient comprises of various aspects such as physical, social, psychological and spiritual. All these aspects are intertwined and depend on one another. If one aspect of the system is affected, the whole body becomes affected. This implies that all these aspects are important and no aspect is better than another. Much as the researcher believes in a Christian philosophy, the researcher also supports a symbolic interactionism because the researcher believes that professional nurses working in psychiatric institutions continuously interact with psychiatric patients, whose behaviour is unpredictable and ever changing. Professional nurses also interact with the psychiatric environment, which is dynamic, and they are expected to react accordingly within the ethical professional principles that govern their practice.

1.7.1.1 Person

In this study, the person refers to a professional nurse who is registered according to the Nursing Act no. 33 of 2005. The person should have undergone training at a nursing education institution that is a college of nursing or a university for duration of at least four years in accordance with Regulation 425 of South African Nursing Council. The professional nurse is subject to the sinful nature of a mortal life that can only be converted through repentance. A professional nurse leads a purpose-driven life and acts on the choice to be a professional nurse, rather than being appointed as a professional nurse for the status of the formal position. Finally, a professional nurse is subjected to the mercy from God and therefore has a unique life narrative that may direct his/her nursing.

1.7.1.2 Health

Health is the balance between body, mind and spirit and not necessarily the absence of illness. Health is dynamic, unique and sensitive and needs conscious input to be maintained and enhanced. World Health Organisation (WHO) defines health as a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity (Sartorius, 2006:662).

Health in this research refers to the employees’ wellness in the workplace. This wellness is a state of balance between the employees’ body, mind and spirit and implies an active attempt by employees to maintain it.
1.7.1.3 Nursing

Nursing is a caring profession practiced by a person registered under section 31 of the Nursing Act, (Act no 33 of 2005), which supports, cares for and treats a healthcare user to achieve or maintain health and where this is not possible, cares for a healthcare user so that he or she lives in comfort and with dignity until death. In this research, the professional nurse provides a purposive and comprehensive service to his/her patients. The goal of this service is to enhance and maintain wellness in the workplace of the patients and significant others to prevent and address aspects that are challenging their level of wellness.

1.7.1.4 Environment

An environment is a setting where nurses interact with other health professionals to promote or improve the well-being of patients, for example a hospital. It is at the work environment where the psychological, physiological, social, economic and cultural concepts of patients are understood and utilized in developing and maintaining a therapeutic milieu. The milieu is structured and/or altered so that it serves the patient’s best interest as an inherent part of the overall therapeutic plan. It is in this environment that psychiatric nurses interact with other members of the multidisciplinary team to assess, plan, implement and evaluate the interventions provided to the psychiatric patients.

1.7.2 Theoretical assumptions

The researcher embarked on an extensive study of the existing theoretical pronouncements to be able to state his or her theoretical assumption (Botes, 1995:5). Theoretical statements are the testable statements that provide epistemic findings about the research domain (Botes, 1995:10). Unlike the meta-theoretical assumptions, theoretical assumptions can be tested to evaluate if they reflect the truth or not. The research findings that are indicated in Chapter 3 and the information extrapolated from Chapter 4, lead to Chapter 5, which reports on the construction of the theory for positive practice environments.

1.7.2.1 Models and theories

Various factors have led to a situation where model and theory are frequently used as synonyms. Theories and models bear a number of important similarities. The differences between models and theories are largely differences of degree. It is not always essential that a rigid distinction be drawn between model and theory, but it shall be argued that the heuristic function is the most common characteristic of models, while the explanatory function is usually attributed to theories (Mouton & Marais, 1994:138). In this research study, the conceptual model for healthy work
environments, also referred to as positive practice environments for nurses, is acknowledged and used as a point of departure.

1.7.2.2 Definitions

The following concepts are central to this research and are defined as follows:

**Nursing science**

Nursing science is the body of knowledge pertaining to the discipline of nursing, which is continuously developed and composed through research findings and tested theories (Burns & Grove, 2009:8). Nursing science is a continuous process that contains research products (Burns & Grove, 2009:8).

In this research, nursing science is the directed receiving discipline in which the theory for positive practice environments for professional nurses in psychiatric institutions is constructed. This discipline is characterized by a current body of knowledge that is being grown and developed dynamically through research output and by testing theories. The theory should be beneficial to nursing science, research and psychiatric nursing practice.

**Psychiatric nursing**

Psychiatric nursing is, according to Stuart and Laraia (2005:6), an integrated process that promotes and maintains patient behaviour that contributes to integrate functioning. The patient may be an individual, family, group, organization or community. The *American Nurses Association Scope and Standards of Psychiatric Mental Health Nursing Practice* defines psychiatric nursing as “a specialized area of nursing practice, employing the wide range of explanatory theories of human behaviour as its science and purposeful use of self as its art” (American Nurses Association [ANA]). Refer to the figure 1-1, below.
According to Stuart and Laraia (2005:8) and Stuart (2009:7), there are three domains of contemporary psychiatric nursing practice: direct care, communication and management. Within these overlapping domains of practice, the nurses have teaching, coordinating, delegating and collaborating functions. Often the communication and management domains of practice are overlooked when discussing the psychiatric nursing role. However, these integrating activities are critically important and are very time consuming aspects of the nurse role. They have become even more important in a reformed healthcare system that place emphasis on efficient patient triage and management.

**Human being**

Human beings are viewed as unique, spiritual and God-created beings who function as units with body, mind and spirit within a mortal, earthly life. Although God creates the human being, the person is conceived and born in sin. Only God can transform man’s mortal life to spiritual immortality through the process of conversion and faith in Jesus Christ. The process of salvation through conversion and faith is achieved by mercy from God and the choice given by God to man (Bester, 2008:5).

**Psychiatric institution**

For the purposes of this study, a psychiatric institution refers to the whole or part of a public or private institution, facility, building or place, whether for profit or not, that is operated or designed
to provide inpatient or outpatient treatment to patients presenting with acute and chronic symptoms, diagnostic or therapeutic interventions, nursing, rehabilitative or preventative health services (Ngako et al., 2013:1).

**Psychiatric rehabilitative unit**

A psychiatric rehabilitative unit is a ward designed to help people with disabilities caused by mental illness to improve their functioning and quality of life by enabling them to acquire the skills and support needed to be successful in ordinary adult roles (Sadock & Sadock, 2007:968; Frisch & Frisch, 2011:266).

**Acute psychiatric unit**

According USLEGAL (2016:1); Robertson et al., (2014:385) an acute psychiatric unit is a psychiatric health facility that is licensed to provide urgent or immediate psychiatric services to individuals with for instance suicidal thoughts.

**Chronic psychiatric unit**

Is a ward where patients with lasting psychiatric conditions are admitted with the aim of rehabilitating them back into the society, for example patients with mood disorders (Willowrock, 2016:1).

**Unit for patients with severe intellectual disability**

A unit for patients with severe intellectual disability is a ward where individuals with significantly sub-average intellectual function with an intelligence quotient (IQ) score of below 70 and with existing concurrent deficits in adaptive behaviour are admitted (MedicineNet, 2016:1).

**Theory**

A theory is a set of integrated and defined concepts and relational statement that sketch a phenomenon. A theory can be used to describe, predict, explain and/or control the phenomenon (Chinn & Kramer, 2004: 79; Walker & Avant, 2005:28). This definition also applies to practice theory.

**Practice theory**

A practice theory is a theory with a point of departure of practice, and its goal is to affect practice. It lends itself to empirical testing because its concepts are more specific and can be readily operationalised (Meleis, 2012:419).
Work environment

According to the Canadian Health Service Research Foundation, CHSRF (2001:1), the term work environment includes the units in which the nurses work, such as wards or programmes and the organization (hospital or community) that employs them to some extent, the social context of government, profession and public opinions. Problems with nurses' work and work environment include stress, heavy workloads, long hours, injury and poor relations with other professions and can affect their physical and psychological health. Research across occupations has shown that long periods of job strain affect personality relationships and increase sick time, turnover and inefficiency (Papastavrou et al., 2014:1).

Positive practice environments

Positive practice environments are settings that support excellence and decent work. In particular, a positive practice environment strives to ensure the health, safety and personal well-being of staff, supports quality patient care and improves the motivation, productivity and performance of individuals and the organization (ICN, 2008:1).

Leadership

Collins and Maxwell (2010:2) define leadership as a process through which a person influences others to accomplish an objective and directs the organisation in a way that makes it more cohesive and coherent.

Burnout

Burnout is a state of emotional, mental and physical exhaustion caused by excessive and prolonged stress. It occurs when you feel overwhelmed and unable to meet constant demands. As the stress continues, you begin to lose the interest or motivation that led you to take on a certain role in the first place (Smith et al, 2008:1). It is further defined by Maslach, Jackson and Leiter (1996) as a consequence of prolonged job stress and is most often characterized by exhaustion, cynicism and reduced professional efficacy (Hatinen et al., 2009:341; Ton et al., 2012:127).

1.7.3 Methodological assumptions

The researcher utilised Botes' research model (1995:5) as a framework to guide the research decisions. Botes' research model for nursing science was derived from the work of Mouton and Marais (1994:3-27) and focuses on research in the social sciences. The Botes model is embedded in the symbolic interactionism view and the functional approach.
Figure 1-2 below provides a graphic illustration of the Botes research model as applied to this research. Botes' model portrays three independent orders of activities that are organized in a specific relationship to one another. These orders are the nursing practice, nursing theory and the presence of a paradigmatic perspective.

Figure 1-2: Research model by Botes applied to this research

The practice is viewed as the first order in this research model. This level is the prescientific level and directs the research questions (Botes, 1995:6). In this research the professional nurse who is employed in psychiatric institutions in South Africa and who is exposed to the realities within their practice environment, is embedded in the first order as the research domain. The second order in the Botes research model is the level where research and theory construction takes place. These actions are performed through rational decision-making within a framework of research determinants (Botes, 1995:6) that guide the researcher’s decisions. This researcher’s planned design and method is discussed in Sections 1.8 and 1.9.

The researcher’s paradigmatic perspective is viewed as the third order in the research model. The researcher’s paradigmatic perspective refers to assumptions that continuously influence the
first and second levels (Botes, 1995:6). This paradigmatic perspective is outlined in Section 1.6. In correspondence with the Botes model, the researcher confines himself with the philosophy of pragmatism. Pragmatism is the doctrine that believes that the content of a concept consists only in its practical ability. It believes that the truth consists not of correspondence with the facts, but of successful coherence with experience. In pragmatism, the meaning of an idea or a proposition lies in its observable practical consequences. It is the character or conduct that emphasizes practical results or concerns rather than the theory or principle. Due to the constant interdependent relationship between the researcher’s paradigmatic perspective, research and theory and the nursing practice, pragmatism is the most relevant and applicable approach to the positive practice environment for professional nurses working in psychiatric institutions. This philosophy further implies that the practice is informed by theory. The core of pragmatism is the pragmatist maxim, a rule for clarifying the contents of hypotheses by tracing their practical consequences. The researcher believes that nursing is a practical career. For a nurse to be competent at the end of the training programme, he or she should be exposed to the practice component throughout the training and should be under the supervision of an experienced professional nurse.

1.8 RESEARCH DESIGN

The purpose of this research is to construct a practice theory of a positive practice environment for professional nurses in selected psychiatric institutions in South Africa. This goal can be reached through a research design that is theory-constructive in nature with components of quantitative, explorative, descriptive, explanatory, and contextual research (Burns & Grove, 2009:238). The following paragraphs provide a condensed description of each of these components, accompanied by the reasons for and applications thereof. The research design is discussed in detail in Chapter 2.

1.8.1 Theory construction

According to Chinn and Kramer (2004:26), theory construction is a multi-step process where empirical evidence is used in “an interrelated system of ideas” (Walker & Avant, 2005:135). During theory construction the focus was on the constructs of research i.e. concepts; statements and conceptual frameworks, followed by the systematization of statements to classify, describe typologies and models or explain theories (Mouton & Marais, 1994:125; Mouton, 2015:195). The process of theory construction requires a systematic process of enquiry and is based on direct and indirect observation, empirical research and literature (Brink et al., 2014:29). It is a continuous written discourse that depends on deductive and inductive logic, concept analysis, derivation and statement synthesis. The main and related concepts to a practice theory for positive practice environments for psychiatric nurses in psychiatric institutions are identified and analysed.
Thereafter, statements are synthesised with the analysed concepts, and a practice theory will be constructed. The theory constructed is detailed in Chapter 5.

1.8.2 Quantitative research

Quantitative research is a form of conclusive research involving large representative samples and fairly structured data collection procedures. The primary role of quantitative research is to test hypotheses. Quantitative research normally gives a weak account of how constructs are derived. Constructs, however, are the central focus in quantitative research. To conduct quantitative research, the constructs studied must be measured. The measurement of constructs was undertaken through questionnaires. When one conducts quantitative research, one must specify precisely how the construct will be measured (Struwig & Stead, 2004:4). Polit and Beck (2008:763) further define quantitative research as the investigation of the phenomena that lend themselves to precise measurement and quantification, often involving a rigorous and controlled design. According to Grove et al. (2013:706), it is a formal, objective, systematic study process to describe and test relationships and to examine cause and effect interactions among variables.

In this research, the purpose is to construct a practice theory of positive practice environment for professional nurses in psychiatric institutions. The quantitative nature of this research is discussed in detail in Chapter 2.

1.8.3 Explorative research

The aim of the explorative research is to explore the full nature of a phenomenon with regard to the manner in which the phenomena exist and manifest as well as any other related factors by means of a formally documented exploration (Burns & Grove, 2009:359). Through this exploration, the researcher gains more knowledge about the phenomena that is explored. This research aimed to explore the present status of practice environments including the burnout of professional nurses in psychiatric institutions as part of theory construction.

1.8.4 Descriptive research

According to Mouton and Marais (1994:43) and Mouton (2015:102), the aim of a descriptive study is to discover new facts about a phenomenon’s characteristics. This research launched an in-depth investigation into ideas structured into concepts using symbols and words (Chinn & Kramer, 2004:72-73). Literature searches provided all the available information about main and related concepts. Empirical evidence was utilized in the form of concept identification, descriptions, definitions and analysis. This is discussed in Chapter 3.

1.8.5 Explanatory research

The goal of explanatory research according to Polit and Beck (2008:22), is to understand the underpinning of specific natural phenomena and to explain systematic relationships among
phenomena. Explanatory research is often linked to a theory, which represents a method of deriving, organising and integrating ideas about the manner in which phenomena are manifested or interrelated, whereas descriptive research provides new information and exploratory research provides promising insights, explanatory research focuses on understanding the causes or full nature of a phenomenon (Polit & Beck, 2014:13).

1.8.6 Contextual research

According to the Oxford English Dictionary, 2002, context is defined as words that come before and after a particular word or phrase and help to fix its meaning. According to the research model by Botes (1995:6), the research context refers to its universal or contextual nature, whereas Mouton and Marais (1994:11) and Mouton (2015:133) distinguish the ontological dimension to answer, “What is the reality of the domain?” applied as “What is the current practice environment of professional nurses in selected psychiatric institutions?” In the description of a contextual study it is important to include a description of the context or setting in which the research is conducted and to explain why this setting was chosen (Klopper, 2008:68).

The research was conducted in two provinces in South Africa, namely North West and Gauteng. In the North West, the following psychiatric hospitals were included: hospital A, which is situated in Potchefstroom and hospital B, which is situated in Mafikeng. In Gauteng, hospital C, which is situated in Pretoria and hospital D, which is situated in Krugersdorp were used as research sites. All these psychiatric hospitals are public institutions that are funded by the government. The management of these institutions gave their permission to conduct the research. A comprehensive description of the context is discussed in Chapter 2.

1.9 RESEARCH METHOD

The research method refers to the steps in the research process that the researcher followed to reach the stated aim and objectives (Polit & Beck, 2014:8). The steps in this process can be listed as the determining the method of data collection, the population and sampling procedure, data collection itself, data analysis, the description of research results and finally, ensuring rigour. The detailed description of research methods used in this study is presented in Chapter 2. However, to provide a brief overview of the research method followed in this study, a summary is provided in Table 1.2. The study was conducted in three phases. Phase 1 focused on concept identification, classification and analysis. To identify the concepts, the researcher uses an emic perspective to understand the empirical world of the psychiatric nurse. Phase 2 focused on theory construction by developing relational statements between identified and classified concepts, and the description of the theory. Phase 3 focused on guidelines for operationalisation of the theory.
Table 1-1: Overview of the research methodology

<table>
<thead>
<tr>
<th>OBJECTIVES</th>
<th>STEP</th>
<th>DATA COLLECTION</th>
<th>POPULATION AND SAMPLE</th>
<th>DATA ANALYSIS</th>
<th>DESCRIPTION OF METHODS</th>
</tr>
</thead>
</table>
| To explore and describe the status of the practice environment in selected psychiatric institutions in South Africa. | **Step 1:** Explore and describe the status of the practice environment in selected psychiatric institutions in South Africa. | Practice Environment Scale Nursing Work Index (PES-NWI) as part of RN4CAST (Lake, 2002). | **Population:** Selected psychiatric units in Gauteng and North West (N=71).  
**Sample:** All-inclusive sample (n=69). | Descriptive Statistics  
| To discuss the prevalence of burnout among professional nurses working in selected psychiatric institutions in South Africa. | **Step 2:** Explore and describe the prevalence of burnout among professional nurses working in selected psychiatric institutions in South Africa. | Maslach Burnout Inventory (MBI) Questionnaire as part of RN4CAST. | **Population:** Professional nurses working in psychiatric units in Gauteng and North West (N=525)  
**Sample:** All-inclusive sample (n=303). | Descriptive and inferential statistics (exploratory and confirmatory factor analysis) (SPSS, 2007). | Discussed in Chapter 3. |
**PHASE 2: ADDRESSING OBJECTIVE 3**

<table>
<thead>
<tr>
<th>OBJECTIVES</th>
<th>STEPS</th>
<th>DATA COLLECTION</th>
<th>POPULATION AND SAMPLE</th>
<th>DATA ANALYSIS</th>
<th>DESCRIPTION OF METHODS</th>
</tr>
</thead>
<tbody>
<tr>
<td>To describe a conceptual framework.</td>
<td><strong>Step 3:</strong> Describe the conceptual framework.</td>
<td>From steps 1 and 2.</td>
<td>Concepts from steps 1 and 2 and all available national and international literature survey list.</td>
<td>Inductive and deductive reasoning.</td>
<td>Discussed in Chapter 4.</td>
</tr>
<tr>
<td></td>
<td><strong>Step 4:</strong> Describe the relations between concepts.</td>
<td>From step 3.</td>
<td></td>
<td>Inductive and deductive reasoning.</td>
<td>Discussed in Chapter 4.</td>
</tr>
<tr>
<td><strong>OVERALL AIM:</strong></td>
<td><strong>Step 5:</strong> Description of the practice theory.</td>
<td>Integration and synthesis of the data.</td>
<td>Evidence from steps 1 – 4.</td>
<td>Theory construction through inductive reasoning and synthesis of the data.</td>
<td>Discussed in Chapter 5.</td>
</tr>
<tr>
<td><strong>PHASE 3</strong></td>
<td><strong>Step 7:</strong> Develop guidelines for operationalisation.</td>
<td>Evidence from all above steps.</td>
<td></td>
<td>Theory construction through inductive reasoning.</td>
<td>Discussed in Chapter 5.</td>
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</table>
1.10 RIGOUR

Rigour is the umbrella term used when describing the strategies that a researcher uses to ensure the generation of valid and scientific knowledge (Klopper & Knobloch, 2010). This concept of quantitative research is based on the principles of validity and reliability. Validity is discussed below as internal and external validity.

Internal validity is the extent to which the effects detected in the study are a true reflection of the construct being studied, rather than the result of other unmeasured variables. Any study may contain threats to internal validity, and these validity threats might lead to an incorrect conclusion (Burns & Grove, 2009:215, Grove et al., 2013:393). External validity, on the other hand, is concerned with the extent to which study findings can be generalized to other populations and other settings or context. In quantitative research, the sample size must be large enough to identify relationships between variables or to determine differences between groups and representative of the target population, so that findings can be generalized to the general population (Burns & Grove, 2009:218-219; Brink et al., 2014:101).

The reliability of a measure denotes the consistency of results obtained in the use of a particular instrument repeatedly over time on the same person, or if used by two researchers, and is an indication of the extent of random error in the measurement method (Jooste, 2010:322). It represents the consistency of the measure obtained (Grove et al., 2013:707).

A discussion on validity and reliability in research follows in Chapter 2.

1.11 ETHICAL CONSIDERATIONS

Ethical standards and principles should be adhered to by the researcher during a research project. The planning of a research project should comply with all standards set down in the recognized standards of an institution and its ethics committee. If participants are involved, the protection of the rights of the participants should be planned for as described in the Patient’s Charter (Bertram & Christiansen, 2014: 54).
Prior to conducting this research, a proposal was submitted to the Health Research Ethics Committee of the North-West University (Potchefstroom Campus), for ethical approval. The certificate number is NWU-0015-08-S1 (see Appendix A). The permission to collect data from the institutions concerned was obtained from the Provincial Department of Health: North West (Appendix C D) and the Gauteng Department of Health (Appendix E and F). Permission to collect data was also obtained from the individual participants (Appendix B ) from all the selected psychiatric institutions (Appendix G and H).

During the research, the following ethical principles were observed and respected:

1.11.1 Permission to conduct a research project

The permission to conduct a research project was obtained from North West Department of Health: North West and the Gauteng Department of Health, the psychiatric institutions where data was collected, and individual participants (professional nurses).

1.11.2 Protecting the research participants and honouring trust

The safety of the participants was ensured throughout the research and a trust relationship was maintained.

1.11.3 The right to privacy, confidentiality and anonymity

The above-mentioned ethical principle was ensured by making sure that no names are written on the questionnaire and the names of the psychiatric hospitals were represented by codes.

1.11.4 The right to justice and equality

Participants were selected for the purpose of the study only and they were all treated the same way without bias.
1.11.5 The right to protection and truthfulness

Participants were protected from any form of exploitation and only the truth related to the research was given to them.

1.11.6 The right to freedom of choice and withdrawal

The participants were informed by the researcher that they have the right not to participate in the research and may withdraw at any stage if they so choose.

1.11.7 Access to information and communication

Participants were informed that they will receive information on the outcomes of the research as soon as the process of the research has been completed.

1.11.8 Respect for persons

The autonomy of the individual participant and the right not to participate were observed throughout.

1.11.9 Beneficence (benefit to the research participants)

The right to protection from any physical or psychological discomfort and any kind of risk or harm was ensured during research.

1.11.10 Informed consent

Before participating in the research, the questionnaire was explained to the participants and they were requested to complete the consent form without coercion.

1.11.11 Preventing harm

The researcher took all precautionary measures to ensure that the participants were not harmed in any way.
1.11.12 Avoiding undue intrusion

The questionnaires were completed in a safe place without disturbance.

1.11.13 Participants’ involvement in research

Participants were informed that participation in the research was a voluntary exercise and no one is forced to be involved (Jooste, 2010:277; Grove et al., 2013:159).

1.12 STRUCTURE OF THE THESIS

Chapter 1: Overview of research study.
Chapter 2: Research design and method.
Chapter 3: Quantitative results of the study.
Chapter 4: Conceptual framework.
Chapter 5: Theory construction, theory evaluation and guidelines for operationalisation.
Chapter 6: Evaluation of the study, limitations and recommendations for nursing science, practice and research.

1.13 SUMMARY

This chapter provided a comprehensive overview of the planned research to construct a theory for positive practice environments for professional nurses working in psychiatric institutions. The background, problem statement, research questions, aim and objectives of the study were discussed. This was followed by a description of the research design and research method. Chapter 2 follows with a detailed discussion of the research design and research method.
CHAPTER 2: RESEARCH DESIGN AND RESEARCH METHOD

2.1 INTRODUCTION

This chapter discusses the research design and research method. The research method is described with specific reference to the following: data collection methods and procedures, population samples and sampling methods, data analysis methods and ensuring the validity and reliability of the study. Ethical considerations were maintained throughout. The reader is again referred to the overall aim of the research, namely to construct a theory of positive practice environment for professional nurses working in selected psychiatric institutions in South Africa.

2.2 RESEARCH OBJECTIVES

In order to achieve the overall purpose of this research, the process to reach the research objectives was divided into three phases.

Throughout the research project, the research questions directed the research objectives. During Phase 1, objectives were formulated for concept identification, classification, descriptions and definitions. Phase 2 entailed theory construction and Phase 3 theory evaluation and guidelines for operationalisation. The research objectives were as follows:

- To explore and describe the status of the practice environment in psychiatric institutions.
- To measure the prevalence of burnout among professional nurses working in psychiatric institutions.
- To describe the conceptual framework for the practice.

2.3 RESEARCH DESIGN

The purpose of this research is to construct a practice theory of positive practice environment for professional nurses working in psychiatric institutions in South Africa. According to Burns and Grove (2009:41), a research design is a blue print for maximum control over factors that could interfere with the researcher’s desired outcomes (Grove et al., 2013:692). The type of design directs the selection of the research method. The choice of research design depends on the researcher’s expertise, the problem and purpose for the research, and the desire to generalise the findings. Designs have been developed to meet unique research needs as they emerge. In this study a theory construction research design was used, which was theory-constructive, quantitative, explorative, descriptive, explanatory and contextual. Each of these elements is described below.
2.3.1 Quantitative research

Quantitative research is a form of conclusive research involving large representative samples and fairly structured data collection procedures (Creswell, 2014:163). The primary role of quantitative research is to test hypotheses. A hypothesis is a proposition (or statement) regarding the relationship between two or more variables (phenomena) and a hypothesis can be tested (Bertram & Christiansen, 2014:204). Quantitative research examines constructs (variables) that are based on the hypothesis derived from a theoretical scheme. It is a formal, objective, systematic study process to describe and test relationships and to examine cause-and-effect interactions among variables. Quantitative research normally gives a weak account of how constructs are derived. Constructs, however, are the central focus in quantitative research. To conduct quantitative research, the constructs studied must be measured. In this research the measurement of constructs was undertaken by means of questionnaires (Maslach Burnout Inventory and RN4CAST), which are discussed in 2.4.1.3. When quantitative research is conducted, the researcher should specify how the construct is measured (Struwig & Stead, 2004:4; Grove et al., 2013:706).

A quantitative style of inquiry is assumed to be inductive because the researcher infers from specific to general in the process of building abstractions, concepts and theories. This is a significant assumption inherent in quantitative approaches, which is therefore congruent with the theory constructive aspect of this research.

2.3.2 Exploratory research

Exploratory studies such as those of Wood and Ross-Kerr (2006:120); Wood and Haber (2014:202) provide an in-depth investigation of a single process, variable, or concept, such as role conflict. When the purpose of the research project is explored, a flexible research design that provides an opportunity to examine all aspects of the problem is needed. It examines the data descriptively to become as familiar as possible with the nature of the data and to search for hidden structures and theories (Grove et al., 2013:694). As knowledge of variables increases, the researcher may have to change direction. This research aimed to explore the status of the practice environments of professional nurses in psychiatric institutions as part of theory construction.

2.3.3 Descriptive

Descriptive designs examine one or more characteristics of a specific population such as psychiatric nursing in South Africa. All descriptive designs have one thing in common: to provide descriptions of the variables to answer the question. The type of description depends on how much information the researcher has about the topic prior to data collection (Wood &
Ross-Kerr, 2006:120; Wood & Haber, 2014:202). The purpose of a descriptive design is to provide a picture of a situation as it occurs naturally. In many areas of nursing, a phenomenon must be clearly delineated before prediction or causality can be examined. A descriptive design may be used to construct theory, identify problems with current practice, justify current practice, make judgements, or determine what others in similar situations are doing (Creswell, 2014:202). Variables are not manipulated, and there is no treatment or intervention. Dependent and independent variables are not appropriate for use within a descriptive design, because the design involves no attempt to establish causality (Grove et al., 2013:215). A description of the practice environment for professional nurses working in psychiatric institutions was formulated (see 1.7.2.2.).

2.3.4 Context

The context emphasises the various levels of the practice environment for professional nurses working in psychiatric institutions, namely the micro level (psychiatric hospitals), meso level (psychiatric nursing in South Africa) and the macro level (international perspective), and how dynamically these contexts interact with one another. It is closely aligned with holism, which examines social environments in their totality. The question of what the current practice environment of professional nurses in selected psychiatric institutions is was answered by the literature review (see Chapter 4). The research was limited to psychiatric institutions in two provinces in South Africa, namely North West and Gauteng. However, the consistency and similarity of psychiatric nursing practice makes inferences about applicability to other provinces in South Africa possible.

2.3.5 Theory construction

A theory is more narrow and specific than a conceptual model and lends itself to be tested (Meleis, 2012:391). It consists of an integrated set of defined concepts, existence statements and relational statements that can be used to describe, explain, predict or control that phenomenon (De Vos et al., 2013:37). Theories are also constructed to provide nurses with the rationale and the guidelines for models of care to change unwanted aspects of a phenomenon (Meleis, 2012:391). Existence statements declare that a given concept exists or that a given relationship occurs. For example, an existence statement may claim that a condition referred to as stress exists and that there is a relationship between stress and health. Relational statements clarify the relationship that exists between or among concepts. For example, a relational statement may propose that high levels of stress are related to declining levels of health. The statements contained in a theory that are tested through research, not the theory itself. Therefore, developing statements within the theory is critical to the research. There are various levels of theory namely: metatheory, grand theories, middle-range theories.
and practice theory. These levels are important in constructing a theory for positive practice environment for professional nurses working in psychiatric institutions and are discussed as follows:

2.3.5.1 Metatheory

Metatheory is the term used to designate theorising about theory and the process of developing theory. Metatheory does not address the substantive content of health sciences, except to define the types of theory appropriate within these disciplines. Its focus is on broad issues, including analysis of the purpose and type of theory needed, and on the proposal and critique of sources and methods for theory development.

2.3.5.2 Grand theories

Grand theories provide a global perspective of a discipline and its scope of practice. As a rule, these theories are so abstract that they are not amendable to direct empirical testing. Some writers consider them synonymous with conceptual models and paradigms (Wood & Haber, 2014:81).

2.3.5.3 Middle-range theories

These theories are less abstract than grand theories and more limited in scope. They usually deal with certain circumscribed phenomena such as pain, stress, coping mechanisms and chemical dependence within a clearly defined context such as psychiatric institutions. They examine a portion of reality and identifying a few key variables. Propositions are clearly formulated and testable hypotheses can be derived. Middle-range theory is generally more practical, more applicable and more easily tested, confirmed or refuted within the empirical world than in grand theories. It is the most useful theory for the development of health sciences (Brink et al., 2009:19; Wood & Haber, 2014:81).

2.3.5.4 Practice theory

Practice theory is characterised by its goal of prescriptive action for healthcare practice. Dickoff et al., (1968:202) identify four levels of practice theory based on the existing body of knowledge about a phenomenon. The lower levels are developed first and they provide a basis for the higher levels of theory. These levels are as follows:

2.3.5.4.1 Factor-isolating theory

Factor-isolating theory focuses on observing, describing and naming concepts. This leads the researcher to construct a factor-isolating or concept-naming theory. This level is also known as the “descriptive level”.

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2.3.5.4.2 Factor-relating theory

Factor-relating theory takes the isolated concepts a step further and relates them to one another as discussed in Chapter 3. Description is still the purpose of the research, but at this level it focuses on the relationships between the concepts.

2.3.5.4.3 Situation-relating theory

Situation-relating theory explains the interrelationships of the concepts or proportions. The researcher attempts to answer the question, “What will happen if the practice environment is improved?” and accordingly designs research to test the relationships.

2.3.5.4.4 Situation-producing theory

Situation-producing theory requires the specifications of an activity and its goal. This theory is also referred to as a “prescriptive theory” as it prescribes what the healthcare professional must do to attain a desired goal such as recommendations (see Chapter 6). The question here is: “How can I improve the practice environment?” Therefore, the purpose of this level of theory is prescriptive (Brink et al., 2014:19-21).

According to Chinn and Kramer (2008:26), theory construction is a multi-step process, where empirical evidence is used in “an interrelated system of ideas” (Walker & Avant, 2005:135). During theory construction, the focus is on the constructs of research, in other words concepts, statements and conceptual frameworks, followed by the systematisation of statements to classify, describe typologies and models or explain theories (Mouton, 2015:188). The process of theory construction is based on direct and indirect observation, empirical research and literature. It is a continuous written discourse that depends on deductive and inductive logic, concept analysis and statement synthesis. The main and related concepts to a theory for positive practice environments for psychiatric nurses working in psychiatric institutions in South Africa were identified and described. Thereafter, statements were synthesized between the described concepts, and a practice theory was constructed.

2.3.5.5 Elements of theory construction

It is necessary to understand the elements of theory and the basic approaches to building these elements as it is of paramount importance to the process of theory construction. Walker and Avant (2011:58) propose three basic elements of theory (see table 2-1), which when cross-tabulate with three overall approaches to theory construction and provide a useful strategic guide to theory construction. These elements include:

**Concepts**, generally referred to as a mental picture or an idea about a thing or an action, are the basic building blocks of a theory. The functionality of concepts is enhanced when
relationships can be stated between two or more concepts, such as practice environment and burnout (Walker & Avant, 2011: 59).

A concept is a procedure for labelling or naming a symbolic statement for describing a phenomena or class of phenomena (Masters, 2015:4). Concepts are single abstract ideas, often expressed in a single word that represents two or more interrelated ideas. A concept can represent a single group of observations or facts that are closely linked to one another in a distinguishable pattern (Mouton, 2015:117). Research can be done on one concept and its component parts, but the interconnections between the ideas, which form the basis for the research, must be discussed (Wood & Ross-Kerr, 2006:30). Concepts differ from constructs in that constructs are abstractions that are deliberately and systematically invented (or constructed) by researchers or theorists for a specific purpose. For example, self-care in Orem’s model of health maintenance is a construct. The term construct and concept may be used interchangeably, although by convention, a construct often refers to a slightly more complex abstraction than a concept (Wood & Ross-Kerr, 2006:30).

**Statements** are the second element of theory and can be stated as either relational or non-relational. Relational statements, according to Walker and Avant (2011:60), specify an association of some kind between two or more concepts, such as work environment and job satisfaction. Non-relational statements, on the other hand, assert the existence of or define a concept. These statements serve as adjuncts to each other and in so doing, help to form meaningful connections needed to construct a theory.

A **theory** therefore is a representation of a set of relational statements that are internally coherent and used to express new insights into a phenomenon of interest (Walker & Avant, 2011:61).

Concepts and statements are integral to theories, and as such, theory construction often begins with these basic elements. Furthermore, Chinn and Kramer (2008:185) state that the process of theory construction requires creative and rigorous structuring of concepts, which in turn are conveyed as relationship statements. Creating conceptual meaning is the basis of theory development, which is ultimately aimed at presenting a systematic view of the phenomena being explored. In this research, the phenomenon professional nurse was explored within the context of psychiatric institutions, and this resulted in a systematic theory construction.
Table 2-1  
Cross-tabulation of elements of a theory with approaches to theory construction (adapted from Walker & Avant, 2011:65; Bruce, 2003:28)

<table>
<thead>
<tr>
<th>ELEMENTS OF THEORY</th>
<th>APPROACHES TO THEORY CONSTRUCTION</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Analysis</td>
</tr>
<tr>
<td></td>
<td>Use: To clarify/refine existing</td>
</tr>
<tr>
<td></td>
<td>concept.</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Use: To clarify/refine a body</td>
</tr>
<tr>
<td></td>
<td>of statements.</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Use: To clarify/refine an</td>
</tr>
<tr>
<td></td>
<td>existing theory.</td>
</tr>
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<td></td>
<td></td>
</tr>
</tbody>
</table>

Because of the different, yet convergent proposed processes for theory construction, the researcher decided on a process that would enable meaningful, contextual theory construction applied in this research (Table 2-2). Successful theory construction is not confined to just one strategy and does not have to be sequential, but can be reiterative (Walker & Avant, 2011; 65). The detail of each strategy used in the process of theory construction in this research is addressed in the research methods (see 2.4).

Table 2-2  
A comparison of processes for theory construction according to Bruce (2003:29) as applied to this research

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Concept construction:</td>
<td>Creating conceptual meaning.</td>
<td>Concept construction:</td>
</tr>
<tr>
<td>• Concept analysis.</td>
<td></td>
<td>• Concept definition and</td>
</tr>
<tr>
<td>• Concept synthesis.</td>
<td></td>
<td>descriptions</td>
</tr>
<tr>
<td>• Concept derivation.</td>
<td></td>
<td><strong>Rationale:</strong> to develop concepts</td>
</tr>
<tr>
<td></td>
<td></td>
<td>based on empirical evidence.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Structural and contextualising</td>
</tr>
<tr>
<td></td>
<td></td>
<td>theory.</td>
</tr>
</tbody>
</table>
Statement construction:
- Statement analysis.
- Statement synthesis.
- Statement derivation.

Generating and testing theoretical relationships.

Statement construction:
- Statement synthesis

Rationale: to specify relationships between concepts developed.

Theory construction:
- Theory analysis.
- Theory synthesis.
- Theory derivation.

Deliberate application of theory.

Theory construction:
- Theory synthesis

Rationale: to express new insights into the phenomenon.

2.4 RESEARCH METHODS

The research methods included data collection techniques, instruments and procedures, population, samples and sampling methods, data analysis and rigour. These methods are discussed as they were applied during the three phases in which this research was realised.

2.4.1 Phase 1: Concept identification, classification and description

Concept identification entails all the major ideas in a theory. All relevant terms that reflect those ideas, should be clearly stated and defined (Walker & Avant, 2011:196). Concept identification is the first step towards a conceptual framework and it was realised in this research when participants completed the questionnaire. This was followed by concept classification, where the survey list by Dickoff et al. (1968:420) was applied. The function of a level one theory (factor isolation theory) requires that concepts should be classified. The survey list is presented and applied in Table 2-3 and the details are discussed in Chapter 4.

Table 2-3: Survey list by Dickoff et al. (1968) for concept classification applied to this research

<table>
<thead>
<tr>
<th>Categories</th>
<th>Description</th>
<th>Application to this research</th>
</tr>
</thead>
<tbody>
<tr>
<td>Agent</td>
<td>The person who executes or creates a particular activity.</td>
<td>Nurse manager</td>
</tr>
<tr>
<td>Recipient</td>
<td>The person who receives the activity.</td>
<td>Professional nurse</td>
</tr>
<tr>
<td>Context</td>
<td>The situation or setting in which the activity takes place.</td>
<td>Psychiatric hospital</td>
</tr>
<tr>
<td>Goal</td>
<td>The outcome or end point to be reached through implementing the activity.</td>
<td>Improved staff outcomes</td>
</tr>
<tr>
<td>Procedure</td>
<td>The guide, technique or protocol to be followed to achieve the goal.</td>
<td>Positive practice environment</td>
</tr>
<tr>
<td>Dynamic</td>
<td>The energy source or the ingredient to drive the activity towards achieving the goal.</td>
<td>Motivation</td>
</tr>
</tbody>
</table>
Data collected from Phase 1 was used to meet the first two objectives of the research, which were:

- To explore and describe the status of the practice environment in psychiatric institutions.
- To measure the prevalence of burnout among professional nurses working in psychiatric institutions.

The following phases within the research process was followed during this research:

| Phase 1 (Chapter 3) | • STEP 1: Data collection: Practice Environment Scale of the Nursing Work Index (PES-NWI).
|                     | • STEP 2: Data collection: Maslach Burnout Inventory (MBI) and part of Registered Nurses Forecast (RN4CAST). |
| Phase 2 (Chapters 4 and 5) | • STEP 1: Describe the conceptual framework of the practice theory.
|                     | • STEP 2: Develop relational statements.
|                     | • STEP 3: Construct a practice theory of positive practice environment for professional nurses working in psychiatric institutions. |
| Phase 3 (Chapters 5 and 6) | • STEP 1: Evaluation of the theory.
|                     | • STEP 2: Formulate guidelines for the operationalisation of the theory. |

### 2.4.1.1 The role of the researcher

As a researcher, had to ensure that ethical clearance is obtained from the Health Research Ethics Committee of the North-West University (Potchefstroom Campus) and that research protocols are observed. The researcher ensured that ethical consideration is noted and respected throughout the research. Permission to conduct the research was requested and obtained from the Director of research, policy planning, monitoring and evaluation from the North West Provincial Department of Health and Gauteng Department of Health. The researcher also had to request permission to conduct the research from the heads of the health establishments where the research was conducted. The researcher had to ensure that instruments (questionnaires) (Appendix I) are available and adequate for data collection. The Chief Executive Officers and the nursing service managers of the identified health establishments were informed in advance about my visit so that they could inform the participants about my coming. When entering the hospitals, the researcher reported to the hospital management before he could proceed to the units. Aspects related to ethics were explained to the participants and permission to participate was obtained by signing the consent form. After the questionnaires had been completed by the participants, the researcher thanked them for participating in the research. The questionnaires were kept safe and sent to the statistician for analysis. The research results were used for constructing the practice theory for professional nurses working in selected psychiatric institutions.
2.4.1.2 Study setting, population and sample

The study was conducted at two provinces namely Gauteng and North West provinces. A total of four psychiatric hospitals were selected, two from each province. All acute psychiatric units, chronic psychiatric units, psychiatric rehabilitative units and units for patients with moderate to severe intellectual disability were included in the research. The number of units/wards that was targeted to participate in the research were as follows: Hospital A =12, Hospital B =13, Hospital C =17. Hospital D=29. A total of 71 units/wards was expected to participate in the research and 69 participated, N=71 and n=69.

According to Polit and Beck (2008:337), a population is the entire aggregation of cases in which the researcher is interested and a sample is a subset of a population selected to participate in a study. Two psychiatric hospitals from each province were selected. The participants and the settings that were considered relevant to the study were included in the sample. The participants and the settings that were selected provided the better opportunity for collecting the most relevant data about the phenomenon under study.

The population for this research included:

Professional nurses working in public psychiatric hospitals in the North West and Gauteng, trained as general nurses with experience in a psychiatric setting and professional nurses with an additional qualification in psychiatric nursing. The professional nurses also had a good command of English.

The aim and objectives of the research already indicated the researcher’s study population, which are professional nurses working in psychiatric institutions. Threats to voluntariness can arise from vulnerabilities of potential research participants because they are open to exploitation (Botma et al., 2010:6).

Sampling was realised as follows:

The sampling of professional nurses took place in two stages. In stage one, an all-inclusive sample of 525 professional nurses (N=525) was invited to participate in the research. A total of 303 professional nurses (n=303) completed the questionnaire, which resulted in the response rate of 57, 7%.

2.4.1.3 Sampling

For various reasons, one cannot usually collect data on all of the target population of a particular study. First, it is unlikely that the whole population would agree to be in the study. Second, there are usually limitations related to time and the budget. It is better to use limited resources to acquire a smaller amount of accurate data rather than large quantities of thin
data. It is therefore customary to study only a part of the target population. This part of the population is called a sample (Brynard et al., 2014:56). Using a sample often allows you to carry out all of the data collection yourself, thereby increasing your control and avoiding the complication of differences among data collectors. The part of the population used for sample selection is a sampling unit, for example, a hospital, a person, or a patient's chart (Taylor et al., 2006:202). In this study, the sample comprised of professional nurses (inclusion criteria) working in selected psychiatric institutions. Other categories of nursing such as enrolled nurses and auxiliary nurses were excluded (exclusion criteria). Figure 2.1 shows the process of sampling.

**Figure 2-1: Process of sampling**

### 2.4.1.4 Data collection

After the researcher obtained ethics clearance from the North-West University’s ethics committee and permission from the North West and Gauteng Provincial Departments of Health, data were collected from the selected psychiatric institutions over a period of 14 weeks from January 2011 to March 2011. The nursing service managers of each psychiatric institution were informed at least two weeks in advance of my visit because the permission to conduct the research was received from the chief executive officer (CEO) of each institution long before that time. It was important to inform the service manager about my visit so that
he/she could inform the professional nurses in the respective units. As part of a courtesy protocol, the researcher reported to the office of the health service manager at every visit, so that he/she could be aware of my presence at the institution. As the researcher moved from one unit/ward to the other, he showed participants a letter of permission signed off by the CEO. Thereafter the researcher introduced himself and gave a brief explanation of the research, including its purpose and the data collection instrument. Participating professional nurses were given an informed consent form to indicate their voluntary participation.

During data collection, the researcher was assisted by fieldworkers. The questionnaires were introduced and explained to each fieldworker so that she could have a better understanding and be conversant on the instrument. After visiting all the units, some questionnaires were handed to fieldworkers to distribute to those professional nurses who were off during the day visits and those working night duty. Any uncertainty related to the questionnaire was directed to the researcher for clarification and further management. It should be noted that the researcher was not an employee of all the identified psychiatric hospitals. Ethical consideration was explained to participants so that they could be familiar with their rights during the study. After completing the questionnaires, they were put in an envelope by the participants, sealed and handed to the fieldworkers. There was regular contact with the fieldworkers to identify and iron out any challenge. Fieldworkers were also tasked with the responsibility of distributing and collecting questionnaires during my absence.

During data collection, step one and two aimed to describe the context in which the research was conducted. Information was gathered to create a demographic profile of psychiatric units in public hospitals in the North West and Gauteng provinces. The data were collected from the context in which the research participants operate, namely the psychiatric practice environment.

For **step one**, I collected data on the following variables in each of the selected units: the type of the unit (long-term, short-term, rehabilitation, admission) and number of nurses registered with the South African Nursing Council (SANC) as general nurses with experience in psychiatric nursing or general nurses with an additional qualification in psychiatric nursing. The demographic characteristics of the units that took part in the research are described in Chapter 3.

In **step two** of phase one, the current practice environment of professional nurses working in selected psychiatric institutions was described by using a reliable and a valid instrument. This instrument is called the Practice Environment Scale of the Nursing Work Index (PES-NWI) (Lake, 2002). As mentioned in Chapter 1, the PES-NWI was administered as part of the instrument used in the Registered Nurses Forecast (RN4CAST) research programme aimed
at developing a human resource forecasting model in nursing. The PES-NWI was derived from the Nursing Work Index (NWI), a nurse survey that measures the organizational characteristics of hospitals that seem to attract and retain nurses even though there is shortage of nurses (Chabedi, 2010:6). This instrument can be summarised as follows:

SECTION A: ABOUT YOUR JOB
This section assessed the practice environment of professional nurses. Statements pertaining to job satisfaction were put forward, for example: “Adequate support services allow me to spend time with my patients”. The participants were expected to indicate to what extent they agree or disagree with the statement as described in Chapter 3.

SECTION B: QUALITY AND SAFETY
In section B, professional nurses were asked to respond to statements related to quality and safety of nursing rendered to psychiatric patients in their respective psychiatric units, for example “In general, how would you describe the quality of nursing care delivered to patients in your unit/ward? Participants were expected to indicate poor, fair, good or excellent in the Practice Environment Scale of the Nursing Work Index.

SECTION C: ABOUT YOUR MOST RECENT SHIFT AT WORK IN THIS HOSPITAL
This section assessed the number of hours and the number of patients allocated in the unit during the most recent shift. For example, “Write in the box the number of hours you worked on your most recent shift in this hospital”.

SECTION D: ABOUT YOU
In this section the demographic information of professional nurses working in selected psychiatric institutions was assessed, for example “What is your gender/age?”; “How satisfied are you with your choice of nursing as a career?”. Participants were expected to indicate the extent to which they are satisfied for choosing nursing as a career in the Practice Environment Scale of the Nursing Work Index.

To evaluate the level of burnout among professional nurses, the Maslach Burnout Inventory (MBI) was used. This instrument can be summarised as follows:

Maslach and Jackson (1981) developed the Maslach Burnout Inventory (MBI), consisting of 22 items that load onto the three-factor structure: emotional exhaustion (EE; nine items); depersonalisation (DP; five items), and personal accomplishment (PA; eight items). The results of this inventory consisted of three separate scores, one for each factor. A combination of high scores on EE and DP, and a low score on PA corresponded to a high level of burnout.
According to Maslach et al., 1996. From the 525 professional nurses targeted to complete the questionnaire, 303 managed to complete it (n=303).

### 2.4.1.5 Data analysis

Once the researcher had collected the data, the next step involved the analysis of the data collected (Terry, 2012:169). According to Pretorius (2009:44), data analysis is the process of microscopic examination of data during which the researcher conducts a detailed, line-by-line analysis to generate the initial categories and potential relationships between these categories. During the initial coding of the data, the researcher analytically compared data, and it is within this process that the researcher entered the scene with no preconceived ideas. Coding was the first step to be considered in analyses. Coding is the process by which the researcher identified and named concepts (Gerrish & Lacey, 2007:198). It is the process that converted the data into numbers entered into a database in an analyses-friendly format (Taylor et al., 2006:258). Coding as a means of categorising is a symbol or abbreviation used to classify words or phrases in the data. Codes may be placed in the data at the time of data collection and/or when entering data into the computer. Through the selection of categories, or codes, the researcher defined the domain of the research. Therefore, it is important that the codes were consistent with the research’s philosophical base. Later in the research, coding progressed to the development of a taxonomy (Burns & Grove, 2009:522).

### 2.4.2 Concept development, relational statements and theory construction

As mentioned earlier, theories are made up of definitions and relational statements that can be represented in a graphical form and should be constructed in a systematic manner in this research. The strategies to construct a practice theory were selected according to the guidelines provided by Chinn and Kramer (1995 & 2008), and Walker and Avant (2014) as indicated in Table 2.1 and those applied in this research indicated in Table 2.4.

#### 2.4.2.1 Concept development

According to Chinn and Kramer (1995:90), problems associated with conceptual meaning often underlie other problems involved in constructing a theory. A major challenge with respect to constructing and testing theoretic relationships is the selection of empiric indicators for a concept. When research reports give conflicting results, the differences are sometimes tied to the use of different definitions and empiric indicators for the concept. If one explores the conceptual meanings within research reports, one can often classify the extent to which various conceptual meanings account for the differing research findings. As one carries out the processes for creating conceptual meaning, one will be able to suggest a full range of possible empiric indicators for a concept and be able to identify the limits of empiric
approaches in specifying indicators for a phenomenon. Conceptual meaning is fundamental if you must distinguish one concept from another closely related one. The process of creating conceptual meaning makes it possible to propose differentiating features that guide research and theory-structuring activities (Mouton, 2015:110).

**Concept synthesis** is based on observation or empirical evidence. The data may come from direct observation, quantitative evidence, literature, or some combination of the three. The concept of concept synthesis is one of the most exciting ways of beginning theory construction. It permits the theorist to use clinical experience as one place to begin (Walker & Avant, 2014:111).

### 2.4.2.2 Statements development

The development of a concept may be an end result for some theorists and an interim stage for others, one leading to further development of a concept through statement development or research implementation. However, concept development may not be possible because the situation requires statement development.

During statement development, explanations related to the phenomenon are provided. The explanations link concepts, antecedents, consequences, and assumptions. Statements are developed to describe, explain, prescribe, or predict, and are developed as an end result or to synthesise other statements for research purposes.

To develop statements, several questions may be helpful. Examples are:

- In what ways can we further explicate the concept being considered?
- In what ways are nursing clients’ health and environment affected by the concept?
- What are some corollaries of the concept? (Meleis, 2012:386).

**Statement synthesis** is aimed at specifying a relationship between two or more concepts based on evidence. The evidence may come from various sources such as qualitative or quantitative methods like observations, interviews of individuals or groups, or literature-based sources such as literature reviews, conclusions extracted from interrelated studies as indicated in Chapters 3 and 4, standards of practice, or practice guidelines as indicated in Chapter 6. Statement synthesis involves two operations, namely moving from evidence to inferences, and then generalising from specific inferences to more abstract ones. In the first of these operations, evidence comprises a thoughtful series of observations that are the basis of interrelating concepts such as positive practice environments and professional nurses (Walker & Avant, 2014:123).
2.4.2.3 Theory construction

Nursing is a practice discipline. Nurses engage in providing complex healthcare to patients at every level of health and illness, at every life stage, and in diverse settings such as psychiatric institutions. From acute care hospital units to public health clinics, to classrooms in schools of nursing, to nursing research laboratories, nurses deal with knowledge to improve the health and well-being of individuals, families, and communities. How does theory construction relate to the complex dimensions of nursing as a practice discipline? Does theory shape practice, or is practice the shaper of nursing theory? Is there such a thing as a unique nursing theory? How should nursing theory influence the research process? Are there different kinds of theory? Such questions are constantly asked in nursing (Walker & Avant, 2011:3). A simple view of theory construction is that it provides a way to identify and express key ideas about the essence of practice. Theory construction may explore that essence. That exploration may be focused on specific practice settings such as psychiatric institutions or population such as professional nurses.

Theory synthesis is aimed at the construction of a theory, an interrelated system of ideas from evidence. In this strategy, a theorist pulls together available information about a phenomenon. Concepts and statements are organized into a network or whole, a synthesized theory. Theory synthesis involves three steps or phases:

- specifying focal concepts to serve as anchors for the synthesized theory,
- reviewing the literature to identify factors related to the focal concepts and to specify the nature of relationships, and
- organising concepts and statements into an integrated and efficient representation of the phenomena of interest (Walker & Avant, 2014:146).

Theory synthesis results in a more complex representation of phenomena than concept or statement synthesis. This is true for several reasons. In contrast to concepts, which serve to highlight phenomena of interest, theories demonstrate the connections among concepts. Further, theories simultaneously embrace more aspects of phenomena and integrate them more thoroughly than statements. A statement may link only two or three concepts together. By contrast, a theory may connect a number of concepts to each other and specify complex direct and indirect linkages among concepts, such as positive practice environments, burnout and professional nurses (Walker & Avant, 2014:146).
Table 2-4: Approach to theory construction

<table>
<thead>
<tr>
<th>ELEMENT OF THEORY</th>
<th>RESEARCHER’S APPROACH TO THEORY CONSTRUCTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Concept development</td>
<td><strong>Strategy:</strong> Concept synthesis. Use: To identify concepts based on empirical data from questionnaires.</td>
</tr>
<tr>
<td></td>
<td><strong>Rationale:</strong> Available concepts were limited and not explored.</td>
</tr>
<tr>
<td>Statement development</td>
<td><strong>Strategy:</strong> Statement synthesis. Use: To construct relationships through relational statements between two or more concepts developed above.</td>
</tr>
<tr>
<td></td>
<td><strong>Rationale:</strong> Evidence available of data from questionnaires and from literature.</td>
</tr>
<tr>
<td>Theory construction</td>
<td><strong>Strategy:</strong> Theory synthesis. Use: To pull together relational statements in a coherent manner to represent the practice theory for professional nurses.</td>
</tr>
<tr>
<td></td>
<td><strong>Rationale:</strong> Availability of systematically developed statements.</td>
</tr>
</tbody>
</table>

2.4.2.3.1 Structure of the theory

Structuring the theory, Chinn and Kramer (1995:91) involved forming systematic linkages between and among concepts, resulting in a formal theoretic structure. There are many approaches that can be used. The choice of a particular approach depends on the purpose of constructing the theory, what you already know or assume to be true, and your underlying philosophic ideas about the nature of nursing philosophy. Approaches to structuring the theory include:

- **Identifying and defining the concepts**

Specify the idea on which the theoretic structure is built. Definitions can evolve from the process of creating conceptual meaning, borrowed from other theories, or formulated from multiple other sources. They should identify as clearly and concisely as possible the theoretic meaning of important concepts within the theory.

- **Identifying assumptions**

Classify the basic underlying truths from which and within which theoretic reasoning proceeds.

- **Classifying the context within which the theory is placed**

Contextual placement describes the circumstances within which the theoretic relationships are expected to be empirically relevant. Clear statements regarding context are particularly important if the theory is to be applied in practice, like in the case of this study.
• Designing relation statements

Designing theoretic statements describes the projected and evolving relationships between and among the concepts of the theory. This conceptual framework of the practice theory is discussed in Chapter 4. These statements, taken as a whole, provide the substance and the form of the practice theory (Chinn & Kramer, 1995:92).

2.4.2.3.2 The process of theory construction

The process of theory construction (Meleis, 2012:448) is a means of facilitating the evolution of nursing science and is the most critical task facing the nursing profession”. Theory construction is discussed in Chapter 5.

2.4.2.4 Guidelines for operationalising the theory

The deliberate application of the theory ensures the achievement of practical goals and involves evidence collection to examine its effect on the practice setting (Bruce, 2003:43). The data for the writing of guidelines for operationalisation was obtained from conclusion statements through deductive and inductive reasoning. A description of these guidelines is outlined in Chapter 6 for the practice theory.

2.5 DESCRIPTION AND EVALUATION OF THE THEORY

According to Chinn and Kramer (2008:126), when evaluating a theory, critical reflection contributes to understanding how well the theory relates to practice, research, or educational activities. Members of a discipline form ideas about what questions to ask and what responses are generally accepted for a theory to be valuable for the discipline. Just as there are many ways to describe theory, there are many critical questions that can be asked about the functional value of theory and many responses to these questions. Once the questions are asked, members of a discipline can consider what responses they tend to value and why. The questions that are suggested are organized around characteristics of theory. These characteristics form the basis for considering the merits and shortcomings of a theory in relation to some purpose. The questions posed are consistent with generally accepted methods for evaluating theories that have been described in the nursing literature. A theory is examined with respect to each of the questions and the responses to the questions are used to form conclusions about how well the theory serves some purpose. The questions for critical evaluation of the theory are:

• How clear is the theory?
• How simple is the theory?
• How general is the theory?
• How accessible is the theory?
• How important is the theory?

2.5.1 Panel of experts

Evaluators with expertise in the construction of a practice theory were chosen to assess the theory. The researcher himself also conducted a self-evaluation. The questions asked in 2.5 above were used as criteria for evaluating the theory. The criteria can be summarised as follows (see Chapter 6):

• **Clarity** refers to how well the theory can be understood and how consistently the ideas are conceptualized. The evaluators will be considering semantic clarity, semantic consistency, structural clarity and structural consistency. Semantic clarity and consistency primarily refers to the understandability of theoretic meaning as it relates to concepts. Structural clarity and consistency reflect the understandability of connection between concepts within the theory and the whole of the theory.

• **Simplicity** means that the number of elements within each descriptive category, particularly concepts and their interrelationships, are minimal.

• **Generality** of a theory refers to its breadth of scope and purpose. A general theory can be applied to a broad array of situations. Parsimony is sometimes used as a synonym to describe the trait of theoretic simplicity, but the concept of parsimony also includes the idea of generality. A parsimonious theory is conceptually simple, but accounts for a broad range of empiric experiences.

• **Accessibility** addresses the extent to which empiric indicators can be identified for concepts within the theory and how attainable the projected outcomes of the theory are. If a theory will be used for explaining and predicting some aspect of the practice world. Concepts can move toward increased empirical accessibility through generating and testing relationships, deliberately applying the theory and clarifying conceptual meaning.

• The **importance** of a theory is closely tied to the idea of its clinical significance or practical value. An important theory is forward-looking, useful and valuable for creating a desired future. The central question is: Does the theory create a reality that is important to nursing? (Chinn & Kramer, 2008:127-134).
2.6 ETHICAL CONSIDERATIONS

The health professions have taken very seriously the importance of ethical considerations in research and practice. There are standards, codes and guidelines that are designed to assure ethical practice in collecting and handling data from human beings. These guidelines address issues such as protection of the dignity and privacy of patients and research subjects and the security of participants’ information. Examples of guidelines are American Nurses Association’s (ANA) Code of ethics with interpretive statements, the American Medical Association’s Code of Medical Ethics and the National Academy of Science guidelines for the responsible conduct of research Health Professions Council of South Africa (HPCSA, 2008:2; Waltz et al., 2010:401).

In accordance with these basic ethical principles, researchers are obliged to recognize and protect the basic rights of subjects in measurement activities. Important ethical dimensions of measurement activities include informed consent, permitting refusal to participate or ability to withdraw without fear of adverse consequences, privacy, confidentiality, anonymity and protection from harm. Measurement-related issues and responsibilities for each of these areas will be addressed.

2.6.1 Informed consent

Informed consent (see Appendix B) applies to many types of patient-professional interaction. It occurs if a patient or research subject who has substantial understanding of what he or she is being asked to do, and who is not being controlled or coerced to do so by others intentionally, authorises a professional to do something. Essential elements of informed consent are: competence of the subject to consent (a precondition), disclosure of information, the subject’s understanding of the information being disclosed, volition or choice in the consent and authorization of consent (Cleaton-Jones & Wassenaar, 2010:715; Waltz et al., 2010:402; Creswell, 2014:97).

2.6.2 Refusal or withdrawal

A generally accepted ethical position is that research subjects should be free to refuse to participate or withdraw from participation without recrimination or prejudice. The ability to refuse or withdraw is necessary to ensure that consent to participate in a measurement activity is given voluntarily. As noted previously, potential research subjects should be informed of this right at the time their informed consent is solicited, and subtle pressures to participate should be avoided. Special attention is required to ensure that no negative consequences stem from refusal or withdrawal from research related measurement activities (Waltz et al., 2010:405; Creswell, 2014:97).
2.6.3 Privacy

The principle of privacy, which is related to the principle of respect for persons and beneficence/ no maleficence, also has many implications for measurement. Although defined in a variety of ways, the right to privacy asserts essentially that an individual should be able to decide how much of himself or herself (including thoughts, emotions, attitudes, physical presence and personal facts) to share with others. It is also important to assure that the information shared or revealed by the individual is not used in a way that will cause harm (DoH, 2006:10; Waltz et al., 2010:406).

2.6.4 Confidentiality and anonymity

Closely related to the principle of privacy and included in the provisions of Health Insurance Portability and Accountability Act (HIPAA), is the ethical assertion, reflected in the codes of professional associations, which the anonymity of subjects be preserved whenever possible and that information that would allow identification of the subjects be held in confidence by the professional. This right not only protects the subject, but also has the important measurement implication of increasing the likelihood that responses will be more truthful and complete. Generally, the principle of anonymity has been operationalised in research by ensuring that subjects will not be identifiable in public reports by name or any other defining characteristics (Waltz et al., 2010:408; Creswell, 2014:98).

Ethics is a system of morals, rules of behaviour that provide researchers with a code of moral guidelines on how to conduct research in a morally acceptable way. Such guidelines seek to prevent researchers from engaging in scientific misconduct. Ethical principles such as respect, justice, autonomy, consent, confidentiality and beneficence were taken into cognizance during the process of the research. The researcher showed respect for the participants throughout data collection. Justice was displayed by being fair and honest with the participants. Participants were allowed to make decisions and choices that suit them. Before the process of data collection, participants were informed about the purpose of the research and were given permission to participate or not to participate and a consent form was signed to indicate that they are voluntarily participating in the research. Confidentiality was maintained by informing participants not to write their names on the questionnaires and not to write the name of the psychiatric institution where they are working. Permission to conduct research was also obtained from the provincial Department of Health North West and Gauteng and from heads of institutions where the research was done. Ethical consideration was also discussed in Chapter 1.
2.7 RIGOUR

Ethical rigour requires the researcher to recognize and discuss the ethical implications related to the conduct of the study. Consent is obtained from the study participants and documented. The report must indicate that the researcher took action to ensure that the rights of the participants were protected during the consent process, data collection, analysis and communication of the findings. The research should examine the consent process, the data gathering process, and the results for potential threats to ethical rigour. Rigour is the striving for excellence in research and involves discipline, scrupulous adherence to detail, and strict accuracy. A rigorous quantitative researcher constantly strives for more precise measurement methods, structured treatments, representative samples, and tightly controlled study designs (Grove et al., 2013:36).

2.7.1 Validity

Instrument validity seeks to ascertain whether an instrument accurately measures what it is supposed to measure, given the context in which it is applied, for example PES-NWI was measuring nurse participation in hospital affairs, nursing foundations for quality of care, nurse manager ability, leadership and support of nurses, staffing and resource adequacy and collegial nurse-physician relation for the practice environment in psychiatric institutions. Unless the researcher can be sure that the instruments are actually measuring the things they are supposed to be measuring, he cannot be certain of what the results mean. (Brink et al., 2009:162; Bertram & Christiansen, 2014:54). Furthermore, it implies that the instrument should be considerate of the differences that exist within the psychiatric practice environment.

2.7.2 Reliability

The reliability of the research instrument is a further concern of the researcher when collecting data. Reliability refers to the degree to which the instrument can be depended upon to yield consistent results if used repeatedly over time on the same professional nurses, or if used by two researchers. The reliability of an instrument is indicated by a correlation measure, which varies between 0 and 1. The nearer the measure was to 1, the higher the correlation (Brink et al., 2014:163; Bertram & Christiansen, 2014:186). Considering the correlation coefficients in Table 3.4, all the factors of the PES-NWI are positively and strongly correlated with each other, with correlation coefficients ranging from \( r = 0.435 \) (collegial nurse physician relations and staffing and resource adequacy) and higher. The strongest correlation is between nursing foundations for quality of care and nurse participation in hospital affairs (\( r = 0.922 \)).
2.8 SUMMARY

In Chapter 2, a discussion on research methodology unfolded. This included the role of the researcher, population and sample, sampling, data collection, data analysis, description and evaluation of the theory. Ethical aspects in research were considered including rigour, validity and reliability. The reader received an overview of the elements of a theory and the process and strategies of theory construction, applied to this research. Chapter 3 presents the quantitative results of the study.
CHAPTER 3: QUANTITATIVE RESULTS OF THE RESEARCH

3.1 INTRODUCTION

Chapter 2 provided an overview of the research methodology. Chapter 3 presents the quantitative results of the research, including the materialisation of the sample, demographic descriptives, construct validity, reliability of the instruments and the relationship among the variables. The PES-NWI and MBI refer to registered nurses while professional nurse is used elsewhere in the thesis. Registered nurse and professional nurse are used interchangeably.

3.2 REALISATION OF RESEARCH SAMPLE

The target group for the research was professional nurses. The research was conducted in two provinces of South Africa, namely the North West and Gauteng. All-inclusive sampling was used at all the levels of selection. All the psychiatric hospitals in the two provinces were included, and at each hospital, all units and all staff working in each unit were selected. The multi-level sampling approach is explained in detail below:

3.2.1 Provinces participating in the research

Gauteng was purposively selected because it is the most densely populated province with the highest number of professional nurses on the SANC register (SANC, 2014b) and with two large psychiatric institutions (hospitals). The North West was purposively selected because it also has two large psychiatric institutions (hospitals), but it has the second lowest population and the second lowest number of professional nurses on the SANC register (SANC, 2014b). This provides two extremes and allows greater generalisability.

3.2.2 Hospitals participating in the research

All-inclusive sampling of psychiatric hospitals in Gauteng and North West provinces was applied. In total, four (4) psychiatric hospitals were included in the research, two from Gauteng and two from the North West provinces.

3.2.3 Wards participating in the research

All acute psychiatric units, chronic psychiatric units, psychiatric rehabilitative units and units for patients with severe intellectual disability were included in the research. Please refer to section 1.7.2.3 for an explanation of these units. The number of wards that participated in the research was as follows: Hospital A = 12, Hospital B = 13, Hospital C = 17 and Hospital D = 29. A total of 71 wards participated in the research.
3.2.4 Nurses participating in the research

In consultation with the nursing service manager of each participating hospital, the total number of professional nurses identified was 525 (N). All-inclusive sampling was applied to the professional nurses, and a total of 303 (n) nurses completed the surveys, with a response rate of 57.7%. This response rate was higher than that of a recent national study among professional nurses in South Africa, where the response rate was below 50% (Coetzee et al., 2012:164).

3.3 DEMOGRAPHIC PROFILE OF PROFESSIONAL NURSES

The demographic profile of the research participants is presented in Table 3.1

<table>
<thead>
<tr>
<th>Table 3-1: Professional nurses’ demographic characteristics (n=303)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Age (mean ± SD)</strong></td>
</tr>
<tr>
<td><strong>Years in nursing (mean ± SD)</strong></td>
</tr>
<tr>
<td><strong>Number (%)</strong></td>
</tr>
<tr>
<td>Female</td>
</tr>
<tr>
<td>Male</td>
</tr>
<tr>
<td><strong>EDUCATION</strong></td>
</tr>
<tr>
<td>Diploma in Nursing</td>
</tr>
<tr>
<td>Baccalaureate degree in Nursing</td>
</tr>
<tr>
<td><strong>SATISFACTION WITH NURSING AS CAREER CHOICE</strong></td>
</tr>
<tr>
<td>Very dissatisfied</td>
</tr>
<tr>
<td>A little dissatisfied</td>
</tr>
<tr>
<td>Moderately satisfied</td>
</tr>
<tr>
<td>Very satisfied</td>
</tr>
</tbody>
</table>

From the above table it is clear that the average age of professional nurses is 40 years. This is younger than the national average, where 77% of nurses are between 40-69 years of age (SANC, 2014a). In line with national statistics, there are more female professional nurses than male professional nurses (SANC, 2014b) and more professional nurses with diplomas than with degrees (SANC, 2014c). Interestingly, 81.9% of professional nurses are moderately to very satisfied with their career choice.

3.4 CONSTRUCT VALIDITY

Construct validity measures the relationship between the instrument and the related theory (Botma et al., 2010:175). According to Grove et al. (2013:200), construct validity examines the fit between the operational definitions (methods of measurement) and the theoretical constructs. In this research exploratory and confirmatory factor analyses were used to ensure construct validity.
Exploratory factor analysis is the analysis of data to examine relationships among the various items of the instrument. Items that are closely related are clustered into a factor. The researcher had to pre-set the minimum loading for an item to be included in a factor. The factors identified were the subcomponents of the construct the instrument was developed to measure. Determining and naming the factors identified through exploratory factor analysis required detailed work on the part of the researcher. In exploratory analysis, correlations coefficients of 0.3 were considered weak, 0.3-0.5 were moderate, and >0.5 strong (Grove et al., 2013:395).

Confirmatory factor analysis is the validation of the number of factors or subcomponents in the instrument and it measures equivalence among comparison groups. Items that do not fall into a factor because they do not correlate with other items, may be deleted. In confirmatory factor analysis multiple measures of goodness of fit are considered, including: 1) the minimum sample discrepancy (Chi-squared test statistic) divided by degrees of freedom (CMIN/DF) value, which should be close to 2, but can be as high as 4-5 (Stevens, 1996: 345), 2) the comparative fit index (CFI) which should be above 0.9 (Mueller, 1996:229) and 3) the root square error of approximation (RMSEA) value with a 90% confidence interval, which should not be above 0.10 (Blunch, 2013).

3.4.1 Practice Environment Scale of the Nurse Work Index (PES-NWI)

The PES-NWI as described in 1.9.2 was used to measure professional nurses’ perception of the practice environment.

3.4.1.1 Exploratory factor analysis of the PES-NWI (Seven factors)

A principal axis exploratory factor analysis with Oblimin rotation of the PES-NWI data extracted seven factors, which is two more factors than the number identified in literature. The Kaizer-Meyer-Olkin (KMO) measure of sampling adequacy for the analysis was found to be 0.901 and a 48.2% of the total variance was explained, which is considered good. During the pattern matrix, Kaizer’s criterion extracted subscales as presented in Table 3.2.

Table 3-2: Pattern matrix for the PES-NWI.

<table>
<thead>
<tr>
<th>Item no.</th>
<th>Item description</th>
<th>Factor</th>
<th>Component</th>
</tr>
</thead>
<tbody>
<tr>
<td>Item 22</td>
<td>A nurse manager who backs up the nursing staff in decision making.</td>
<td>Leadership and support</td>
<td>.701</td>
</tr>
</tbody>
</table>
## PATTERN MATRIX

<table>
<thead>
<tr>
<th>Item no.</th>
<th>Item description</th>
<th>Factor</th>
<th>Component</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>even if the conflict is with a physician.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>A nurse manager who is a good manager and leader.</td>
<td>Leadership and support</td>
<td>.583</td>
</tr>
<tr>
<td>23</td>
<td>Management that listens and responds to employee concerns.</td>
<td>Nurse participation</td>
<td>.474</td>
</tr>
<tr>
<td>3</td>
<td>A supervisory staff that is supportive of nurses.</td>
<td>Leadership and support</td>
<td>.473</td>
</tr>
<tr>
<td>11</td>
<td>A nursing director who is highly visible and accessible to staff.</td>
<td>Nurse participation</td>
<td>.471</td>
</tr>
<tr>
<td>20</td>
<td>Working with nurses who are clinically competent.</td>
<td>Quality of care</td>
<td>.266</td>
</tr>
<tr>
<td>21</td>
<td>Physicians respect nurses as professionals.</td>
<td>Nurse-physician</td>
<td>.776</td>
</tr>
<tr>
<td>26</td>
<td>Collaboration between nurses and physicians.</td>
<td>Nurse-physician</td>
<td>.762</td>
</tr>
<tr>
<td>30</td>
<td>Physicians hold nurses in high esteem.</td>
<td>Nurse-physician</td>
<td>.727</td>
</tr>
<tr>
<td>7</td>
<td>Physicians value nurses’ observations and judgements.</td>
<td>Nurse-physician</td>
<td>.710</td>
</tr>
<tr>
<td>13</td>
<td>Physicians recognize nurses’ contributions to patient care.</td>
<td>Nurse-physician</td>
<td>.679</td>
</tr>
<tr>
<td>Item no.</td>
<td>Item description</td>
<td>Factor</td>
<td>Component 1</td>
</tr>
<tr>
<td>---------</td>
<td>-----------------------------------------------------------------------------------</td>
<td>-------------------------------</td>
<td>-------------</td>
</tr>
<tr>
<td>Item 17</td>
<td>Much teamwork between nurses and physicians.</td>
<td>Nurse-physician</td>
<td>.667</td>
</tr>
<tr>
<td>Item 2</td>
<td>Physicians and nurses have good working relationships.</td>
<td>Nurse-physician</td>
<td>.601</td>
</tr>
<tr>
<td>Item 8</td>
<td>Enough time and opportunity to discuss patient care problems with other nurses.</td>
<td>Staffing and resources</td>
<td></td>
</tr>
<tr>
<td>Item 19</td>
<td>A clear philosophy of nursing that influences the patient care environment.</td>
<td>Quality of care</td>
<td></td>
</tr>
<tr>
<td>Item 31</td>
<td>Written, up-to-date care plans for all patients.</td>
<td>Quality of care</td>
<td></td>
</tr>
<tr>
<td>Item 15</td>
<td>The management expects high standards of nursing care.</td>
<td>Quality of care</td>
<td></td>
</tr>
<tr>
<td>Item 16</td>
<td>A nursing director is equal in power and authority to other top-level hospital executives.</td>
<td>Nurse participation</td>
<td></td>
</tr>
<tr>
<td>Item 5</td>
<td>Career development/clinical ladder opportunity.</td>
<td>Nurse participation</td>
<td></td>
</tr>
<tr>
<td>Item 4</td>
<td>Active staff development or continuing education programmes for nurses.</td>
<td>Quality of care</td>
<td></td>
</tr>
<tr>
<td>Item 18</td>
<td>Opportunities for development.</td>
<td>Nurse participation</td>
<td></td>
</tr>
<tr>
<td>Item 6</td>
<td>Opportunity for registered nurses to participate in policy decisions.</td>
<td>Nurse participation</td>
<td>.210</td>
</tr>
<tr>
<td>Item 1</td>
<td>Adequate support services allow me to spend time with my patients.</td>
<td>Staffing and resources</td>
<td></td>
</tr>
<tr>
<td>Item no.</td>
<td>Item description</td>
<td>Factor</td>
<td>Component</td>
</tr>
<tr>
<td>---------</td>
<td>-----------------</td>
<td>--------</td>
<td>-----------</td>
</tr>
<tr>
<td>Item 9</td>
<td>Enough registered nurses on staff to provide quality patient care.</td>
<td>Staffing and resources</td>
<td>-0.780</td>
</tr>
<tr>
<td>Item 12</td>
<td>Enough staff to get the work done.</td>
<td>Staffing and resources</td>
<td>-0.744</td>
</tr>
<tr>
<td>Item 28</td>
<td>Nursing care is based on nursing rather than a medical model.</td>
<td>Quality of care</td>
<td>-0.517</td>
</tr>
<tr>
<td>Item 27</td>
<td>An induction programme for newly hired nurses.</td>
<td>Quality of care</td>
<td>-0.438</td>
</tr>
<tr>
<td>Item 29</td>
<td>Registered nurses have the opportunity to serve on hospital and nursing committees.</td>
<td>Nurse participation</td>
<td>0.207</td>
</tr>
<tr>
<td>Item 24</td>
<td>An active quality assurance programme.</td>
<td>Quality of care</td>
<td>0.206</td>
</tr>
<tr>
<td>Item 32</td>
<td>Patient care assignments that foster continuity of care (i.e., the same nurse cares for the patient from one day to the next).</td>
<td>Quality of care</td>
<td>0.264</td>
</tr>
</tbody>
</table>

The content of the factors identified were analysed to determine to what degree it resembles the five subscales identified in literature (Lake, 2002). Items with double loadings, also loading on theoretically identified subscales, were kept within the initial factor/subscale. The themes identified were as follows:

- Nurse manager ability, leadership and support of nurses (factor 1): 22, 10, 23, 3, 14, 25.
- Collegial nurse–physician relations (factor 2): 21, 26, 30, 7, 13, 17, 2.
- Nursing foundations for quality of care (factor 3): 20, 8, 19, 31, 15, 16.
- Nurse participation in hospital affairs (factor 4): 11, 5, 4, 18, 6.
- Staffing and resource adequacy (factor 5): 1.
- Staffing and resource adequacy (factor 6): 9, 12.
- Nursing foundations for quality of care (factor 7): 28, 27, 29, 24, 32.
Based on the results of the analysis, some items included in specific subscales in the literature, loaded onto other factors. The following items, discussed in the order in which they appear in the table, loaded on other factors:

**Item 23: Management that listens and responds to employee concerns.**

This item did not load on nurse participation in hospital affairs subscale, but rather loaded on the nurse manager ability, leadership and support of nurses' subscale. This could be because the question has to do with management and because the function described may be one that the nurse manager fulfills in the psychiatric hospitals.

**Item 25: Registered nurses are involved in the internal governance of the hospital (e.g. practice and policy committees).**

This item did not load on the nurse participation in hospital affairs subscale, but rather loaded on the nurse manager ability, leadership and support of nurses. This could be due to the fact professional nurses felt that this was a function fulfilled only by nurse managers.

**Item 8: Enough time and opportunity to discuss patient care problems with other nurses.**

This item did not load on staffing and resource adequacy subscale, but rather loaded on nursing foundations for quality of care subscale. This could be because professional nurses in this study felt that discussing patient care problems was a general expectation to ensure good quality patient care.

**Item 4: Active staff development or continuing education programmes for nurses.**

This item did not load on nursing foundations for quality of care, but rather loaded on nurse participation in hospital affairs. This could be because professional nurses in this research felt that continuing education programmes was a hospital function that nurses could influence and participate in.

**Item 29: Registered nurses have the opportunity to serve on hospital and training committees.**

This item did not load on nurse participation in hospital affairs, but rather loaded on the nursing foundations for quality of care. This could be because professional nurses in this study felt serving on hospital and training committees contributed to quality of care.

Although with more subscales, this represents the theoretical factors to a greater extent, therefore a confirmatory factor analysis was performed.
3.4.1.2 Confirmatory factor analysis of PES-NWI (five factors)

Confirmatory factor analysis was done to confirm the five factors of the PES-NWI that were determined in the literature. The confirmatory factor analysis that was performed is presented in Figure 3.1

![Figure 3-1: Confirmatory factor analysis for PES-NWI (five factors)](image)

Table 3-3: Standardised regression weights PES-NWI (five factors)

<table>
<thead>
<tr>
<th>Item no</th>
<th>Item</th>
<th>Factor</th>
<th>Estimate</th>
<th>P value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Item 32</td>
<td>Patient care assignments that foster continuity of care (i.e. the same nurse cares for the patients from one day to the next).</td>
<td>Quality of Care</td>
<td>.277</td>
<td>&gt;0.001</td>
</tr>
<tr>
<td>Item 31</td>
<td>Written up-to-date care plans for all patients.</td>
<td>Quality of Care</td>
<td>.243</td>
<td>&gt;0.001</td>
</tr>
<tr>
<td>Item 28</td>
<td>Nursing care is based on a nursing rather than a medical model.</td>
<td>Quality of Care</td>
<td>.359</td>
<td>&gt;0.001</td>
</tr>
</tbody>
</table>
All items had statistically significant regression weights above 0.243, indicating that items loaded significantly on the theoretical factors. The correlation among the factors of the PES-NWI is summarized in Table 3.4.

Table 3-4: Correlations among factors of the five – PES-NWI

<table>
<thead>
<tr>
<th>Factor</th>
<th>Factor</th>
<th>Estimate</th>
<th>P value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality of Care</td>
<td>Physicians</td>
<td>.637</td>
<td>&gt;0.001</td>
</tr>
<tr>
<td>Quality of Care</td>
<td>Participation</td>
<td>.922</td>
<td>&gt;0.001</td>
</tr>
<tr>
<td>Leadership</td>
<td>Quality of Care</td>
<td>.783</td>
<td>&gt;0.001</td>
</tr>
<tr>
<td>Quality of Care</td>
<td>Staffing</td>
<td>.719</td>
<td>&gt;0.001</td>
</tr>
<tr>
<td>Physicians</td>
<td>Staffing</td>
<td>.435</td>
<td>&gt;0.001</td>
</tr>
<tr>
<td>Physicians</td>
<td>Participation</td>
<td>.504</td>
<td>&gt;0.001</td>
</tr>
<tr>
<td>Leadership</td>
<td>Physicians</td>
<td>.611</td>
<td>&gt;0.001</td>
</tr>
<tr>
<td>Leadership</td>
<td>Staffing</td>
<td>.722</td>
<td>&gt;0.001</td>
</tr>
<tr>
<td>Staffing</td>
<td>Participation</td>
<td>.761</td>
<td>&gt;0.001</td>
</tr>
<tr>
<td>Leadership</td>
<td>Participation</td>
<td>.919</td>
<td>&gt;0.001</td>
</tr>
</tbody>
</table>

Considering the correlation coefficients in Table 3.4, all the factors of the PES-NWI are positively and strongly correlated with each other, with correlation coefficients ranging from \( r = 0.435 \) (collegial nurse physician relations and staffing and resource adequacy) and higher. The strongest correlation is between nursing foundations for quality of care and nurse participation in hospital affairs \( (r = 0.922) \). Measures of goodness of fit for the five-factor model yielded a CMIN/DF value of 2.438, which indicates a good model fit. A relatively unacceptable
CFI of 0.821 was obtained, while an acceptable RMSEA value of 0.069 with a 90% confidence interval of [0.064; 0.074] was obtained. A summary of the measures of goodness of fit is provided in Table 3.5.

**Table 3-5: Measures of goodness of fit five PES-NWI (five factors)**

<table>
<thead>
<tr>
<th>Factor</th>
<th>Chi Squire</th>
<th>CMIN/DF</th>
<th>CFI</th>
<th>RMSEA [90%]</th>
</tr>
</thead>
<tbody>
<tr>
<td>5 (32 items)</td>
<td>&lt;.0001</td>
<td>2.438</td>
<td>0.821</td>
<td>0.069 [0.064;0.074]</td>
</tr>
</tbody>
</table>

### 3.4.2 Maslach Burnout Inventory (MBI)

The MBI as described in 2.4.3 was used to measure professional nurses' burnout levels.

#### 3.4.2.1 Exploratory factor analysis of the MBI (five factors)

A principal axis exploratory factor analysis with Oblimin rotation of the MBI data extracted five factors, which is two more factors than the number identified in literature. The Kaizer-Meyer-Olkin (KMO) measure of sampling adequacy for the analysis was 0.841 and a 42.3 % of the total variance was explained, which is considered good. During the pattern matrix, Kaizer’s criterion extracted subscales as presented in Table 3.6.

**Table 3-6: Pattern matrix for the MBI**

<table>
<thead>
<tr>
<th>Item no</th>
<th>Item description</th>
<th>Factor</th>
<th>Component</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Item 13</td>
<td>I feel frustrated by my job.</td>
<td>Emotional Exhaustion</td>
<td>.778</td>
</tr>
<tr>
<td>Item 20</td>
<td>I feel like I am at the end of my rope.</td>
<td>Emotional Exhaustion</td>
<td>.632</td>
</tr>
<tr>
<td>Item 11</td>
<td>I worry that this job is hardening me emotionally.</td>
<td>Depersonalization</td>
<td>.603</td>
</tr>
<tr>
<td>Item 8</td>
<td>I feel burned out from my work.</td>
<td>Emotional Exhaustion</td>
<td>.583</td>
</tr>
<tr>
<td>Item 14</td>
<td>I feel I'm working too hard on my job.</td>
<td>Emotional Exhaustion</td>
<td>.321</td>
</tr>
<tr>
<td>Item 17</td>
<td>I can easily create a relaxed atmosphere with my patients.</td>
<td>Personal Accomplishment</td>
<td>.625</td>
</tr>
<tr>
<td>Item 18</td>
<td>I accomplish many worthwhile things in this job.</td>
<td>Personal Accomplishment</td>
<td>.555</td>
</tr>
<tr>
<td>Item no</td>
<td>Item description</td>
<td>Factor</td>
<td>Component</td>
</tr>
<tr>
<td>--------</td>
<td>----------------------------------------------------------------------------------</td>
<td>-----------------------------</td>
<td>-----------</td>
</tr>
<tr>
<td>19</td>
<td>I feel exhilarated after working closely with my patients.</td>
<td>Personal Accomplishment</td>
<td>.484</td>
</tr>
<tr>
<td>7</td>
<td>I deal very effectively with the problems of my patients.</td>
<td>Personal Accomplishment</td>
<td>.480</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>.228</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>-.299</td>
</tr>
<tr>
<td>21</td>
<td>In my work, I deal with emotional problems very calmly.</td>
<td>Personal Accomplishment</td>
<td>-.304</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>.480</td>
</tr>
<tr>
<td>12</td>
<td>I feel very energetic.</td>
<td>Personal Accomplishment</td>
<td>.471</td>
</tr>
<tr>
<td>4</td>
<td>I can easily understand how my patients feel about things.</td>
<td>Personal Accomplishment</td>
<td>.435</td>
</tr>
<tr>
<td>9</td>
<td>I feel I'm positively influencing other people's lives.</td>
<td>Personal Accomplishment</td>
<td>.365</td>
</tr>
<tr>
<td>16</td>
<td>Working directly with people puts too much stress on me.</td>
<td>Emotional Exhaustion</td>
<td>.758</td>
</tr>
<tr>
<td>6</td>
<td>Working with people all day is really a strain for me.</td>
<td>Emotional Exhaustion</td>
<td>.668</td>
</tr>
<tr>
<td>22</td>
<td>I feel patients blame me for some of their problems.</td>
<td>Depersonalization</td>
<td>.239</td>
</tr>
<tr>
<td>5</td>
<td>I feel I treat some patients as if they were impersonal objects.</td>
<td>Depersonalization</td>
<td>.514</td>
</tr>
<tr>
<td>15</td>
<td>I don't really care what happens to some patients.</td>
<td>Depersonalization</td>
<td>.463</td>
</tr>
<tr>
<td>10</td>
<td>I've become more insensitive toward people since I took this job.</td>
<td>Depersonalization</td>
<td>.327</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>.339</td>
</tr>
</tbody>
</table>
The content of the factors identified were analysed to determine to what degree it resembles the three subscales identified in literature (Maslach & Jackson, 1985). Items with double loadings, also loading on theoretically identified subscales were kept within the initial factor/subscale. The themes identified were as follows:

- Emotional Exhaustion (Factor 1): 13, 20, 11, 8, 14.
- Personal Accomplishment (Factor 2): 17, 18, 19, 7, 21, 12, 4, 9.
- Emotional Exhaustion (Factor 3): 16, 6, 22.
- Depersonalization (Factor 4): 5, 15, 10.
- Emotional Exhaustion (Factor 5): 3, 1, 2.

Based on the results of the analysis, some items included in specific subscales in the literature, loaded onto other factors. The following items, discussed in the order they appear in the table, loaded on other factors:

- **Item 11: I worry that this job is hardening me emotionally.**

  This item did not load on the depersonalisation subscale, but rather loaded on the emotional exhaustion subscale. This could be because professional nurses in this research felt that the item rather had to do with emotional exhaustion, and not with depersonalisation.

- **Item 22: I feel patients blame me for some of their problems.**

  This item did not load on depersonalization, but rather loaded on emotional exhaustion factor. This could be because nurses in this research experience blame as emotionally exhausting.
Although with more subscales, this represents the theoretical factors to a large degree, and therefore a confirmatory factor analysis was conducted.

3.4.2.2 Confirmatory factor analysis of the MBI (three factors)

Confirmatory factor analysis was done to confirm the three factors that were determined in the literature. The confirmatory factor analysis that was performed is presented in Figure 3.2.
Table 3.7 presents the standardized regression weights for each of the items for the MBI (three factors).

Table 3-7: Standardised regression weights MBI (three factors)

<table>
<thead>
<tr>
<th>Item no</th>
<th>Item</th>
<th>Factor</th>
<th>Estimate</th>
<th>P value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Item 1</td>
<td>I feel emotionally drained from my work.</td>
<td>EE</td>
<td>.740</td>
<td>&gt;0.001</td>
</tr>
<tr>
<td>Item 2</td>
<td>I feel used up at the end of the workday.</td>
<td>EE</td>
<td>.711</td>
<td>&gt;0.001</td>
</tr>
<tr>
<td>Item 3</td>
<td>I feel fatigued when I get up in the morning and have to face another day on the job.</td>
<td>EE</td>
<td>.785</td>
<td>&gt;0.001</td>
</tr>
<tr>
<td>Item 6</td>
<td>Working with people all day is really a strain for me.</td>
<td>EE</td>
<td>.474</td>
<td>&gt;0.001</td>
</tr>
<tr>
<td>Item 8</td>
<td>I feel burned out from my work.</td>
<td>EE</td>
<td>.785</td>
<td>&gt;0.001</td>
</tr>
<tr>
<td>Item 13</td>
<td>I feel frustrated by my job.</td>
<td>EE</td>
<td>.719</td>
<td>&gt;0.001</td>
</tr>
<tr>
<td>Item 14</td>
<td>I feel I’m working too hard on my job.</td>
<td>EE</td>
<td>.472</td>
<td>&gt;0.001</td>
</tr>
<tr>
<td>Item 16</td>
<td>Working directly with people puts too much stress on me.</td>
<td>EE</td>
<td>.436</td>
<td>&gt;0.001</td>
</tr>
<tr>
<td>Item 20</td>
<td>I feel like I am at the end of my rope.</td>
<td>EE</td>
<td>.580</td>
<td>&gt;0.001</td>
</tr>
<tr>
<td>Item 22</td>
<td>I feel patients blame me for some of their problems.</td>
<td>DP</td>
<td>.371</td>
<td>&gt;0.001</td>
</tr>
<tr>
<td>Item 15</td>
<td>I don’t really care what happens to some patients.</td>
<td>DP</td>
<td>.247</td>
<td>&gt;0.001</td>
</tr>
<tr>
<td>Item 11</td>
<td>I worry that this job is hardening me emotionally.</td>
<td>DP</td>
<td>.712</td>
<td>&gt;0.001</td>
</tr>
<tr>
<td>Item 10</td>
<td>I’ve become more insensitive towards people since I took this job.</td>
<td>DP</td>
<td>.460</td>
<td>&gt;0.001</td>
</tr>
<tr>
<td>Item 5</td>
<td>I feel I treat some patients as if they were impersonal objects.</td>
<td>DP</td>
<td>.424</td>
<td>&gt;0.001</td>
</tr>
<tr>
<td>Item 4</td>
<td>I can easily understand how my patients feel about things.</td>
<td>PA</td>
<td>.458</td>
<td>&gt;0.001</td>
</tr>
<tr>
<td>Item 7</td>
<td>I deal very effectively with the problems of my patients.</td>
<td>PA</td>
<td>.553</td>
<td>&gt;0.001</td>
</tr>
<tr>
<td>Item 9</td>
<td>I feel I’m positively influencing other people’s lives.</td>
<td>PA</td>
<td>.398</td>
<td>&gt;0.001</td>
</tr>
<tr>
<td>Item 12</td>
<td>I feel very energetic.</td>
<td>PA</td>
<td>.496</td>
<td>&gt;0.001</td>
</tr>
<tr>
<td>Item 17</td>
<td>I can easily create a relaxed atmosphere with my patients.</td>
<td>PA</td>
<td>.617</td>
<td>&gt;0.001</td>
</tr>
<tr>
<td>Item 18</td>
<td>I accomplish many worthwhile things in this job.</td>
<td>PA</td>
<td>.524</td>
<td>&gt;0.001</td>
</tr>
<tr>
<td>Item 19</td>
<td>I feel exhilarated after working closely with my patients.</td>
<td>PA</td>
<td>.427</td>
<td>&gt;0.001</td>
</tr>
</tbody>
</table>
In my work, I deal with emotional problems very calmly. All items had statistically significant regression weights above 0.247, indicating that items loaded significantly on the theoretical factors. The correlation among the factors of the MBI are summarised in Table 3.8.

### Table 3-8: Correlations among factors of the MBI

<table>
<thead>
<tr>
<th>Factor</th>
<th>Factor</th>
<th>Estimate</th>
<th>P value</th>
</tr>
</thead>
<tbody>
<tr>
<td>EE</td>
<td>&lt; -- &gt;</td>
<td>DP</td>
<td>.844</td>
</tr>
<tr>
<td>PA</td>
<td>&lt; -- &gt;</td>
<td>EE</td>
<td>-.073</td>
</tr>
<tr>
<td>PA</td>
<td>&lt; -- &gt;</td>
<td>DP</td>
<td>-.184</td>
</tr>
</tbody>
</table>

Considering the correlation coefficients in Table 3.8, the subscales of emotional exhaustion and depersonalization are positively and strongly correlated ($r = .844$), meaning that as emotional exhaustion increases, so does depersonalization. On the other hand, there is a small negative correlation between depersonalization and personal accomplishment. Measures of goodness of fit for the three-factor model yielded a CMIN/DF value of 2.984, which indicates a good model fit. A relatively unacceptable CFI of 0.774 was obtained, while an acceptable RMSEA value of 0.081 with a 90% confidence interval of [0.074; 0.089] was obtained.

### Table 3-9: Measures of goodness of fit MBI (three factors)

<table>
<thead>
<tr>
<th>Factor</th>
<th>Chi Squire</th>
<th>CMIN/DF</th>
<th>CFI</th>
<th>RMSEA [90%]</th>
</tr>
</thead>
<tbody>
<tr>
<td>3 (22 items)</td>
<td>.001</td>
<td>2.984</td>
<td>0.774</td>
<td>0.081 [0.074; 0.089]</td>
</tr>
</tbody>
</table>

### 3.4.3 Exploratory factor analysis of job satisfaction (JS)

A principal axis exploratory factor analysis with Oblimin rotation of the job satisfaction data extracted two factors. The Kaizer-Meyer-Olkin (KMO) measure of sampling adequacy for the analysis was found to be 0.812 and a 59.18% of the total variance was explained, which is considered good. During the pattern matrix, Kaizer’s criterion extracted subscales as presented in Table 3.10.
<table>
<thead>
<tr>
<th>Item no</th>
<th>Item</th>
<th>Component</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Item 46</td>
<td>Educational opportunities</td>
<td>.905</td>
</tr>
<tr>
<td>Item 42</td>
<td>Opportunities for advancement</td>
<td>.847</td>
</tr>
<tr>
<td>Item 49</td>
<td>Study leave</td>
<td>.774</td>
</tr>
<tr>
<td>Item 45</td>
<td>Wages</td>
<td>.367</td>
</tr>
<tr>
<td>Item 48</td>
<td>Sick leave</td>
<td></td>
</tr>
<tr>
<td>Item 47</td>
<td>Annual leave</td>
<td></td>
</tr>
<tr>
<td>Item 44</td>
<td>Professional status</td>
<td>.403</td>
</tr>
<tr>
<td>Item 43</td>
<td>Independence at work</td>
<td>.343</td>
</tr>
<tr>
<td>Item 41</td>
<td>Work schedule flexibility</td>
<td>.289</td>
</tr>
</tbody>
</table>

The factors seemed to divide into two subscales, namely educational and workplace:

- Educational (Factor 1): 2, 6, 9.
- Workplace (Factor 2): 3, 4, 5, 7, 8, 1.

### 3.4.3.1 Confirmatory factor analysis of job satisfaction (two factors)

Confirmatory factor analysis was done to confirm the two factor subscales that were determined from the exploratory factor analysis. The confirmatory factor analysis that was performed is presented in Figure 3.3.
Figure 3-3: Confirmatory factor analysis for Job satisfaction (two factors)

Table 3-11: Standardised regression weights Job Satisfaction (two factors)

<table>
<thead>
<tr>
<th>Item no</th>
<th>Item</th>
<th>Factor</th>
<th>Estimate</th>
<th>P value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Item 42</td>
<td>Opportunities for advancement</td>
<td>Opportunities for</td>
<td>.805</td>
<td>≤0.001</td>
</tr>
<tr>
<td>Item 46</td>
<td>Educational opportunities</td>
<td>Opportunities for</td>
<td>.857</td>
<td>≤0.001</td>
</tr>
<tr>
<td>Item 49</td>
<td>Study leave</td>
<td>Opportunities for</td>
<td>.678</td>
<td>≤0.001</td>
</tr>
<tr>
<td>Item 43</td>
<td>Independence at work</td>
<td>Workplace</td>
<td>.780</td>
<td>≤0.001</td>
</tr>
</tbody>
</table>
All items had statistically significant regression weights above 0.425, indicating that items loaded significantly on the factors as identified in the exploratory factor analysis. The correlation between the two factors of the job satisfaction is summarized in Table 3.12.

### Table 3-12: Correlations between factors of Job satisfaction

<table>
<thead>
<tr>
<th>Factor</th>
<th>Factor</th>
<th>Estimate</th>
<th>P value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Workplace</td>
<td>&lt; ---</td>
<td>Opportunities for advancement</td>
<td>.604</td>
</tr>
</tbody>
</table>

The two factors of the job satisfaction scale were positively and strongly correlated with each other. Measures of goodness of fit for the two-factor model yielded a CMIN/DF value of 5.793, which is unacceptable. A relatively unacceptable CFI of 0.872 was obtained, and an unacceptable RMSEA value of 0.126 with a 90% confidence interval of [0.425; 0.857] was obtained. A summary of the measures of goodness of fit is provided in Table 3.13.

### Table 3-13: Measures of goodness of fit Job Satisfaction (two factors)

<table>
<thead>
<tr>
<th>Factor</th>
<th>Chi Squire</th>
<th>CMIN/DF</th>
<th>CFI</th>
<th>RMSEA [90%]</th>
</tr>
</thead>
<tbody>
<tr>
<td>2 (9 items)</td>
<td>.001</td>
<td>5.793</td>
<td>0.872</td>
<td>0.126 [0.425;0.857]</td>
</tr>
</tbody>
</table>

From the above, it is clear that the two factor subscales do not have a good model fit, therefore the researcher, in consultation with the statistician and promoters, decided to do a confirmatory factor analysis of the job satisfaction scale as one factor.

### 3.4.3.2 Confirmatory factor analysis (one factor)

A confirmatory factor analysis was done to determine whether the job satisfaction scale would satisfactorily load as one subscale. The confirmatory factor analysis that was performed is
presented in Figure 3.4.

Figure 3-4:  Confirmatory factor analysis of Job Satisfaction (one factor)

Table 3-14:  Standardised regression weights of Job Satisfaction (one factor)

<table>
<thead>
<tr>
<th>Item no</th>
<th>Item</th>
<th>Factor</th>
<th>Estimate</th>
<th>P value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Item 41</td>
<td>Work schedule flexibility</td>
<td>&lt; ---</td>
<td>.613</td>
<td>≤0.001</td>
</tr>
<tr>
<td>Item 42</td>
<td>Opportunities for advancement</td>
<td>&lt; ---</td>
<td>.687</td>
<td>≤0.001</td>
</tr>
<tr>
<td>Item 43</td>
<td>Independence at work</td>
<td>&lt; ---</td>
<td>.713</td>
<td>≤0.001</td>
</tr>
<tr>
<td>Item 44</td>
<td>Professional status</td>
<td>&lt; ---</td>
<td>.776</td>
<td>≤0.001</td>
</tr>
<tr>
<td>Item 45</td>
<td>Wages</td>
<td>&lt; ---</td>
<td>.452</td>
<td>≤0.001</td>
</tr>
<tr>
<td>Item 46</td>
<td>Educational opportunities</td>
<td>&lt; ---</td>
<td>.649</td>
<td>≤0.001</td>
</tr>
<tr>
<td>Item 47</td>
<td>Annual leave</td>
<td>&lt; ---</td>
<td>.479</td>
<td>≤0.001</td>
</tr>
<tr>
<td>Item 48</td>
<td>Sick leave</td>
<td>&lt; ---</td>
<td>.450</td>
<td>≤0.001</td>
</tr>
<tr>
<td>Item 49</td>
<td>Study leave</td>
<td>&lt; ---</td>
<td>.557</td>
<td>≤0.001</td>
</tr>
</tbody>
</table>

All items had statistically significant regression weights above 0.450, indicating that items loaded significantly on the theoretical factors. Measures of goodness of fit for the one factor model yielded a CMIN/DF value of 11.57, which is unacceptable. A relatively unacceptable
CFI of 0.708 was obtained and an unacceptable RMSEA value of 0.187 with a 90% confidence interval of [0.450; 0.776] was obtained. A summary of the measures of goodness of fit is provided in Table 3.15.

Table 3-15: Measures of goodness of fit Job Satisfaction (one factor)

<table>
<thead>
<tr>
<th>Factor</th>
<th>Chi Squire</th>
<th>CMIN/DF</th>
<th>CFI</th>
<th>RMSEA [90%]</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 (9 items)</td>
<td>.001</td>
<td>11.57</td>
<td>0.708</td>
<td>0.187</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>[0.450;0.776]</td>
</tr>
</tbody>
</table>

From the above, it is clear that the one factor subscale does not have a good model fit, therefore the researcher, in consultation with the statistician and promoters, decided to do a second exploratory factor analysis with a three-factor subscale.

3.4.4 Exploratory factor analysis of job satisfaction (three factors)

A principal axis exploratory factor analysis with Oblimin rotation of the job satisfaction data extracted three factors. The Kaizer-Meyer-Olkin (KMO) measure of sampling adequacy for the analysis was found to be 0.812 and a 69.64% of the total variance was explained, which is considered good. During the pattern matrix, Kaizer’s criterion extracted subscales as presented in Table 3.2.

Table 3-16: Matrix of Job Satisfaction scale (three factors)

<table>
<thead>
<tr>
<th>Item no</th>
<th>Item</th>
<th>Component</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Item 46</td>
<td>Educational opportunities</td>
<td>.908</td>
</tr>
<tr>
<td>Item 49</td>
<td>Educational opportunities</td>
<td>.824</td>
</tr>
<tr>
<td>Item 42</td>
<td>Educational opportunities</td>
<td>.703</td>
</tr>
<tr>
<td>Item 45</td>
<td>Educational opportunities</td>
<td>.451</td>
</tr>
<tr>
<td>Item 48</td>
<td>Educational opportunities</td>
<td>.333</td>
</tr>
<tr>
<td>Item 47</td>
<td>Educational opportunities</td>
<td>.861</td>
</tr>
<tr>
<td>Item 43</td>
<td>Educational opportunities</td>
<td>.848</td>
</tr>
<tr>
<td>Item 44</td>
<td>Educational opportunities</td>
<td>-.834</td>
</tr>
<tr>
<td>Item 41</td>
<td>Educational opportunities</td>
<td>-.721</td>
</tr>
</tbody>
</table>

The factors seemed to divide into three subscales, namely opportunities for advancement, general leave and workplace:

- Opportunities for advancement (Factor 1): 2, 6, 9, 5.
- General leave (Factor 2): 7, 8.
- Workplace (Factor 3): 1, 3, 4.

### 3.4.4.1 Confirmatory factor analysis of Job satisfaction (three factors)

Confirmatory factor analysis was done to confirm the three factor subscales that were determined in the exploratory factor analysis. The confirmatory factor analysis that was performed is presented in Figure 3.5.

**Figure 3-5:** Confirmatory factor analysis (three factors)
Table 3-17: Standardised regression weights Job Satisfaction (three factors)

<table>
<thead>
<tr>
<th>Item no</th>
<th>Item</th>
<th>Factor</th>
<th>Estimate</th>
<th>P value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Item 42</td>
<td>Work schedule flexibility</td>
<td>Opportunities for advancement</td>
<td>.794</td>
<td>≤0.001</td>
</tr>
<tr>
<td>Item 46</td>
<td>Opportunities for advancement</td>
<td>Opportunities for advancement</td>
<td>.868</td>
<td>≤0.001</td>
</tr>
<tr>
<td>Item 49</td>
<td>Independence at work</td>
<td>Opportunities for advancement</td>
<td>.672</td>
<td>≤0.001</td>
</tr>
<tr>
<td>Item 47</td>
<td>Professional status</td>
<td>General leave</td>
<td>.808</td>
<td>≤0.001</td>
</tr>
<tr>
<td>Item 48</td>
<td>Wages</td>
<td>General leave</td>
<td>.771</td>
<td>≤0.001</td>
</tr>
<tr>
<td>Item 41</td>
<td>Educational opportunities</td>
<td>Workplace</td>
<td>.614</td>
<td>≤0.001</td>
</tr>
<tr>
<td>Item 43</td>
<td>Annual leave</td>
<td>Workplace</td>
<td>.793</td>
<td>≤0.001</td>
</tr>
<tr>
<td>Item 44</td>
<td>Sick leave</td>
<td>Workplace</td>
<td>.882</td>
<td>≤0.001</td>
</tr>
<tr>
<td>Item 45</td>
<td>Study leave</td>
<td>Opportunities for advancement</td>
<td>.436</td>
<td>≤0.001</td>
</tr>
</tbody>
</table>

All items had statistically significant regression weights above 0.436, indicating that items loaded significantly on the identified factors. The correlations between the factors of Job satisfaction are summarized in Table 3.18.

Table 3-18: Correlation between factors of job satisfaction

<table>
<thead>
<tr>
<th>Factor</th>
<th>Factor</th>
<th>Estimate</th>
<th>P-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Opportunities for advancement</td>
<td>General leave</td>
<td>.189</td>
<td>≤0.001</td>
</tr>
<tr>
<td>Workplace</td>
<td>Opportunities for advancement</td>
<td>.232</td>
<td>≤0.001</td>
</tr>
<tr>
<td>Workplace</td>
<td>General leave</td>
<td>.206</td>
<td>≤0.001</td>
</tr>
</tbody>
</table>

Considering the correlation coefficients in Table 3.17, all the factors of the job satisfaction have a small positive correlation with each other of between \( r = 0.189 \) (opportunities for advancement and general leave) and \( r = 0.232 \) (workplace and opportunities for advancement. Measures of goodness of fit for the three-factor model yielded a CMIN/DF value of 2.970, which is acceptable. An acceptable CFI of 0.952 was obtained and an acceptable RMSEA value of 0.081 with a 90% confidence interval of [0.436; 0.882] was obtained. A summary of the measures of goodness of fit is provided in Table 3.19.
Table 3-19: Measures of goodness of fit Job Satisfaction (three factors)

<table>
<thead>
<tr>
<th>Factor</th>
<th>Chi Squire</th>
<th>CMIN/DF</th>
<th>CFI</th>
<th>RMSEA [90%]</th>
</tr>
</thead>
<tbody>
<tr>
<td>3 (9 items)</td>
<td>.001</td>
<td>2.970</td>
<td>0.952</td>
<td>0.081</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>[0.436;0.882]</td>
</tr>
</tbody>
</table>

The three-factor model provided a good fit for the data of this study and it was therefore selected for use.

3.4.5 Reliability

Following the construct validity, reliability testing was done by calculating Cronbach’s Alpha coefficient to determine the coherence and internal consistency of the scales and subscales (Graveter & Forzano, 2012). Reliability is the ability of the questionnaire to produce the same results under the same conditions. To be reliable the questionnaire must first be valid (Burns & Grove, 2009:364).

The Cronbach Alpha (α) coefficient of a scale is acceptable at a value of 0.6 to 0.7. Values of 0.7 to 0.9 (low-stakes testing) is regarded as good, with values higher as 0.9, regarded as excellent (high-stakes testing). Values of α ≥ 0.5 to 0.6 are regarded as poor and values lower than 0.5 are unacceptable (DeVellis, 2012). The Cronbach’s Alpha values are summarized in Table 3.20.

Table 3-20: Cronbach’s Coefficient α for the instruments used in the research

<table>
<thead>
<tr>
<th>Scale</th>
<th>Subscale/Factor</th>
<th>Number of items</th>
<th>α</th>
</tr>
</thead>
<tbody>
<tr>
<td>PES-NWI</td>
<td>Staffing and resource adequacy.</td>
<td>4</td>
<td>0.71</td>
</tr>
<tr>
<td></td>
<td>Collegial nurse-physician relations.</td>
<td>7</td>
<td>0.90</td>
</tr>
<tr>
<td></td>
<td>Leadership and support.</td>
<td>4</td>
<td>0.74</td>
</tr>
<tr>
<td></td>
<td>Nursing foundations for quality of care.</td>
<td>9</td>
<td>0.67</td>
</tr>
<tr>
<td></td>
<td>Nurse participation in hospital affairs.</td>
<td>8</td>
<td>0.83</td>
</tr>
<tr>
<td>MBI</td>
<td>Emotional Exhaustion</td>
<td>9</td>
<td>0.86</td>
</tr>
<tr>
<td></td>
<td>Personal Accomplishment</td>
<td>3</td>
<td>0.72</td>
</tr>
<tr>
<td></td>
<td>Depersonalization</td>
<td>5</td>
<td>0.58</td>
</tr>
<tr>
<td>JS</td>
<td>Workplace</td>
<td>3</td>
<td>0.80</td>
</tr>
<tr>
<td></td>
<td>General leave</td>
<td>2</td>
<td>0.76</td>
</tr>
<tr>
<td></td>
<td>Opportunities for advancement</td>
<td>4</td>
<td>0.77</td>
</tr>
</tbody>
</table>

From the table it is clear that all the subscales of the instruments are reliable.
Table 3-21: Descriptive statistics of the instruments

<table>
<thead>
<tr>
<th>Dimensions</th>
<th>n</th>
<th>Minimum</th>
<th>Maximum</th>
<th>Mean (M)</th>
<th>Std. Deviation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emotional exhaustion.</td>
<td>302</td>
<td>0.00</td>
<td>54.00</td>
<td>20.98</td>
<td>12.08</td>
</tr>
<tr>
<td>Depersonalization</td>
<td>301</td>
<td>0.00</td>
<td>23.00</td>
<td>5.39</td>
<td>5.19</td>
</tr>
<tr>
<td>Personal accomplishment.</td>
<td>302</td>
<td>6.00</td>
<td>48.00</td>
<td>34.83</td>
<td>8.94</td>
</tr>
<tr>
<td>Staffing and resource adequacy.</td>
<td>300</td>
<td>1.00</td>
<td>4.00</td>
<td>2.71</td>
<td>0.72</td>
</tr>
<tr>
<td>Collegial nurse physician relations.</td>
<td>300</td>
<td>1.00</td>
<td>4.00</td>
<td>2.78</td>
<td>0.68</td>
</tr>
<tr>
<td>Nurse manager ability, leadership and support of nurses.</td>
<td>300</td>
<td>1.00</td>
<td>4.00</td>
<td>2.6</td>
<td>0.74</td>
</tr>
<tr>
<td>Nursing foundations for quality of care.</td>
<td>300</td>
<td>1.29</td>
<td>4.00</td>
<td>3.15</td>
<td>0.46</td>
</tr>
<tr>
<td>Nurse participation in hospital affairs.</td>
<td>300</td>
<td>1.00</td>
<td>4.00</td>
<td>2.58</td>
<td>0.62</td>
</tr>
<tr>
<td>Workplace.</td>
<td>299</td>
<td>1.00</td>
<td>4.00</td>
<td>2.92</td>
<td>0.73</td>
</tr>
<tr>
<td>General leave.</td>
<td>300</td>
<td>1.00</td>
<td>4.00</td>
<td>3.14</td>
<td>0.82</td>
</tr>
<tr>
<td>Opportunities for advancement.</td>
<td>300</td>
<td>1.00</td>
<td>4.00</td>
<td>2.37</td>
<td>0.78</td>
</tr>
</tbody>
</table>

Maslach and Jackson (1985) state that when the total score of emotional exhaustion is 27 or over it is considered high, when it is between 17 and 26 it is considered moderate, and between 0 and 16 it is considered low. For depersonalization, when the score is 13 or over, it is considered high, when it is 7 to 12, it is moderate, and when it is 0 to 6, it is low. According to the table above, professional nurses experience moderate levels of emotional exhaustion, low levels of depersonalization, and moderate levels of personal accomplishment.

According to Lake (2002), the characteristics of a practice environment is considered positive when the mean score of a subscale is above 2.5. From the above table, it is clear that professional nurses experience the practice environment as positive, with the subscale nursing participation in hospital affairs having the lowest mean score (M = 2.58) and the subscale nursing foundations for quality of care having the highest mean score (M= 3.15).

For job satisfaction, a mean score of above 2.5 indicates that the participant experienced job satisfaction. From the above table it is clear that professional nurses are satisfied with their
jobs, with workplace having the lowest mean score ($M = 2.92$) and general leave having the highest mean score ($M = 3.14$).

### 3.5 ASSOCIATION BETWEEN DEMOGRAPHICS AND THE PES-NWI, MBI AND JS

What follows is the nominal data that is analysed using the t-test. The practical significance, also referred to as the effect sizes, is used to determine the importance of differences in the sample population (Terrel, 2012:165). (Cohen’s d-values is used to measure effect sizes. Interpretation of effect sizes (Cohen, 1988) are as follow 0.2 is regarded as small, 0.5 is medium and 0.8 is large.

**Table 3-22: Comparison between female and male participants**

<table>
<thead>
<tr>
<th>Gender</th>
<th>N</th>
<th>Mean</th>
<th>Std. Deviation</th>
<th>p-value</th>
<th>Effect size</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emotional exhaustion</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>216</td>
<td>20.3414</td>
<td>12.4512</td>
<td>.116</td>
<td>0.19</td>
</tr>
<tr>
<td>Male</td>
<td>85</td>
<td>22.6597</td>
<td>11.0392</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Depersonalization</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>215</td>
<td>5.1837</td>
<td>5.2038</td>
<td>.241</td>
<td>0.15</td>
</tr>
<tr>
<td>Male</td>
<td>85</td>
<td>5.9647</td>
<td>5.1673</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Personal accomplishment</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>216</td>
<td>34.9867</td>
<td>8.9416</td>
<td>.563</td>
<td>0.07</td>
</tr>
<tr>
<td>Male</td>
<td>85</td>
<td>34.3238</td>
<td>8.9440</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Staffing and resource adequacy</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>214</td>
<td>2.7504</td>
<td>.7235</td>
<td>.049</td>
<td>0.24</td>
</tr>
<tr>
<td>Male</td>
<td>85</td>
<td>2.5745</td>
<td>.6805</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Collegial nurse physician relations</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>214</td>
<td>2.8010</td>
<td>.6806</td>
<td>.392</td>
<td>0.11</td>
</tr>
<tr>
<td>Male</td>
<td>85</td>
<td>2.7263</td>
<td>.6767</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nurse manager ability, leadership and support of nurses</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>214</td>
<td>2.5954</td>
<td>.7571</td>
<td>.909</td>
<td>0.01</td>
</tr>
<tr>
<td>Male</td>
<td>85</td>
<td>2.6059</td>
<td>.6982</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nursing foundations for Quality of care</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>214</td>
<td>3.1865</td>
<td>.4355</td>
<td>.27</td>
<td>0.27</td>
</tr>
<tr>
<td>Male</td>
<td>85</td>
<td>3.0549</td>
<td>.4926</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nurse participation in hospital affairs</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>214</td>
<td>2.6151</td>
<td>.6384</td>
<td>.173</td>
<td>0.16</td>
</tr>
<tr>
<td>Male</td>
<td>85</td>
<td>2.5111</td>
<td>.5722</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Workplace</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>213</td>
<td>2.9538</td>
<td>.7251</td>
<td>.196</td>
<td>0.16</td>
</tr>
<tr>
<td>Male</td>
<td>85</td>
<td>2.8294</td>
<td>.7517</td>
<td></td>
<td></td>
</tr>
<tr>
<td>General leave</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>214</td>
<td>3.1215</td>
<td>.8581</td>
<td>.500</td>
<td>0.08</td>
</tr>
<tr>
<td>Male</td>
<td>85</td>
<td>3.1882</td>
<td>.7318</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nurse manager ability, leadership and support of nurses</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>214</td>
<td>2.4303</td>
<td>.7702</td>
<td>.039</td>
<td>0.27</td>
</tr>
<tr>
<td>Male</td>
<td>85</td>
<td>2.5954</td>
<td>.6982</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
From the above table it is clear that only three subscales had a practically significant effect with gender: “Staffing and resource adequacy” (d = 0.24; p = 0.049), “Nursing foundations for quality of care” (d = 0.27; p = 0.033) and “Opportunity for advancement” (d = 0.27; p = 0.039). In all cases, females were more positive than males, and in all cases the results were statistically significant. In the next table, Table 3.22 participants were asked the question “Do you have a baccalaureate degree in nursing” and were expected to indicate “yes” or “no”.

### Table 3-23: Number of participants with baccalaureate degree in nursing

<table>
<thead>
<tr>
<th>Baccalaureate degree in nursing</th>
<th>N</th>
<th>Mean</th>
<th>Std. Deviation</th>
<th>p-value</th>
<th>Effect size</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emotional exhaustion</td>
<td>Yes</td>
<td>78</td>
<td>23.0556</td>
<td>12.32568</td>
<td>0.21</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>214</td>
<td>20.4660</td>
<td>12.08990</td>
<td></td>
</tr>
<tr>
<td>Depersonalization</td>
<td>Yes</td>
<td>78</td>
<td>6.4391</td>
<td>5.69549</td>
<td>0.24</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>213</td>
<td>5.0575</td>
<td>5.01289</td>
<td></td>
</tr>
<tr>
<td>Personal accomplishment</td>
<td>Yes</td>
<td>78</td>
<td>34.1728</td>
<td>8.91738</td>
<td>0.09</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>214</td>
<td>34.9830</td>
<td>8.97523</td>
<td></td>
</tr>
<tr>
<td>Staffing and resource adequacy</td>
<td>Yes</td>
<td>78</td>
<td>2.6122</td>
<td>.76927</td>
<td>0.15</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>212</td>
<td>2.7296</td>
<td>.68688</td>
<td></td>
</tr>
<tr>
<td>Collegial nurse-physician relations</td>
<td>Yes</td>
<td>78</td>
<td>2.7378</td>
<td>.72080</td>
<td>0.07</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>212</td>
<td>2.7871</td>
<td>.67360</td>
<td></td>
</tr>
<tr>
<td>Nurse manager ability, leadership and support of nurses</td>
<td>Yes</td>
<td>78</td>
<td>2.5267</td>
<td>.80296</td>
<td>0.11</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>212</td>
<td>2.6148</td>
<td>.71327</td>
<td></td>
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<tr>
<td>Nursing foundations for quality of care</td>
<td>Yes</td>
<td>78</td>
<td>3.1002</td>
<td>.52924</td>
<td>0.12</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>212</td>
<td>3.1629</td>
<td>.42066</td>
<td></td>
</tr>
<tr>
<td>Nurse participation in hospital affairs</td>
<td>Yes</td>
<td>78</td>
<td>2.5627</td>
<td>.68360</td>
<td>0.03</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>212</td>
<td>2.5834</td>
<td>.59195</td>
<td></td>
</tr>
<tr>
<td>Workplace</td>
<td>Yes</td>
<td>78</td>
<td>2.8611</td>
<td>.81314</td>
<td>0.07</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>211</td>
<td>2.9186</td>
<td>.70455</td>
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<tr>
<td>General leave</td>
<td>Yes</td>
<td>78</td>
<td>3.1218</td>
<td>.80254</td>
<td>0.00</td>
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<tr>
<td></td>
<td>No</td>
<td>212</td>
<td>3.1250</td>
<td>.83592</td>
<td></td>
</tr>
</tbody>
</table>
Although there were small effect sizes between some of the research variables and professional nurses who had a baccalaureate degree, none of these findings were statistically significant. Table 3.24 describes the relationship between age, work experience and satisfaction with nursing as a career. These demographic variables have order (interval and ratio data) and the Spearman Rank Order Correlations were used. Correlations of 0.1 are considered small, 0.3 medium and 0.5 large.

### Table 3-24: Relationship between age, number of years and level of satisfaction

<table>
<thead>
<tr>
<th>Baccalaureate degree in nursing.</th>
<th>N</th>
<th>Mean</th>
<th>Std. Deviation</th>
<th>p-value</th>
<th>Effect size</th>
</tr>
</thead>
<tbody>
<tr>
<td>Opportunity for advancement</td>
<td>212</td>
<td>2.3762</td>
<td>.75686</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Correlation Coefficient</th>
<th>Sig. (2-tailed)</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emotional exhaustion</td>
<td>.028</td>
<td>.638</td>
<td>294</td>
</tr>
<tr>
<td>Depersonalization (DP)</td>
<td>-.031</td>
<td>.591</td>
<td>294</td>
</tr>
<tr>
<td>Personal accomplishment</td>
<td>.097</td>
<td>.096</td>
<td>294</td>
</tr>
<tr>
<td>Staffing and resource adequacy</td>
<td>.039</td>
<td>.509</td>
<td>292</td>
</tr>
<tr>
<td>Collegial nurse physicians Relations</td>
<td>.160”</td>
<td>.006</td>
<td>292</td>
</tr>
<tr>
<td>Nurse manager ability, leadership and support of nurses</td>
<td>.101</td>
<td>.085</td>
<td>292</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>How satisfied are you with your choice of nursing as a career?</th>
</tr>
</thead>
<tbody>
<tr>
<td>What is your age?</td>
<td></td>
</tr>
<tr>
<td>How many years have you worked as a registered nurse in your career?</td>
<td></td>
</tr>
<tr>
<td>N</td>
<td>Mean</td>
</tr>
</tbody>
</table>

Opportunity advancement for No 212 2.3762 .75686

<table>
<thead>
<tr>
<th>Correlation Coefficient</th>
<th>Sig. (2-tailed)</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td>.070</td>
<td>.238</td>
<td>282</td>
</tr>
<tr>
<td>-.036</td>
<td>.548</td>
<td>282</td>
</tr>
<tr>
<td>.052</td>
<td>.387</td>
<td>282</td>
</tr>
<tr>
<td>.175”</td>
<td>.003</td>
<td>280</td>
</tr>
<tr>
<td>.039</td>
<td>.516</td>
<td>280</td>
</tr>
<tr>
<td>.039</td>
<td>.516</td>
<td>280</td>
</tr>
<tr>
<td>.073</td>
<td>.087</td>
<td>280</td>
</tr>
<tr>
<td>.102</td>
<td>.087</td>
<td>280</td>
</tr>
<tr>
<td>.155”</td>
<td>.102</td>
<td>280</td>
</tr>
<tr>
<td>.147’</td>
<td>.087</td>
<td>280</td>
</tr>
<tr>
<td>.155”</td>
<td>.087</td>
<td>280</td>
</tr>
<tr>
<td></td>
<td>What is your age?</td>
<td>How many years have you worked as a registered nurse in your career?</td>
</tr>
<tr>
<td>--------------------------------</td>
<td>-------------------</td>
<td>---------------------------------------------------------------</td>
</tr>
<tr>
<td><strong>Nursing foundations for quality of care</strong></td>
<td>Sig. (2-tailed) N 292</td>
<td>.008</td>
</tr>
<tr>
<td></td>
<td>297</td>
<td>0.008</td>
</tr>
<tr>
<td><strong>Nurse participation in hospital affairs</strong></td>
<td>Correlation Coefficient N 292</td>
<td>.081</td>
</tr>
<tr>
<td></td>
<td>297</td>
<td>0.081</td>
</tr>
<tr>
<td><strong>Workplace</strong></td>
<td>Correlation Coefficient N 291</td>
<td>.083</td>
</tr>
<tr>
<td></td>
<td>296</td>
<td>0.083</td>
</tr>
<tr>
<td><strong>General leave</strong></td>
<td>Correlation Coefficient N 292</td>
<td>.132</td>
</tr>
<tr>
<td></td>
<td>297</td>
<td>0.132</td>
</tr>
<tr>
<td><strong>Opportunity for advancement</strong></td>
<td>Correlation Coefficient N 292</td>
<td>.249</td>
</tr>
<tr>
<td></td>
<td>297</td>
<td>0.249</td>
</tr>
</tbody>
</table>

The above table reveals that age has a small positive correlation with the subscales “Collegial nurse physician relations” ($r = 0.160; p = 0.006$), “Nursing foundations for quality of care” ($r = 0.155; p = 0.008$) and “Opportunity for advancement” ($r = 0.249; p = 0.000$).

There is a small positive correlation between years of working as a nurse and “Staffing and resource adequacy” ($r = 0.175; p = 0.003$), and a medium positive correlation with “Opportunity for advancement ($r = 0.268; p = 0.000$).

There is a small negative correlation between career satisfaction and “Emotional exhaustion (EE)” ($r = -0.166; p = 0.04$), and small positive correlations with “Personal accomplishment (PA)” ($r = 0.220; p = 0.000$), “Staffing and resource adequacy” ($r = 0.166; p = 0.004$), “Collegial nurse physician relations” ($r = 0.223; p = 0.000$), “Nurse manager ability, leadership and support of nurses” ($r = 0.147; p = 0.011$), “Nurse participation in hospital affairs” ($r = 0.178; p = 0.002$), “General leave” ($r = 0.214; p = 0.000$), and “Opportunity for advancement” ($r = 0.209; p = 0.000$). There are medium positive correlations with “Nursing foundation for quality of care” ($r = 0.278; p = 0.000$) and “Workplace” ($r = 0.298; p = 0.000$).
When looking at the relationship between the subscales of burnout with the practice environment and job satisfaction, it is clear that emotional exhaustion has medium negative correlations with “Staffing and resource adequacy” ($r = -0.291; p = 0.000$), “Collegial nurse physician relations” ($r = 0.290; p = 0.000$), “Nurse manager ability, leadership and support of nurses” ($r = -0.342; p = 0.000$), “Nursing foundations for quality of care” ($r = -0.270; p = 0.000$), “Nurse participation in hospital affairs” ($r = -0.366; p = 0.000$), “Workplace” ($r = -0.340; p = 0.000$), “General leave” ($r = -0.143; p = 0.13$) and “Opportunity for advancement” ($r = -0.303; p = 0.000$). It also has a small negative correlation with “General leave” ($r = -0.143; p = 0.013$).
“Depersonalization” has a medium negative correlation with “Collegial nurse physician (r = -0.276; p = 0.000), “Nurse manager ability, leadership and support of nurses” (r = -0.284; p = 0.000) and “Workplace” (r= -0.335; p = .000). It also has a small negative correlation with “Staffing and resource adequacy” (r = -0.240; p = 0.000), “Nursing foundations for quality of care” (r = -0.223; p = 0.000), “Nurse participation in hospital affairs” (r = -0.238; p = 0.000), “General leave” (r= 0.196; p = 0.001), and “Opportunity for advancement” (r=-0.214; p = 0.000).

“Personal accomplishment” has a medium positive correlation with “Nursing foundations for quality of care” (r = 0.297; p = 0.000) and “Workplace” (r = 0.286; p = 0.000). It also has a small positive correlation with “Staffing and resource adequacy” (r = 0.179; p = 0.002), “Collegial nurse physician relations” (r = 0.180; p = 0.002), “Nurse manager ability, leadership and support of nurses” (r = 187; p =0.001), “Nurse participation in hospital affairs” (r = 0.242; p = 0.000), “General leave” (r = 0.213; p = .000) and “Opportunity for advancement” (r = 0.216; p = 0.000).

When looking at the relationship between the job satisfaction subscales and the practice environment, the table shows that workplace has a large positive correlation with “Collegial nurse physician relations” (r = 0.472; p = 0.000), “Nurse manager ability, leadership and support of nurses” (r = 0.453; p = 0.000), “Nursing foundations for quality of care” (r = 0.548; p = 0.000) and “Nurse participation in hospital affairs” (r = 0.475; p = 0.000). It also has a medium positive correlation with “Staffing and resource adequacy” (r = 0.381; p = 0.000).

“General leave” has a medium positive correlation with “Collegial nurse physician relations” (r = 0.342; p = 0.000), “Nurse manager ability, leadership and support of nurses” (r = 0.246; p = 0.000) and “Nursing foundations for quality of care” (r = 0.363; p = 0.000). It also has a small positive correlation with “Staffing and resource adequacy” (r = 0.236; p = 0.000), and “Nurse participation in hospital affairs” (r = 0.232; p = 0.000).

“Opportunity for advancement” has a large positive correlation with “Nursing foundations for quality of care” (r = 0.505; p = 0.000) and “Nurse participation in hospital affairs” (r = 0.558; p = 0.000). It also has a medium positive correlation with “Staffing and resource adequacy” (r = 0.395; p = 0.000), “Nurse physician relations” (r = 0.270; p = 0.000), and “Nurse manager ability, leadership and support of nurses” (r = 0.441; p = 0.000).

3.6 INTEGRATED DISCUSSION

This research provides insight into how professional nurses working in psychiatric institutions in South Africa perceive their practice environment, their levels of burnout and their job satisfaction. In this section, the main findings are highlighted and integrated with literature.
The average age of professional nurses in this research is 40 years. This is younger than the national average, where 77% of nurses are between 40-69 years of age (SANC, 2014a). The average number of years that professional nurses have been working in the nursing profession is 11 years, which is consistent with the average age, meaning that the majority of nurses started their career in nursing at around 29 years of age. The majority of participants were female (71.8%), which is more than the average indicated by the SANC statistics. This means that 28.2% of the psychiatric hospital workforce is male, which is much higher than the national average of 8% (SANC, 2014b).

The research findings further indicated that 73.3% of professional nurses have a diploma in nursing and 26.7% has a baccalaureate degree in nursing, which is in line with the national statistics (SANC, 2014c).

Of significance is that 81.9% of professional nurses working in the selected psychiatric institutions are moderately to very satisfied with nursing as their career of choice. This is a higher level of satisfaction than has been reported by medical and surgical nurses in similar research conducted by Klopper and Knobloch (2010). The professional nurses indicated that nursing was the career of choice because they love helping others. They are truly passionate about the human spirit and really want to make a difference in the lives of others. They are hard working, pay attention to detail and are able to analyse data in addition to behavioural cues when doing nursing research. They have a passion for the protection, promotion and optimization of health and abilities, prevention of illness and injury, alleviation of suffering through the diagnosis and treatment of human response, and advocacy in the care of individuals, families, communities and populations.

Nursing can be very lucrative, especially if you move into roles that are more specialized such as psychiatric nursing, or move up into leadership and management roles. Nurses administer care on an ongoing basis to ensure successful recuperation of the patients. They are particularly adept at interacting with patients, putting them at ease, and assisting them in their recovery and overall wellbeing because they may actually spend more face-to-face time with a patient than doctors. If individuals work where they are passionate, there is a possibility for better nurse and patient outcomes.

Looking at the five subscales of the PES-NWI, all were above the mean of 2.5 (M = 2.6 – 3.2), with the subscale “nursing participation in hospital affairs” having the lowest mean score (M = 2.6) and the subscale “nursing foundations for quality of care” having the highest mean score (M= 3.2). This implies that professional nurses working in psychiatric institutions experience the practice environment as positive. The reason why “nursing participation in hospital affairs” has the lowest mean, could be that professional nurses feel that the hospital management
does not involve them in hospital issues such as strategic planning, decision making and problem solving.

Generally speaking, professional nurses working in psychiatric institutions are satisfied with their practice environment. The study conducted by Klopper et al. (2012:691) produced evidence that positive practice environments are key in staff and patient outcomes. The results of their research illustrate that the practice environment is positive and supports the work of the critical care nurse, except for two aspects, namely staffing and resource adequacy ($M = 2.35$) and governance ($M = 2.48$), indicating that the requisite features of theses subscales are not present in the critical care nurses’ current practice environment. Governance, the newly derived subscale, is positively correlated with nurse manager ability, leadership and support ($r = 0.569; p = 0.00$), nurse participation in hospital affairs ($r = 0.479; p = 0.00$), nursing foundations for quality of care ($r = 0.540; p = 0.00$) and job satisfaction: professional advancement and award ($r = 0.498; p = 0.00$).

In another paper published by Coetzee et al. (2012:170) that looked at the five subscales of the PES-NWI, all were above the mean of 2.5 ($M = 2.6 – 3.0$), except for staff and resource adequacy ($M = 2.28$). This signifies that the requisite features of this subscale were not present in the nurses current practice environment. The findings also show that patient to nurse workloads are significantly associated with poor nurse-reported quality of care, patient safety and nurse workforce outcomes, but primarily in public hospitals.

In a study conducted by Van Bogaert et al. (2012:1519), entitled “Nurse practice environment, workload, burnout, job outcomes, and quality of care in psychiatric hospitals”, the mean ratings of nurse-physician relationship and nurse management at the unit level were in the favourable range ($> 2.5$, with predominantly positive responses to questions about desirable elements being present) with values of $2.76$ and $2.88$ respectively, and hospital management and organizational support ($2.5$) were neither favourable nor unfavourable. Workload was assessed as fairly reasonable, with a mean score of $2.35$.

The burnout results show that professional nurses working in psychiatric institutions experience moderate levels of emotional exhaustion, low levels of depersonalization, and moderate levels of personal accomplishment. In the study conducted by Van Bogaert and others, a different picture was discovered as it was found that there was a high level of burnout among nurses and that this was associated with unfavourable job outcomes, patient and family complaints, and patient and family verbal abuse (Van Bogaert et al., 2013: 1129). In the recent past, several Asian studies have focused on burnout syndrome in nurses. Compared with the studies of hospital staff in other countries, doctors and nurses in Mongolia had relatively higher burnout rates. Singaporean nurses experienced high levels of stress related to work.
Emergency and surgical nurses appear to experience higher levels of stress than ward and clinic-based nurses. The most stressful situations for Singaporean nurses were patient-related difficulties and conflicts with colleagues. Organizational issues, such as lack of participation in planning and difficulty in making changes also contributed to work stress experienced by nurses. They also felt vulnerable to stress arising from the interface between work and family commitments. Problems with childcare were significantly associated with emotional exhaustion among Turkish nurses. Iranian nurses also perceived work dissatisfaction and health threats and disequilibrium between family and work demands. Psychiatric nurses in Iran experienced a significantly greater degree of emotional exhaustion than the medical nurses (Chakraborty et al., 2012:122). High nurse burnout levels were found to be significantly associated with nurses “appraisals of quality of care independent of nurse characteristics, working conditions, and other related variables” (Poghosyan et al., 2010:296). A study entitled “Impact of a physical activity program on the anxiety, depression, occupational stress and burnout syndrome of nursing professionals” suggests an association between care environment factors with job outcome and quality of care variables, confirming the mediating position of emotional exhaustion, depersonalization and personal accomplishment, along with perceived workload. Almost one of five respondents reported high or very high levels of emotional exhaustion (Freitas et al., 2014:335). Drawing from the study findings, it appears that staff in psychiatric healthcare settings, although different in some ways from acute care nursing staff, cope with the same types of issues and problems.

As previously explained, for “Job satisfaction”, a mean score of above 2.5 indicates that the participant experienced job satisfaction. Job satisfaction is defined as an employee’s affective reaction to a job, based on comparing actual outcomes with desired outcomes (Klopper et al., 2012:693). Among the results of “Job satisfaction”, “Workplace” has the mean score (M = 2.92) and “General leave has the highest mean score (M = 3.14). “Opportunity for advancement” had a score of (M = 2.37) (Table 3.20). This implies that professional nurses are satisfied with the workplace and general leave and dissatisfied with opportunities for advancement.

A substantial body of research has established the relationship of characteristics of the practice environment with patient and nurse outcomes. A key requirement in further developing an understanding of these relationships in mental health is the identification of the relative influence of the variables on the nurse’s work. The research conducted by Roche et al. (2011:1484) suggests that individual and practice environment factors do affect nurses’ ability and willingness to engage in the therapeutic relationship, a critical aspect of the nurse’s role in mental health. It further suggests that targeted approaches to workplace support,
development and continued education of nurses in mental health may enhance the environment, with potential positive outcomes for nurses and patients.

3.7 CONCLUSION STATEMENTS FROM THE RESULTS

From the findings of the research and the review of the relevant literature, the following conclusions are drawn:

Professional nurses working in psychiatric hospitals in the North West and Gauteng provinces are an average age of 40 years old, indicating a younger mean than the national average.

Professional nurses have an average of 11 years of work experience in nursing, indicating that nursing is possibly a second career option or that they start nursing education at a later stage than school leaving age. Nursing is a female dominated profession as evidenced by the number of the participants in the research, of which 71.8% were female and 28.2% male. The national average is 8% males in nursing, indicating that psychiatric hospitals attract more males than other clinical settings, resulting in a very positive trend.

More professional nurses hold a diploma in nursing (73.3%). Only 26.7% hold baccalaureate degree in nursing. This is a national trend because more nurses qualify from colleges of nursing than from university nursing schools.

A high number of professional nurses is moderately to very satisfied with nursing as career of choice as evidenced by an 81.9% satisfaction rate.

Professional nurses experience the practice environment as positive, with the subscale nursing participation in hospital affairs having the lowest mean score (M = 2.58) and the subscale nursing foundations for quality of care having the highest mean score (M = 3.15).

Professional nurses are satisfied with their jobs, with workplace having the lowest mean score (M = 2.92) and general leave having the highest mean score (M = 3.14).

Professional nurses experience moderate levels emotional exhaustion (M = 20.98), low levels of depersonalization (M = 5.39) and moderate levels of personal accomplishment (M = 34.83).

For the association between demographics and PES-NWI, MBI and JS, only three subscales had a practically significant effect with gender: “Staffing and resource adequacy” (d = 0.24; p = 0.049), “Nursing foundations for quality of care” (d = 0.27; p = 0.033), and “Opportunity for advancement” (d = 0.27; p = 0.039). In all cases, females were more positive than males, and in all cases, the results were statistically significant.
3.8 SUMMARY

This chapter presented the findings of the quantitative research, which was Phase 1 Step 2 as indicated in Chapter 1. The research questions asked in Chapter 1 were answered. The chapter offered an integrated discussion of how professional nurses perceive their practice environment, their levels of burnout and job satisfaction, was followed by the conclusion statements. The next chapter discusses the conceptual framework.
CHAPTER 4: CONCEPTUAL FRAMEWORK

4.1 INTRODUCTION

The previous chapter offered a detailed analysis and description of the quantitative results of the study. In Chapter 4, I discuss the conceptual framework (Step 1 of Phase 2). Using deductive reasoning, main concepts were identified from the empirical data (refer to Figure 4.1) and were classified using the survey list of Dickoff et al., (1968). In this chapter the identified and classified concepts are described by way of reviewing relevant literature. Conclusion statements are deduced after the discussion of each concept.

4.2 DEFINING CONCEPTUAL FRAMEWORK

Current usage of the terms conceptual framework and theoretical framework are vague and imprecise. In this research, conceptual framework is defined as a network of interlinked concepts that together provide a comprehensive understanding of a phenomenon or phenomena (Meleis, 2012:25). It is an abstract, logical structure of meaning that guides the development of the research and enables one to link the findings to the body of knowledge in nursing (Grove et al., 2013:116). The concepts that constitute a conceptual framework support one another, articulate the respective phenomena and establish a framework-specific philosophy. Conceptual frameworks possess ontological, epistemological and methodological assumptions, and each concept within a conceptual framework plays an ontological or epistemological role. Ontological assumptions relate to knowledge of the “way things are,” “the nature of reality,” “real” existence, and “real” action. The epistemological assumptions relate to “how things really are” and “how things really work” in an assumed reality. The methodological assumptions relate to the process of building the conceptual framework and assessing what it can tell us about the “real” world.

Concepts are central to a conceptual framework. A concept is a term used to describe a phenomenon or a group of phenomena and denotes a degree of classification or categorization. A concept provides us with a concise summary of thoughts related to a phenomenon or a group of phenomena, and without such concise labelling, we would have to go into great detail to describe the concepts (Meleis, 2012:25). There is a difference between describing the effect of the practice environment on burnout among professional nurses who work in psychiatric hospitals and summarizing all those details as concepts. The latter is a more concise and a more efficient way of communicating the ideas contained in and related to certain phenomenon. Labelling a concept may make it more feasible to analyse and develop further. A labelled phenomenon or set of phenomena forms a concept, and a concept can be
operationalised further and is more amendable for translation into a research tool (Meleis, 2012:26). Subsequently, considerations on the features of conceptual frameworks follow below.

4.2.1 Features of conceptual frameworks

According to Jabareen (2009:51), the main features of conceptual frameworks are as follows:

- A conceptual framework is not merely a collection of concepts, but rather a construct in which each concept plays an integral role. A conceptual framework “lays out the key factors, constructs, or variables, and presumed relationships among them”. To discourage loose usage of the term conceptual framework, it is proposed that the conceptual framework not be based on variables or factors only, but on concepts. A conceptual framework provides not a casual/analytical setting, but rather an interpretive approach to social reality.

- Rather than offering a theoretical or empirical explanation, as do quantitative models, conceptual frameworks provide understanding.

- A conceptual framework does not provide knowledge of “hard facts” but, rather, “soft interpretation of intentions”.

- Conceptual frameworks are endless in nature and therefore do not enable us to predict an outcome. The idea that human behaviour can be explained and predicted is roughly based on the concept of external factors being caught in an accidental cohesion, and the idea that human actions can be understood, but not predicted, is based on the concept of freedom.

- Conceptual frameworks can be developed and constructed through a process of quantitative or qualitative analysis.

- The sources of data consist of many discipline-oriented theories that become the empirical data of the conceptual framework analysis. Although conceptual framework analysis generates theories or conceptual frameworks from multidisciplinary bodies of knowledge, synthesis, a systematic synthesis of findings across studies seeks to generate new interpretations for which there is a consensus within a particular field of research. In this research the concepts of the conceptual framework is deduced from the quantitative data.

After discussing the features of conceptual frameworks, detail will now be provided on concept identification and concept classification. It is followed by a description of each of the concepts.
4.3 CONCEPT IDENTIFICATION

Concepts were identified from the results of the empirical data, the integrated discussion and the conclusions drawn from the data and the discussion. Figure 4.1 provides the conclusions from Chapter 3 and the concepts identified from results.

4.4 CONCEPT CLASSIFICATION

- The concept classification was done by using the survey list of Dickoff et al. (1968:420) to ensure that main and related concepts were systematically arranged. The survey list of Dickoff et al. (1968:422) uses the following six (6) modified questions for concept classifications in relation to activities:
  - AGENT: Who or what performs the activity?
  - RECIPIENT: Who or what benefits from the activity?
  - CONTEXT: In what context is the activity performed?
  - GOAL: What is the targeted outcome of the activity?
  - PROCEDURE: What is the guiding procedure, protocol or technique of the activity?
  - DYNAMIC: What is the energy source for the activity?

Figure 4.1 shows the process followed from concept identification to concept classification. The concept classification resulted in:

- Agent: The nurse manager
- Recipient: The professional nurse
- Context: Psychiatric nursing and psychiatric hospital
- Goal: Improved staff outcomes
- Procedure: Creation of a positive practice environment
- Dynamics: Motivation

Each of these concepts was discussed and conclusions formulated. Thereafter followed a visual presentation of the concepts, after which they were combined towards the practice theory. The conclusions from both the empirical data and the conclusions from the conceptual framework were used as the basis for the generation of the relational statements of the practice theory.
### Figure 4-1: Procedure for concept classification

- **AGENT:** the nurse manager

Dickoff *et al.* (1968:425) refer to the agent as the person who carries out a certain activity. The agent has the creative freedom to look at what kinds of activities are required to realise any
specified nursing goal. Goals should be constructive and feasible suggestions offered as to such activities. Health professionals such as nurse managers count among those who theoretically maybe feasible agents of nursing activities. The agent in this research is the nurse manager.

4.4.2 **RECIPIENT: The professional nurse**

According to Dickoff *et al.* (1968:426), the recipient refers to the person who receives the activity. In this research, the recipient was the professional nurse.

4.4.3 **CONTEXT: Psychiatric nursing and psychiatric hospital**

Context implies the setting or the environment in which the activity is taking place. Including context within a framework implies that not only physical features of time, space, or structure constitute the framework, though surely these are factors within the framework (Dickoff *et al.* 1968:428). In this research, the context was psychiatric nursing in psychiatric hospitals in South Africa.

4.4.4 **GOAL: Improved staff outcomes**

Goal refers to the end result or the outcome that should be achieved after an activity is implemented (Dickoff *et al.* 1968:428). In this research, the goal was improved staff outcomes.

4.4.5 **PROCEDURE: Creation of a positive practice environment**

Dickoff *et al.* (1968:430) indicate that one function of a procedure is to provide detail sufficient to enable activity to be carried out. Another function of procedure is to safeguard the agent, recipient, and organisation (context) that encompasses the people and the activity. By its very nature a procedure is a general rule rather than a directive to a specified agent at a specified time and place. As an outline of activity, a procedure may include the agent, recipient and context and typical accompaniments of the procedure. In this research, the procedure was the creation of a positive practice environment.

4.4.6 **DYNAMIC: Motivation**

Finally, Dickoff *et al.* (1968:431) argue that to consider activity explicitly based on dynamics is to emphasize the power or energy source of that activity. The dynamics explore all possible power and energy sources, whether chemical, physical, biological, or psychological for any person or thing functioning as agent, as recipient, or as part of a framework for activities to realise a nursing goal. People should limit themselves to considering only psychological power input. In this research, the dynamic is motivation.
Figure 4.1 illustrates the use of deductive logic from concept identification to concept classification according to the modified survey list of Dickoff et al. (1968). A detailed description follows each of the main concepts, namely nurse manager, professional nurse, psychiatric hospitals, improved staff outcomes, creation of a positive practice environment and motivation.

4.5 AGENT: NURSE MANAGER

Nurse managers are directly responsible for maintaining standards of care, managing fiscal resources and development of staff. Some of the titles for this middle management position include “nurse manager”, “head nurse”, “nursing unit manager” or “nurse coordinator.” (Finkelman, 2012:18). Nurse manager responsibilities vary from organisation to organisation, but the most effective nurse managers recognize the importance of point-of-care leaders. Nurse managers are internal stakeholders who play essential roles in managing change, cultural integration, retention, and direction of staff attitudes towards changing healthcare structures. Many nurse managers have to be prepared to deal with staff stress, low morale, staff uncertainty, staff turnover, inadequate quality care outcomes and a decreasing budget, all of which are common problems today. Nurse managers as leaders are involved in visioning, interprofessional team building, workload and work process analysis, stakeholder analysis, and interactive planning (Finkelman, 2012:18). Critical competencies to accomplish these activities include directing others, group management, interpersonal sensitivity, self-confidence, use of influence strategies, analytical thinking, initiative, achievement orientation and direct persuasion. The nurse manager, according to Kelly (2012:375), determines the appropriate mix of personnel in a psychiatric unit and may have personnel with a variety of skills, knowledge and educational levels.

According to Yoder-Wise (2011:55), management is a generic function that includes similar basic tasks in every discipline and in every society. Management is defined as the process of coordinating and integrating resources through the activities of planning, organizing, coordinating, directing, and controlling to accomplish specific institutional goals and objectives (Huber, 2014:21). However, before the nurse manager can be effective, he or she must be well grounded in nursing practice. Five basic functions form part of each manager’s duties, namely to establish objectives and goals for each area and to communicate them to the persons who are responsible for attaining them; to organise and analyse the activities, decisions, and relations needed and to divide them into manageable tasks; to motivate and communicate with the people responsible for various jobs through team work; to analyse, appraise and interpret performance and to communicates the meaning of measurement tools and their results to staff and superiors; and to develop people, including the self. Table 4.1
show the basic management functions as applicable to the nurse manager (Yoder-Wise, 2011:56).

Table 4-1: Basic management functions and nurse management functions

<table>
<thead>
<tr>
<th>Basic manager functions</th>
<th>Nurse manager functions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Establishes and communicates goals and objectives.</td>
<td>Delineates objectives and goals for assigned nursing area.</td>
</tr>
<tr>
<td></td>
<td>Communicates objectives and goals effectively in a nursing unit to staff members who will help attain goals.</td>
</tr>
<tr>
<td>Organises, analyses, and divides work into tasks.</td>
<td>Assesses and evaluates activities on assigned nursing areas.</td>
</tr>
<tr>
<td></td>
<td>Makes sound decisions about dividing daily work activities for staff in a nursing unit.</td>
</tr>
<tr>
<td>Motivates and communicates.</td>
<td>Stresses the importance of being a good team player in a nursing unit.</td>
</tr>
<tr>
<td></td>
<td>Provides positive reinforcement within a nursing environment.</td>
</tr>
<tr>
<td>Analyses, appraises, and interprets performance and measurements.</td>
<td>Completes performance appraisals of individual staff members in a nursing unit.</td>
</tr>
<tr>
<td></td>
<td>Communicates results to staff and management in a nursing unit.</td>
</tr>
<tr>
<td>Develops people including self.</td>
<td>Addresses staff development continuously in a nursing unit through mentoring and preceptorships.</td>
</tr>
<tr>
<td></td>
<td>Furthers self-development by attending educational programmes related to nursing and seeking specialty certification and credentials.</td>
</tr>
</tbody>
</table>

The nurse manager is the environmentalist of the unit. In other words, the manager is constantly assessing the context in which a positive and healthy practice and work environment can affect people’s performance. Therefore, the nurse manager’s role is to ensure that the principles and elements of such an environment are present as defined by the American Organisation of Nurse Executives (Yoder-Wise, 2011:56-57). They are as follows:

- A culture that promotes collaboration through trust, diversity and team orientation.
- A culture with clear, respectful, open and trusting communication.
- A culture in which everyone is accountable and knows what is expected.
- Adequate numbers of qualified staff to meet patient expectations and to provide staff with a balance between work and home life.
- A presence of leadership, who serves as an advocate for nursing, supports empowerment of nurses and ensures availability of resources.
- A structure for participation in shared decision making.
- Recognition of contributions of nursing staff.
• Recognition by nurses of the contribution they provide to practice.

Therefore, a positive practice environment in psychiatric units is characterized by the presence of adequate and competent professional nurses and other health professionals so that care of a higher standard can be made possible. It is also characterised by trust, respect and open communication between those entrusted with the provision of care to psychiatric patients. Nurse leaders and managers are expected to engage professional nurses when important decisions are taken about the operation of the institution. Efficient nurse managers according to Duffield et al. (2010:23) play an important role in staff retention and satisfaction. Improved retention will lead to savings for the organisation, which may be allocated to activities such as training and mentorship to help nurse leaders in developing these critical leadership skills. Strategies also have to be put in place to ensure that nurse leaders receive sufficient organisational support from senior nursing managers.

Another important aspect related to the nurse manager and positive practice environment is quality management, which is discussed below.

4.5.1 Quality management

Defining and measuring quality care are essential for healthcare providers to demonstrate accountability to insurers, patients and legislative and regulatory bodies (Marquis & Huston, 2012: 518). However, achieving quality is not just a matter of better training for providers or delivering more care. The problem is multidimensional, and its complexity begins with the very quality itself. Roussel and Roussel (2009:524) defines quality as a state of mind or work ethic involving everyone in the healthcare agency, while Marquis and Huston (2012:518) define quality as the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge. Management on the other hand is the process of leading and directing all or part of an organisation, often a business, through the deployment and manipulation of resources (Marquis & Huston, 2012:31). Decisions and commitment to improve care must be visible at all levels of the organization, seeking participation from front-line workers to reduce or eliminate errors. Deming is considered by many as the pioneer in quality management. Being an advocate for the principle of management for quality, Deming found that 80% to 85% of the problems were with the system; only 15% to 20% were with workers. Workers should be told this and should be given the freedom to speak and contribute as thinking, creative human beings. Deming also warns against the seven “deadly diseases” that decrease productivity and profitability because they destroy employee morale. These “deadly diseases” are a lack of constancy of purpose; emphasis on short-term benefits evaluation of performance, merit rating, or annual reviews; management by use of only visible figures; mobility of management;
excessive medical costs and excessive costs of liability (Roussel & Roussel, 2009:526; Deming, 2004:1).

Deming’s (2004:1) theory of quality management includes 14 points to ensure positive practice environment:

- **Create constancy of purpose towards the improvement of the product and service that is provided.** Everyone should have a clear view every day, month after month. Satisfy the customer and reduce variation so that employees do not have to shift their priorities constantly.

- **Adopt a new philosophy by learning how to improve systems in the presence of variation, thereby reducing variation in materials, people, processes and product.** End tempering and overreaction to variations.

- **Reduction of dependence on inspection to achieve quality by thoroughly understanding the sources of variation in processes and working to reduce variation.**

- **End the practice of awarding business on the basis of price tag alone.** Instead, minimize total cost by working with a single supplier where possible.

- **Constantly improve the process of planning, production and service provision.** Everyone should use PTCA (plan-to-check-act) cycle.

- **Encourage training on the job.** Know methods of performing tasks and standardize training. Accommodate variation in the ways people learn.

- **Adopt an institute leadership.** Work to help employees do their jobs better and with less effort. Learn which employees are within the system and which are not. Support institutional goals, focus on internal and external customers, coach and nurture pride in workmanship.

- **Drive out fear, including fear of reprisal, fear of failure, fear of providing information, fear of not knowing, fear of giving up control, and fear of change.** Fear makes accurate data non-existent because an individual may fail to implement the information at their disposal.

- **Break down barriers among staff areas, between departments.** Promote cooperation in all the departments.

- **Eliminate slogans, exhortations and targets for the work force.** Improvement requires changed methods and processes. Leaders and managers have to change the system.
• Eliminate numerical quotas for the work force and numerical goals for management. All people do not work at the same level of competency and speed.

• Remove barriers that rob people of pride of workmanship. Encourage the annual rating or merit system.

• Institute a vigorous programme of education and self-improvement for everyone. This can be any education mechanism that improves self-esteem and potential to contribute to improvements in the existing processes and advances in technology.

• Let everyone in the institution work to accomplish the transformation that may be necessary for the organisation.

In addition to quality management, nurse managers are expected to display certain qualities as they interact with other health professionals and psychiatric patients in ensuring a positive practice environment.

4.5.2 The qualities of an effective manager

Two-thirds of people who leave their jobs say the main reason was an ineffective or incompetent manager. A survey of 3,266 newly qualified nurses in a hospital in Philadelphia found that lack of support from their managers was the primary reason for leaving their position, followed by a stressful work environment as the second reason (Whitehead et al., 2010:15). Following are some of the indicators of their stressful work environment: 25% reported at least one needle stick in their first year, 39% reported at least one strain or sprain, 62% reported experiencing verbal abuse and 25% reported a shortage of supplies needed to do their work (Laschinger et al., 2014:1615; Whitehead et al., 2010:15). These results underscore the importance of having effective nurse managers who can create an environment in which new nurses thrive. According to the RN4CAST, nurses do not believe that nurse managers will act if they report shortage of staff and resources, poor quality care and lack of opportunity for advancement. The findings indicate that depersonalisation has a medium negative correlation with “Collegial nurse–physician” (r = -0.276; p = 0.000), “Nurse manager ability, leadership and support of nurses” (r = -0.284; p = 0.000) and “Workplace” (r = -0.335; p = 0.000). It also has a small negative correlation with “Staffing and resource adequacy” (r = -0.240; p = 0.000), “Nursing foundations for quality of care” (r = -0.223; p = 0.000), “Nurse participation in hospital affairs” (r = -0.238; p = 0.000), “General leave” (r = 0.196; p = 0.001), and “Opportunity for Advancement” (r = -0.214; p = 0.000).

The effective nurse manager possesses a combination of qualities such as leadership, clinical expertise and business sense (Whitehead et al., 2010:16). None of these alone is enough; it is the combination that prepares an individual for the complex task of managing a unit or team
of healthcare providers. These three qualities, namely leadership, clinical expertise and business sense, are briefly outlined as follows:

• **Leadership:** The complexities of healthcare requires new leadership approaches to achieve institutional goals while developing and sustaining healthy practice environments (Fennimore & Wolf, 2011:204). All the skills of the leader are essential for the effective manager. They are skills needed to function as a manager. The leadership characteristics of the nurse manager are integral to achieving clinical quality and patient care outcomes through the establishment of structures and processes that support nurse empowerment and evidence-based practice (Clavelle et al., 2012:195). Traditionally, nurses have been inadequately led and over-managed, yet today they are faced with different challenges and opportunities and institutions are continuously facing changes that require an adaptive and flexible leadership (Doody & Doody, 2012:1). According to Germaine and Cummings (2010:425), nursing managers and leaders may enhance nurses’ performance by addressing and understanding factors that affect the motivation and the ability of nurses to work. Effective leaders ensure that adequate staffing and other resources are available to achieve safe care and optimal patient outcomes (Wong et al., 2013:709). At institutional level, senior nurse managers contribute to strategic directions through their involvement in senior level decision making and their ability to influence how nursing is valued and practiced. It should be remembered that leadership that focus on task completion alone is not sufficient to achieve optimum outcomes for the nursing workforce (Cummings et al., 2009:363). Nurse managers are recognised as leaders with attributes that could enable patient care and enterprise to achieve organisational objectives. Key leadership attributes that are necessary to influence organisational success (Zori et al., 2010:306) are being a visionary, an expert achiever, a communicator, a mentor and a critical thinker. Both critical thinking skills (interpretation, analysis, evaluation, inference, explanation and self-regulation) and dispositions of critical thinking such as being truth seeking, open-mindedness, analytic, systematic and self-confident, are seen as important competencies for nurse leaders.

• **Clinical expertise:** According to Whitehead et al. (2010:16), it is very difficult to help others develop their skills and evaluate how well they have done so without possessing clinical expertise oneself. It is probably not necessary (or even possible) to know everything all other professionals on the team know, but it is important to be able to assess the effectiveness of their work in terms of patient outcomes.

• **Business sense:** Nurse managers also have to be concerned with the “bottom line”, the cost of providing the care that is given, especially in comparison with the benefit received
from that care and the funding available to pay for it. This complex requires knowledge of
budgeting, staffing, and measurement of patient outcomes (Linette & Sherman, 2014:35).

Furthermore, nurse managers have certain powers such as (Marquis & Huston, 2012:31) an
assigned position within the formal organisation, a legitimate source of power due to the
delegated authority that accompanies their position, they are expected to carry out specific
functions, duties and responsibilities, emphasize control, decision making, decision analysis
and results, manipulate people, the environment, money, time, and other resources to achieve
organisational goals, have a greater formal responsibility and accountability for rationality and
control than leaders and they also direct willing and unwilling subordinates.

Nurse managers are confronted with challenges or negative workplace behaviours that they
are expected to manage on a daily basis. These negative behaviours could include
aggression, emotional abuse, interpersonal harassment, horizontal violence, bullying (a
repeated mistreatment, including humiliation and intimidation that interferes with job
performance), mobbing and incivility (Lindy & Schaefer, 2010:285). Bullying has a serious
negative effect on the individuals and the institution. It contributes to increased worker
compensation, decreased morale and engagement, and diminished satisfaction among staff
members and patients. Direct costs associated with bullying are increased turnover,
decreased quality of work and increased absenteeism among staff members. On the other
hand indirect costs include decreased staff commitment and loss of productivity (Brewer et al.,
2013:409).

4.5.3 Conclusion statements on the agent: the nurse manager

In conceptualizing the agent, the nurse manager, the following statements are deduced:

- Nurse managers are responsible for maintaining standards of care through clinical
expertise, ensuring the availability of adequate resources and providing direction and
leadership in the management of a health facility.

- Nurse managers are change agents, usually has business sense and ensures that the
objectives and goals of the institution are achieved.

- Nurse managers motivate and communicate effectively, are responsible for team building,
managing staff turnover, reducing stress levels and low morale among staff members to
create a positive practice environment.

- Nurse managers ensure that staff members are engaged in staff development on a
continuous basis to maintain quality patient care.
They are responsible for planning, organizing, directing and controlling the activities of the institution.

Managers should display self-confidence when interacting with employees during decision making and problem solving.

The conceptualisation of the agent is depicted in Figure 4.2 (next page):

![Diagram](image)

**Figure 4-2: Conceptualisation of the nurse manager**

The figure above shows that the nurse manager possesses clinical expertise in psychiatric nursing in a psychiatric hospital environment. The nurse manager is a change agent who provides direction and leadership as she/he executes management activities on a daily basis to create a positive practice environment.

**4.6 RECIPIENT: PROFESSIONAL NURSE**

According to the Nursing Act, (Act No. 33 of 2005), section 30, a professional nurse is a person who is qualified and competent to independently practice comprehensive nursing in the manner and to the level prescribed and who is capable of assuming responsibility and accountability for such practice. The person is registered with the nurse regulatory and registering authority of the country and is trained at a higher education institution for a period of three to four years. He or she is called a registered or professional nurse and mainly works in clinical nursing services (Awases et al., 2013:2; Burton & Ormrod, 2011:1). A professional
nurse, according to Muller (2013:34), is a person who is educated and competent to practice comprehensive nursing independently, who assumes responsibility and accountability for such practice and who is registered and licensed as a professional nurse. The word profession is derived from the Latin word profiteer, which means to make an open or public statement of one’s beliefs and intentions and of one’s acknowledgement of a certain way of life (Searle et al., 2009:8). The truly professional person is one who, by virtue of intellectual capacity, education and moral outlook, is capable of exercising intellectual and moral judgement at a high level of responsibility. The professional nurse maintains judgement based on broad knowledge, penetrating wisdom about the particular circumstances, and great moral certitude about her actions and the actions that promote societal trust. This is the essence of all professionalism. The criteria that form the conceptual framework of professionalism for nursing in South Africa are: the existence of body of specialized knowledge and skill pertaining to the profession of nursing derived from the sciences basic to medicine – the biological, physical, medical and pharmacological sciences, the social sciences – sociology, psychology, cultural anthropology, philosophy and ethics; the legal and ethical foundations on which professional practice rests; the role and function that the profession undertakes in society; the development of a specialised body of knowledge obtained through research and empirical experience; the education and training of professionals or neophytes – those who are new to the profession at institutions of higher education; the autonomy of the nursing profession in making prudent and binding decisions consistent with the scope of practice. This autonomy is described in the dependent, interdependent and independent functions of a nurse (Nursing Act, 33 of 2005; Searle et al., 2009:8).

The other criteria for professional status are that the aspirant to a professional status must prove his/her competence by submitting proof of the content of his/her education and training and of supporting examinations that he/she has passed to the statutory registering body (SANC, 1985). The examination dealing with the practice of the profession and with the synthesis of all the knowledge that culminates in professional practice must be conducted by persons who are members of the profession (Nursing Act, 33 of 2005).

South Africa is experiencing a serious shortage of professional nurses that has to be addressed to prevent crises in healthcare facilities. According to Mokoka et al. (2010:1), nurse turnover in South Africa influences the country’s nursing shortages. This appears to be the case globally (Twigg & McCullough, 2013:85). Internal migration in the South African healthcare and emigration to other countries are two major factors contributing to the increased turnover rate of South African professional nurses. South African nurses are attracted to more affluent countries that can offer more in terms of competitive incentives, better working conditions and resources, safety and the low prevalence of HIV/AIDS.
Job satisfaction and retention of professional nurses are major concerns for nurse managers, particularly as the demand for professional nurses continues to exceed the supply (McGlynn et al., 2011:260). As job satisfaction decreases, the possibility of nurses leaving their employment increases.

The functions of a professional nurse according to the Nursing Act no.33 of 2005 are the collection of key activities perceived as essential for the delivery of knowledgeable, competent, legally and ethically based nursing care to a patient, family, group or community. These functions can be classified as:

- **Dependent function**

  The dependent functions of the professional nurse are to obey the law that authorizes his/her practice and the common and relevant statutory laws. He/she can function as a nurse only if he/she is either registered or enrolled. He/she is dependent on the law to be a nurse and to perform certain functions, his/her practice is not based on that which the doctor prescribes, requests or directs for the patient. If the nurse does not observe the provisions of Nursing Act, Act no. 33 of 2005, he/she becomes criminally liable, and if he/she does not observe other health-related legislation, he/she may become civilly or criminally liable (Searle et al., 2009:109; Yoder-Wise, 2011:355).

- **Independent function**

  As mentioned earlier, nursing is a profession separate from that of medicine and the professional nurse must therefore have a function independent of the doctor. Despite the assumption by nurses and doctors before the 1920s that nurses were dependent on doctors, this was in fact not the case, as the Pharmacy Act, Act no. 101 of 1965 provided, that the nurse was a practitioner who could be disciplined for his/her misdemeanours under the same regulations that pertained to medical practitioners and dentists, thereby indicating his/her personal professional accountability. He/she is totally responsible and accountable for her actions and the doctor cannot be held accountable for them. He/she is entitled to expect that the nurse, as a professional person, is competent and has the integrity to carry out his/her functions with accuracy and skill. He/she can decide whether he/she has the knowledge and competence, and whether the act would be legally and/or ethically permissible for his/her to participate in or carry out on his/her own. He/she has a duty to act responsibly within the parameters of his/her scope of practice, the legal and ethical constraints, and her own level of competence. This duty forms the basis of his/her accountability (Searle et al., 2009:109; Yoder-Wise, 2011:114).
• **Interdependent function**

Interdependence is the interrelationship between various members of the healthcare team as they performing certain activities to care for the psychiatric patient. It is particularly significant in the relationship between doctor and nurse, for both have an interdependent function that is executed through the actions of the particular healthcare team member to whom an action is delegated, or that authorizes such a member to perform an act that the law requires a specific category of practitioner to perform. For example, certain medications may only be obtained on prescription by a registered medical practitioner (Searle *et al.*, 2009:114; Yoder-Wise, 2011:14).

The role of professional nursing continues to expand and incorporate increasingly higher levels of expertise, specialization, autonomy and accountability from both a legal and ethical perspective. This expansion has caused concerns for nurse managers and a heightened awareness of the interaction of legal and ethical principles (Yoder-Wise, 2011:69). Areas of concern include professional nursing practice, legal issues and ethical principles. These are subsequently discussed.

**4.6.1 Professional nursing practice**

The scope of nursing practice, those actions and duties that are allowable in the nursing profession, is defined and guided by the government in (Yoder-Wise, 2011:70), Act no. 33 of 2005 in South Africa (Yoder-Wise, 2011:70). The Nursing Act is the most important piece of legislation for nursing because it affects all facets of nursing practice. Professional nurses are well advised to know and understand the provisions of the Nursing Act. This is especially true in the areas of diagnosis and treatment. Legislations vary greatly on whether professional nurses can diagnose and treat or merely assess and evaluate. Professional nurses are expected to display professionalism throughout their career. Professionalism refers to the extent to which the individual has accepted the culture, values, norms and behaviours of the profession as part of his/her professional self (Mellish *et al.*, 2011:125). According to Mulaudzi *et al.* (2014:4), it begins with a need that is identified by the society.

In ensuring a positive practice environment in psychiatric institutions, professional nurses have to be familiar with the provisions of the Nursing Act no. 33 of 2005 and the Mental Health Care Act, Act 17 of 2002 so that they should know what is expected of them as they provide care to patients.

**4.6.2 Legal issues**

Professional nurses frequently serve as mentors and consultants for the nurses whom they supervise. It is imperative that professional nurses have a full appreciation for this area of the
law as negligence and malpractice continue to be the major causes of action brought against nursing staff members (Yoder-Wise, 2011:71). Professional nurses cannot guide and counsel their subordinates unless they are fully knowledgeable about this area of the law. Negligence denotes conduct that is lacking in care and typically concerns an act that is not professionals. Many experts equate negligence with carelessness, a deviation from the standard of care that a reasonable person would deliver. Malpractice, sometimes referred to as professional negligence, concerns professional actions and is the failure of a person with professional education and skills to act in a reasonable and prudent manner. Issues of malpractice have become increasingly important to the professional nurse as the authority, accountability and autonomy of professional nurses have increased. Accountability means that individuals, organisations and the community are responsible for their actions and they may be required to explanation to others (Burton & Ormrod, 2011:57). As professional nurses execute their responsibilities, they need to avoid negligent behaviour, thereby ensuring a safe and positive practice environment for patients and complying with ethics.

4.6.3 Ethical principles

Ethics is an area of professional practice in which professional nurses should have a solid foundation, because it is becoming increasingly more prominent in clinical practice settings (Yoder-Wise, 2011:89). However, it remains an area in which many professional nurses feel the most inadequate. This is partially because ethics is much more nebulous than are laws and regulations. In ethics, there are no right and wrong answers, just better or worse answers and professional nurses seek mentorship and counselling from nurse managers when they encounter difficult situations. Therefore, professional nurses must have a deep understanding of ethical principles and their application. Ethical principles, those incorporated daily in patient care situations are equally paramount in the effective professional nurse’s work. Ethical principles that the professional nurse should consider when making decisions include autonomy, beneficence, non-maleficence, veracity, justice, paternalism, fidelity and respect for others (Yoder-Wise, 2011:89; Muller, 2013:62-63). Respect as a function of human dignity is the primary ethical responsibility for nurses in practice. Respect requires that each person should be valued as a unique individual equal to others and that every aspect of a person’s life is valued (Chitty & Black, 2011:108). In order to ensure a positive practice environment, these ethical principles have to be considered at all times. Some of these ethical principles were discussed in Chapter 1 and Chapter 2 of this research.

To have a better understanding of a positive practice environment in psychiatric institutions, the responsibilities of a professional nurse should be looked into.
4.6.4 Responsibilities of a professional nurse

Responsibility according to Kelly (2012:370) implies reliability, dependability and the obligation to accomplish work when an assignment is accepted. It is the obligation to perform required tasks to achieve certain goals (Booyens & Bezuidenhout, 2013:139). Delegation has long been a function of professional nurses, although the scope of delegation and the tasks being delegated have changed dramatically over the last two decades (Huston, 2010:122). In the 1900s, some healthcare institutions began assigning non-nursing healthcare workers to nursing departments under the supervision of a nurse manager. As a result, the professional nurse’s role changed in many acute care institutions from one of direct care provision to one requiring delegation of patient care to others. This role of delegator and supervisor increased the scope of legal liability for the professional nurse. Although there is limited case law involving nursing delegation and supervision, it is generally accepted that the professional nurse is responsible for adequate supervision of the person to whom an assignment has been delegated. Although professional nurses are not automatically held liable for all acts of negligence on the part of those they supervise, they may be held liable if they were negligent in the supervision of those employees at the time that those employees committed the negligent acts. Liability is based on the professional nurse’s failure to determine which patient needs could safely be assigned to a subordinate or for failing to closely monitor a subordinate who requires such supervision. Experienced professional nurses have traditionally been expected to work with minimal supervision. The professional nurse who delegates care to another competent professional nurse does not have the same legal obligation to supervise that person’s work closely as when the care is delegated to auxiliary or enrolled nurses. In assigning tasks to these categories of nurses, the professional nurse must be aware of the job description, knowledge base and demonstrated skills of each person (Huston, 2010:123; Hinno et al., 2011:133).

The positive practice environment can be maintained by ensuring that care provided by professional nurses is patient-centred.

4.6.5 The core competency: Patient–centred care

Patient-centred care is described as identifying, respecting and caring about patients’ differences, values, preferences and expressed needs, relieving pain and suffering, coordinating continuous care, listening to, clearly informing, communicating with, educating patients, sharing decision making and management, continuously advocating disease prevention, wellness and promotion of healthy lifestyles, including a focus on population health (Finkelman, 2012:216). Patient-centred care is designed to focus on patient needs rather than staff needs and the required care and services are brought to the patient (Kelly, 2012:359).
The main issue is for professional nurses to move away from a focus on disease or medical problems to focus on the individual. Patients who are involved in their own care have better outcomes. However, if there is a positive practice environment, the patient outcomes are better.

Over the last fifteen years researchers and experts have examined the skills required by healthcare professionals to provide effective patient-centred care, which includes sharing power and responsibility with patients and caregivers, communicating with patients in a shared and fully open manner, taking into account patients' individuality, emotional needs, values and life issues, implementing strategies to reach those who do not present for care on their own, including care strategies that support the broader community and enhancing prevention and health promotion. Effective patient-centred care requires that professional nurses collaborate and coordinate care. The patient, and when appropriate the patient's family, should be engaged in the care delivery process. Diversity issues have to be considered to ensure that the patient's values and preferences are integrated in the process. Patient-centred care is directly related to consumerism and the need for patient advocacy, which means that the patient is supported and makes decisions, not the healthcare provider. Informatics is also an area that supports patient-centred care. Patients can get more current information and access experts when they need it, and professional nurses can get information easily to plan care with the patient (McCallin & Frankson, 2010:319; Finkelman, 2012:217).

The economic state of the country has an impact on the availability of professional nurses and positive practice environment and is discussed below.

4.6.6 The impact of the socio-economic conditions on the availability of professional nurses

According to Armstrong et al. (2013:6), nurses belong to the largest group of healthcare professionals and are affected by any economic factors that impact indirectly or directly on healthcare delivery and nursing. The brain drain of professional nurses is often linked directly to the socio-economic status of the country in as far as nurses usually constitute a greater number of the public servants in the public sector (Searle et al., 2009:370). A small increase in salary for nurses therefore has a major impact on the national budget. Nurses then tend to migrate to ‘richer’ countries for better remuneration. This phenomenon is significant in South Africa and in other countries around the world. It should be kept in mind that positive practice environment attracts and retains nurses. Poorer countries, specifically those in the developing world, suffer most and have high morbidity and mortality figures and the least trained professionals. As far as the nursing professions of the African regions are concerned, according to the (Southern African Development Community) SADC agreements, greater
cooperation and the possible development of a common market system has been negotiated. Within the SADC countries, strategies have been designed to facilitate the countries assisting one another in recruiting and retaining nurses and other health professionals to meet their health needs. The World Health Organisation (WHO) (Searle et al. 2009:370) predicts that in a few decades there may be an international deficit of four million nurses. The focus on morbidity and mortality patterns will then shift to a major concern of who is taking care of the ill. In terms of proactive strategies to recruit and retain professional nurses and to enhance patient satisfaction, the following principles should be further explored by the nursing profession, as well as the South African Nursing Council (SANC) and the Department of Health (Searle et al., 2009:370):

- Create innovative strategies and structures to establish an enabling environment for professional nurses to function effectively and to experience job satisfaction.
- Design recruitment strategies targeted at school children and young adults to enter the profession.
- Develop training to accommodate school leavers and persons whose families have been established and who wish to enter the profession.
- Develop support systems for professional nurses, such as flexi-time shifts, crèche and after-school care facilities to enable persons with family commitments to enter and stay in the profession.
- Develop re-training and in-service training programmes for nurses who wish to re-enter the profession.
- Develop structures and systems within nursing services to create facilitative rather than threatening or punitive work environments.
- Conduct relevant and appropriate research, and implement the research findings.
- Create partnerships between public sector, private sector and even non-profit organisations to complement healthcare.
- Include nurses at all levels in decision-making.
- Involve community members in terms of open days at health facilities, health consumer satisfaction surveys or community-initiated projects for fundraising and volunteering.
- Work closely with government to add to remuneration packages, incentives and/or allowances.
Professional nurses should always ensure that quality and safety is maintained in psychiatric hospitals throughout their practice and this is briefly discussed in the next paragraph.

4.6.7 Quality and safety

The rapidly changing healthcare delivery system is driven by many forces that influence the current movement toward improved quality and safety (Whitehead et al., 2010:132). Some of these forces include economics, societal demographics and diversity, regulation and legislation, technology, healthcare delivery and practice, and environment and globalization. Quality is the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current and professional knowledge (Whitehead et al., 2010:135). According to Huber (2014:292), quality refers to characteristics and the pursuit of excellence. Professional nurses have to be aware that quality has characteristics such as: a link to key elements of the organisation’s strategic plan, a quality council consisting of the institution’s top leadership, training programmes for all levels of personnel, mechanisms for selecting improvement opportunities, formation of process improvement teams, staff support for process analysis and redesign and personnel policies that motivate and support staff participation in process improvement (Whitehead et al., 2010:135). The assessment of the practice environment in a psychiatric institution should include issues of safety for the patients and nurses and strategies must be identified for dealing with suicidal or aggressive behaviour (Stuart, 2013:655). One way to ensure quality and the safety of patients is the implementation of clinical pathways. Professional nurses work in collaboration with other health professional through clinical pathways, which are explained below.

4.6.8 Clinical pathways

Healthcare organisations are dependent on providing effective, efficient care. This requires a clear framework of practice for the inter-professional team. Collaborative care and inter-professional care are intertwined, as the development of clinical pathways and their implementation requires inter-professional collaboration (Finkelman, 2012:225). Clinical pathways are defined as an optimal sequencing and timing of interventions by physicians, professional nurses and other staff for a particular diagnosis or procedure designed to minimize delays and resource utilization and to maximize the quality of care (Finkelman, 2012:225). They are care management tools that outline the expected clinical course and outcomes for a specific patient type and should be evidence-based, reflecting the best knowledge to date for patient care (Kelly, 2012:362). Pathways provide direction in the coordination of care and ensure that outcomes are met within a designated time frame. The emphasis is on efficient use of resources and controlling costs. They have an inter-
professional focus, and therefore include all aspects of the patient’s care that are critical to meeting outcomes. They can be used to demonstrate compliance with standards of care, accreditation and regulatory requirements. These tools assist professional nurses during orientation and in teaching nursing and medical students and other health professionals. Clinical pathways have the following advantages for the institution: they organize data logically, prepare professional nurses for computerization, improve outcomes, reduce resource utilization and provide teaching tools for the professional nurse (Finkelman, 2012:226).

This would imply that to promote a positive practice environment in a psychiatric institution, there should be a collaboration between doctors, nurses and other health professionals to improve patient outcomes in psychiatric institutions.

Politics influence the work environment. This can never be overlooked, because it affects what happens in health establishments. It is, however, the professional nurses’ reaction to this that will result in a positive or toxic work relationship.

4.6.9 Politics in the workplace

Politics is the art of using legitimate power wisely and requires clear decision making, assertiveness, accountability and the willingness to express one’s own views (Marquis & Huston, 2012:294). It also requires being proactive rather than reactive and demands decisiveness. Managers in power positions in today’s healthcare settings are more likely to recognize their innate abilities that support the effective use of power and managers should understand politics within the context of their employing organisation. Political instability paralyses forward thinking and constructive planning. (Searle et al., 2009:371). Nurses as political constituents have a right to petition, lobby or persuade policymakers to ensure that their concerns and interests are heard (Cherry & Jacob, 2008:478). Such actions provide those individuals who are stakeholders in a particular issue an opportunity to be heard. Through lobbying, policymakers are provided with needed information from health experts on which to base their decisions. Professional nurses are expected to take an active role in promoting fairness and equality and to manage discrimination at work on a daily basis (Sharples & Elcock, 2011:135). According to Hall and Ritchie (2011:16), nursing does not exist in a vacuum, the social and political context prevailing during the development of nursing is critical in determining an outcome.

In South Africa, there are different ethnic groups with different cultures and different belief systems. These differences can be managed by formulating good policies that are considerate of these differences, thereby promoting a positive practice environment for all health professionals and patients.
4.6.9.1 The government’s health policy

- The goal of “health for all” and initiatives such as the Millennium Development Goals (MDG) are strategies designed to address current and future needs of populations (WHO, 2011). Comprehensive health services, with primary healthcare as the baseline, have become vital in ensuring accessible and equitable healthcare for all, as evidenced by the title of the World Health Organisation (WHO) 2011 report Primary Healthcare, now more than ever. Governments’ health policies are important determinants in healthcare delivery and have a direct impact on the number of professional nurses required for healthcare delivery, the nature of their training and the impact on the population’s health status. According to WHO, health systems do not gravitate naturally towards the goals of primary healthcare, which is also applicable to psychiatric nursing. The report furthermore highlights three “particularly worrisome trends” (WHO, 2011):

- Some health systems tend to focus disproportionately on curative care. If curative care is a government’s health delivery model, the curriculum for professional nurses is curatively orientated and the health system is hospital-centred, as opposed to decentralisation. If primary healthcare is the delivery model, the system is clinic-centred.

- Health systems that respond reactively to disease and that focus on short-term results often provide fragmented healthcare.

- If a government does not act strategically and effectively in a health system, there is a gap for unregulated commercialisation of health.

The WHO sees the professional nurse as the main provider of healthcare in all countries, especially in developing countries. In line with the policy of primary healthcare and provided that there is the political will to realize the MDG, professional nurses have to gear their philosophy of service, their education programmes and their organisational abilities towards providing effective comprehensive healthcare services, in particular the component dealing with primary healthcare (Haffeld, 2013:43). Government can make a success of health policies only with the wholehearted support of health professionals. It is therefore necessary to involve professional nurses in policy development and implementation. Despite the United Nations (UN) Secretary General’s call for a new generation of sustainable development goals (SDG), the SDG’s have been accepted for implementation by countries, but where the MDG’s were mainly directed at the developing world, the SDG’s have bearing in all countries. They are part of an agenda that goes beyond development for the world’s poorest populations to achieving the goal of planetary sustainability. Therefore, the SDG’s can be seen as complementary to the MDG’s, offering an opportunity to fulfil the Millennium Declaration (Haffeld, 2013:43).
People are at the centre of sustainable development. The promise is to thrive in a world that is just, equitable, and inclusive where all stakeholders have to work together to promote sustained and inclusive economic growth, social development and environmental protection benefiting all without distinction of age, sex, disability, culture, race, ethnicity, origin, migratory status, religion, economic or other status (DoH, 2015; Tangcharoensathien et al., 2015:2). Based on these inspirations, the 17 interconnected sustainable development goals (SDG’s) are proposed:

- **Goal 1**: Poverty should be ended in all its forms everywhere.
- **Goal 2**: End hunger, achieve food security and improved nutrition and promote sustainable agriculture.
- **Goal 3**: Ensure healthy lives and promote the well-being for all at all ages.
- **Goal 4**: Ensure inclusive and equitable quality education and promote lifelong learning opportunities for all.
- **Goal 5**: Achieve gender equality and empower all women and girls.
- **Goal 6**: Ensure availability and sustainable management of water and sanitation for all.
- **Goal 7**: Ensure access to affordable, reliable, sustainable and modern energy for all.
- **Goal 8**: Promote sustained, inclusive, sustainable economic growth, full and productive employment and decent work for all.
- **Goal 9**: Build resilient infrastructure, promote inclusive and sustainable industrialization and foster innovation.
- **Goal 10**: Reduction of inequality within and among countries.
- **Goal 11**: Make cities and human settlements inclusive, safe, resilient and sustainable.
- **Goal 12**: Ensure sustainable consumption and production patterns.
- **Goal 13**: Take urgent action to combat climate change and its impacts.
- **Goal 14**: Conserve and sustainably use the oceans, seas, and marine resources for sustainable development.
- **Goal 15**: Protect, restore, and promote sustainable use of terrestrial ecosystems, sustainably manage forests, combat desertification, and halt and reverse land degradation and halt biodiversity loss.
• **Goal 16**: Promote peaceful and inclusive societies for sustainable development, provide access to justice for all and build effective, accountable and inclusive institutions at all levels.

• **Goal 17**: Strengthening the means of implementation and revitalize the global partnership for sustainable development.

Ensuring healthy lives and promoting the wellbeing of all ages imply that when policies are formulated by policymakers, they should be such that they provide for adequate appointment of professional nurses. Therefore, addressing the challenge of the shortage of professional nurses and ensuring the implementation of the sustainable development goals will ultimately promote positive practice environment in psychiatric institutions.

### 4.6.10 Conclusion statements on the recipient: the professional nurse

In conceptualising the recipient, professional nurse, the following statements are deduced and graphically depicted in Figure 4.3:

- Professional nurses are responsible and accountable for their practice and actions and are expected to practice within the legislative framework.

- Professional nurses are capable of exercising intellectual and moral judgement when executing duties because of the knowledge and skills acquired during training.

- Professional nurses have a responsibility to delegate tasks to their subordinates and are able to consider whether the subordinate is capable of carrying out the delegated task, but remain accountable.

- When providing care to patients, professional nurses should always involve the patient in the decision making as it improves patient outcomes.

- Quality improvement should be maintained at health facilities to ensure that patients receive care that is of a high standard.

- Professional nurses have to work in collaboration with other health professionals to ensure quality patient care.

- Professional nurses who are placed in positions where political factors dominate their daily work need a great deal of support from healthcare authorities, their professional association and their colleagues.

The conceptualisation of the recipient is depicted in Figure 4.3.
In summary, a professional nurse is a person who has undergone formal education and training at a higher education institution to acquire knowledge, skills and competence that enables her or him to provide quality care. The professional nurse is expected to function independently, dependently and interdependently, interacts with other members of the multidisciplinary team and functions within the legal-ethical framework.

4.7 CONTEXT: PSYCHIATRIC NURSING AND THE PSYCHIATRIC HOSPITAL

The context is discussed by referring to three levels, namely the micro level (psychiatric hospital), the meso level (psychiatric practice in South Africa) and the macro level (international perspectives).

4.7.1 Psychiatric hospital

Psychiatric hospitals are hospitals specializing in the treatment of serious psychiatric disorders (Porter, 2006). Psychiatric hospitals differ in their methods and goals. Some hospitals specialise only in outpatient treatment or short-term treatment for low-risk patients. Others specialise in the permanent or temporary care of individuals who need routine care, treatment or a specialized and controlled environment as a result of a psychiatric disorder. Patients are often admitted on a voluntary basis, but involuntary admission occurs when an individual poses a danger to themselves or others (Mental Health Care Act no.17 of 2002). Modern psychiatric hospitals emanate from and eventually replaced the older “lunatic asylums”. The development of the modern psychiatric hospital coincides with the rise of organized, institutional psychiatry (Porter, 2006). While there were earlier institutions that accommodated the psychiatrically ill individuals, the arrival of institutionalization as a solution to the problem
of psychiatric illness was an event of the nineteenth century. Psychiatric hospitals are confronted with various challenges and violent incidences. According to Times Live (2015:3), juvenile psychiatric patients who do not receive treatment in government institutions are at risk of being raped. The head of the department for psychiatric services allocates small budget for mental health. A widow sued the government after her husband fell from a 14 storey while he was admitted and died, there is a shortage of specialized hospitals, there is shortage of specialized healthcare professionals such as psychologists, psychiatric nurses and psychiatrists. For the second time in just over a year at the maximum security unit (Clifton T Perkins) public psychiatric hospital was charged for killing a patient and a female patient was strangled to death by a male patient in a medium security unit in September 2010 (Kilar & Fenton, 2011).

There are different types of modern psychiatric hospitals, but all of them house persons with a variety of psychiatric illnesses (Porter, 2006). The emphasis of these hospitals is to make life as normal as possible for patients while they are taking their treatment until they are ready to be discharged. It is important to note that patients are not allowed to keep their medication in their rooms to prevent the risk of overdose. While some open units remain unlocked, others use locked entrances depending on the type of patients admitted. Another type of psychiatric hospital is a medium–term hospital, which provides care lasting for several weeks. Most medications used for psychiatric purposes take several weeks to take effect, and the main objective of these hospitals is to monitor the patient for the first few weeks of treatment to ensure that the treatment is effective (Porter, 2006). Juvenile wards are sections of psychiatric hospitals or psychiatric wards set aside for children and/or adolescents with mental illness. There are institutions that specialize only in the treatment of juveniles, particularly managing problems such as self-harm, drug abuse and eating disorders. Long-term care facilities are intended to reintegrate the patient into the society once the medication has stabilized the condition (Porter, 2006). An example of this unit is the Bophelong hospital in Mahikeng and Sterkfontein hospital in Krugersdorp. These hospitals provide rehabilitation and stabilization for those who have conditions such as depression, eating disorders and so on. Halfway houses are facilities that provide assistance for patients with mental illness for an extended period of time and often assist in the transition to self-sufficiency. Many psychiatrists regard the availability of these institutions as one of the most significant aspects of mental health system, although the system requires sufficient funding (Mokgothu et al., 2015:1).

Current psychiatric services should be seen against the background of recent developments in psychiatry. During the first half of the 20th century, as the numbers of chronic patients in psychiatric hospitals in Europe and North America began to rise, it became increasingly difficult to continue providing humane care (Robertson et al., 2014:417). After positive
experiences with community and outpatient treatment during World War II, a rising opinion in favour of treating mental illness in the community gave rise to community mental health. Simultaneously, attempts were made to phase out custodial approaches to care in psychiatric hospitals by introducing multi-professional teams and psychotherapeutic principles of treatment. These developments also characterized community mental health centres, day programmes (psychiatric day hospitals), and psychiatric units in general hospitals, which proliferated as a result of the emphasis on community-based care, which aims at preventing mental illness and promoting mental health (Robertson et al., 2014:418).

In spite of these achievements, the community mental health movements have had disappointing results with regard to the provision of community-based residential, social and occupational facilities, acceptance by the community of chronic patients, and the provision of adequate medical and psychiatric care for them (Robertson et al., 2014:418). This led to increasing numbers of chronic patients drifting onto the streets. Furthermore, new problems became apparent in countries where chronic patients are not institutionalized. These include alcohol and drug abuse, suicide attempts, violence and criminality, unplanned pregnancies and unfit parenting, and an increased social and economic burden. Aggressive and violent behaviour of inpatients in psychiatric health facilities occur globally. This is a frequent and serious nursing care challenge (Van Wijk et al. 2014:1). These behaviours may contribute to psychiatric nurses experiencing burnout, emotional exhaustion and occupational stress (Ngako et al., 2012:1). Temane et al. (2014:2) believe that nurses working in psychiatric hospitals have to be provided with a support system to assist them to cope when working under such environments.

Every discipline in nursing has its own history and so does psychiatric nursing. What follows is an overview of historical perspectives in psychiatric nursing.

**Historical perspectives**

In 1873, Linda Richards graduated from the New England Hospital for Women and Children in Boston. She developed better nursing care in psychiatric hospitals and organized nursing services and educational programmes in state mental hospitals in Illinois (Stuart, 2013:2). Linda believed that mentally ill patients have to be taken care of just like patients who are physically ill. For these activities, Richards was called the first American psychiatric nurse. One of the most important contributions was her emphasis on assessing both the physical and the emotional needs of the patients. In this early period of nursing history, nursing education separated these two needs; nurses were taught either in the general hospital or in the psychiatric hospital. It was not until the late 1930s that nursing education recognized the importance of psychiatric knowledge in general nursing care for all illnesses. An important
factor in the development of psychiatric nursing was the emergence of various somatic therapies, including insulin shock therapy. These techniques required the medical-surgical skills of nurses. Although these therapies did not help patients understand their problems, they did control behaviour and make the patients more open to psychotherapy. Somatic therapies also increased the demand for improved psychological treatment for patients who did not respond. As nurses became more involved with somatic therapies, they began the struggle to define their role as psychiatric nurses. An editorial in the American Journal of Nursing in 1940 describes the conflict between nurses and physicians as nurses tried to implement what they considered appropriate care for psychiatric patients. This conflict continued in later nursing practice. The period after World War II was one of major growth and change in psychiatric nursing. By 1947, eight graduate programmes in psychiatric nursing had been started (Stuart, 2013:2).

The origin of psychiatry can be traced back to the seventeenth century, where it was derived from several disciplines, including medicine, anthropology and religion, and later psychology and sociology (Baumann, 2015:12). However, for many years, psychiatry remained essentially exploratory and speculative, offering people with psychiatric disorders very little effective treatment and care. Many factors, including work-related stress, disease, poverty, abuse, sexual violence and the decay of the traditional value system contribute to the high occurrence of mental health issues in South Africa. In research conducted by the Mental Health and Poverty Research Programme, Ministry of Healthcare South Africa (2015:3), it was found that approximately 16.5% of the adult population in South Africa suffers from mental illness, with 1% suffering from a severe debilitating mental disease. Thirty per cent of South Africans are likely to suffer a mental illness in their lifetimes, depression being the most common ailment.

However, these statistics may be an underestimation. Among some population, many still believe that mental illness results from a demonic possession. As a result, many individuals for fear of social ostracism, keep their mental illness secret instead of seeking the much needed medical attention. This means that there is still a significant population suffering from mental illness that is currently not recorded in mental health statistics.

The next discussion addresses mental healthcare in South Africa.

### 4.7.2 Mental healthcare in South Africa

Mental illness is also prevalent in South Africa, yet the country lacks many of the necessary resources and policies needed to execute an effective mental health strategy (Ministry of Health South Africa, 2015:1). According to Papillon (2014), between 1% and 3% of the South African population are likely to suffer from a psychiatric problem. Many factors, including violence, communicable diseases, and urbanization have increased the prevalence of mental
disorders in the country. The way in which mental illness is treated has changed over the years. For a while, mental healthcare was institutionalized. However, following the White Paper Act of 1997, the South African government moved to deinstitutionalize mental healthcare and relegate it to the primary care setting. According to Baumann (2015:17), data indicates that the goal of deinstitutionalization and effective primary mental care has not been fulfilled. African traditional medicine still plays a huge role in African society (Baumann, 2015:18). Even though it often functions in an inhibitory manner, a comprehensive health plan with a focus on collaboration between traditional practices and western medicine could prove very beneficial. It was found that 45% of the black patients that attended a community mental health clinic had consulted a healer for their problem (Baumann, 2015:18). Additionally, 26% were simultaneously seeking treatment from both the traditional healers and the psychiatrists. Traditional healers are often instrumental in treating mental illness.

Another factor regarding the very nature of mental illness complicates this issue even further. A complete cure for a mental illness is nebulous and can only be attained gradually with time. For this reason, mental illnesses are hard to cure with such a paucity of resources. Without the necessary intermediate care and continuity in therapy, many patients regress when released from the hospital. Psychological healing relies more on a cultural and emotional understanding than it does on possessing medical knowledge.

Dr Mustafa Elmasri, a Gaza-based psychologist with over twenty years of experience, describes how he has often collaborated with African traditional medicine. Instead of labelling traditional healers as primitive and demonic, he worked with them and even trained some of them in scientific methods for identifying certain mental illnesses such as epilepsy and psychosis (Ministry of Health South Africa, 2015: 3). Dr Elmasri found that “traditional healers were the key partner beyond the patients and their families in gaining an understanding of the psychological experience and access to social support structures.” Beliefs are fundamental to behaviour, and therefore a deeper understanding of traditional medicine will help to improve the effectiveness of psychological care. Dr Elmasri also recounts how he occasionally referred mild stress cases to the healers as these patients require a holistic approach from individuals who they know and trust. The Traditional Health Practitioners Act in South Africa, (No. 22 of 2007) attempted to formalise, regulate and professionalise traditional doctors. Effective treatment of mental illness necessitates the recognition and identification of cultural differences. Neglect to recognize these essential cultural factors will result with impotent and detrimental treatment (Ministry of Health South Africa, 2015:3).

South Africa inherited a highly institutionalized and custodial system of mental healthcare in 1994. The past 18 years have seen these services develop and change to a greater or lesser
extent within the context of a new democracy, economic challenges and South Africa’s entry into the global domain (Baumann, 2015:5). In the new democratic South Africa, mental health services have been integrated into general health services with varying degrees of success, with the intention that mental health services should be available at all levels of care. Most of the components of mental health policy such as the rights of psychiatric patients were legislated in the Mental Health Care Act (Act no.17 of 2002). However, the implementation of the policy and legislation has been a challenge. With many competing health priorities such as resources, the development of mental health services has not received adequate funding. Additional resources are needed to develop appropriate services and to address the burden of mental disorders in the country. The proportion of mental health and the prevention of mental disorders are important components of mental health policy. The promotion and prevention of mental health is dependent on a wide range of variables such as inter-sectoral collaboration. Initiatives to promote mental health and prevent mental disorders should be based on evidence of effectiveness and sustainability (Baumann, 2015:5).

Treatment and care of psychiatric patients is provided both in private and government psychiatric institutions. For example, Akeso clinics is a group of private specialized inpatient psychiatric clinics that provide individual, integrated and family oriented treatment for different psychiatric, psychological and addictive conditions (Akeso, 2016). At the heart of the Akeso treatment philosophy lies the belief that no one should be treated in isolation, not in terms of the condition from which they suffer, nor in terms of their separation from the family. Therefore, treatment programmes are integrated, implying that the multidisciplinary team of nurses, psychiatrists, psychologists, occupational therapists, social workers and pharmacists work together to ensure that the patient receives the best possible care and best outcomes. The Life Path Health group is a network of private psychiatric hospitals providing mental health treatment including addiction treatment (Life Path Health Group, 2015:1).

Most of the world’s big countries are decentralised to some extent, as South Africa is with its strong provincial government structure (Hendricks et al., 2014:60). However, a number of health systems have devolved even further by transferring various functions from provincial level down to local level, this being the model that South Africa is now pursuing. Prior to 1997, mental health in South Africa was mainly institutionalized and little emphasis was placed on promotive and preventive care. Due to a paucity of resources, it was more cost effective to simply isolate mentally unstable individuals rather than invest in effective, yet costly care. Following the 1997 White Paper and the National Health Act (Act no. 61 of 2003), the government made an attempt to deinstitutionalise mental healthcare and to transfer the bulk of this responsibility to the level of Primary Health Care (PHC).
The general category of psychopharmacological drugs, which had previously only been available at mental institutions, are now present with 96% availability at primary healthcare facilities. However, it was found in research conducted by the World Health Organisation (WHO, 2011) that approximately 56% of mental healthcare still takes place in an institutionalised setting. In South Africa, there are only 290 registered psychiatrists, providing a physician to population ratio of 1:183 000. With PHC facilities, there are only 0.04 psychiatrists per patient.

PHC facilities are so severely understaffed that physicians often do not have time to do anything other than refer psychiatric patients to the district hospital (Ministry of Health South Africa, 2015:1). In addition, less serious cases such as depression are often overlooked and rarely diagnosed. Physicians have to prioritise their work and spending time on a patient with mood disorder is seen as an ineffective use of their time. There is also a lack of communication between PHC facilities and district hospitals. PHC physicians often refer psychiatric patients to the district hospital, but rarely get feedback. Since the PHC physician never learns the new diagnosis or changes in treatment, the physician is unable to provide adequate follow-up care. Not only does this break the continuity of care, but it also obstructs physicians from learning about these mental illnesses and the appropriate treatment for different sets of symptoms. This severely restricts any potential for a more autonomous primary care division (Ministry of Health South Africa, 2015:2; Baumann, 2015:17).

South Africa is one of only 19 African countries to have an officially endorsed mental health policy. Consistent with the WHO’s recommendations, the South African mental health policy is committed to the provision of a comprehensive, community-based service that is integrated with general healthcare (Spedding et al., 2014:76). The Mental Health Care Act no.17 of 2002, which was promulgated in late 2004, was not only in keeping with international human rights standards, but also developed the means through which services could be decentralized, mental health could be integrated into general healthcare, and community-based care could be made possible.

In research conducted in 2009 in South Africa it was found that of the 16.5% of people suffering from mental illness, only 25% had received treatment. It has been found that the very factors that contribute to this high prevalence of mental illness also serve to inhibit its treatment (Ministry of Health South Africa, 2015:3). Communicable diseases, civil strife and poverty run rife throughout South African society. However, faced with limited resources, the South African government should prioritise its problems and mental illness does not often take precedence. As a result, many mental health facilities remain both severely understaffed and underfunded.
An additional challenge is the high turnover of hospital staff, which is a global problem and which has negative financial implications for institutions in that more staff members have to be recruited (Mogale et al., 2015:1). The unique nature of psychiatric illness necessitates a certain degree of experience before effective treatment can be rendered. However, many nurses leave before they are appropriately trained. This is largely due to the lack of oversight from mental health specialists, as many nurses stationed at the primary care facilities have little to no interaction with them. As a result, this lack of direction results in the nurses becoming overwhelmed and eventually many experience burnout and take a transfer to other institutions. Any progress made in the training of these nurses is lost and the training process must be started again (Ministry of Health South Africa, 2015: 3). Additionally, the psychiatric nurses in the district hospitals lack specialization. Due to staff shortages, it is necessary to rotate nurses through all areas of the hospital. As a result, the nurses caring for the psychiatric patients have varying degrees of experience and many have minimal familiarity with mental illness.

In addition, there is lack of intermediate care once a patient is released from the hospital. Services such as support groups, special housing, and supported employment are virtually non-existent in South Africa (Ministry of Health South Africa, 2015:3). The Mental Health Care Act (Act no. 17 of 2002) states that follow-up care should be provided for chronic cases within the available resources. However, due to the lack of resources, this intermediate care is never provided. Once treatment at a mental health facility is completed, the patient is handed back into the care of his family members and they are informed of the discharge instructions. However, a lack of adherence to these instructions results in many patients regressing after being released and they often end up being readmitted to a psychiatric hospital.

Despite South Africa’s progressive mental health legislation, namely the Mental Health Care Act (no 17 of 2002) (MHCA), multiple barriers to the financing and development of mental health services exist, which result in psychiatric hospitals remaining outdated, falling into disrepair and often unfit for human use; serious shortages of mental health professionals; an inability to develop vitally important tertiary level psychiatric services (such as child and adolescent services, etc.); and community mental health and psychosocial rehabilitation services remaining undeveloped, so that patients end up institutionalized, without hope of rehabilitation back into their communities. This state of affairs remains unchanged despite the legislated commitments to reform mental healthcare in the MHCA (DoH, 2007; van Wijk et al. 2014:3).

Research conducted in KwaZulu-Natal reveals gross inequity in the allocation of provincial health budgets to psychiatric facilities. Budget increases to six psychiatric hospitals over the 5-year period (2006-2010) ranged from 8% to 25%, with a mean 5-year increase of 19% and
a mean annual increase of 3.8% (DoH, 2007). This contrasts with budget increases to seven general hospitals over the same 5-year period, which ranged from 29% to 64%, with a mean 5-year increase of 51% and a mean annual increase of 10.2%. The median cumulative budget increase for psychiatric hospitals was significantly lower than that of general hospitals, clearly illustrating a pattern of inequitable treatment of psychiatric hospitals in relation to general hospitals.

According to the South African Society of Psychiatrist, there are currently about 350 practicing psychiatrist in South Africa, about 60% of which are from the private sector (Baumann, 2015:6). There are similar shortages of psychologists, psychiatric social workers, psychiatric occupational therapists and psychiatric nurses working in the public sector. Nurses who work in psychiatric units are not only faced with the challenge of having to provide care to patients, but there is also a severe shortage of psychiatric nurses in psychiatric hospitals (Sobekwa & Arunachallam, 2015:1). South Africa therefore has a critical shortage of skilled mental healthcare professionals. In addition, there is a mal-distribution of these professionals, many tending to concentrate in urban areas, and few choosing to work in rural areas. In order for all South Africans to have access to mental healthcare, mental healthcare professionals have to be utilised with the greatest efficiency. In other resource-constrained countries and in other disciplines, the principle of task-shifting has been used to address skills shortage and treatment gaps. An essential component of the work of every trained mental healthcare provider in South Africa should therefore be to train other healthcare workers to identify and manage mental disorders at the appropriate level of care (Temane et al., 2014:1).

In an unequal society such as in South Africa, the majority of the population, who are poor, do not have access to private medical insurance or services and rely on the public health service for care (Baumann, 2015:7). Private health services deliver services to a minority of the population and spending in these services is disproportionately high. This situation is not sustainable and requires change. The National Health Insurance (NHI) green paper released for public comment in August 2011 outlined how the state plans to provide universal health coverage in the country. According to these proposals, all South Africans earning an income will contribute to a National Health Insurance (NHI) Fund, and providers, whether public or private, will be contracted to provide care to all people through this fund. The plan outlines a comprehensive package of primary care, which necessitates the re-engineering of primary healthcare services to focus mainly on health promotion, preventative care and appropriate curative and rehabilitative services. Services should be population-oriented with extensive community outreach programmes provided by community health workers, who will form the link between home and health facilities. School-based health services are an important component of the proposals, as are municipal ward-based primary healthcare agents and
district clinical specialist support teams (Tangcharoensathien et al., 2015:2; Baumann, 2015:7).

Of concern is that the NHI green paper (SA, 2011:24) does not mention psychiatric or mental health services in the section on district health services. No mental health professional is envisaged to be part of the district clinical specialist support teams. The only mention of psychiatric services is in the section on specialized hospitals. This is iniquitous and inexplicable in a country that has a community-based mental health policy and legislation. A national Mental Health Summit called by the Minister of Health in April 2012 sought to address these deficiencies and motivated strongly for the establishment of a mental health team in each district in South Africa. The summit also considered proposals for a new mental health policy for the country, which will hopefully address some of the ongoing difficulties in achieving adequate mental health services for South Africa (Baumann, 2015:7).

South Africa is also confronted with the burden of mental health, which is discussed in the subsequent paragraphs.

**The mental health burden in South Africa**

South Africa is a middle-income country with a population of 47 million, characterized by multiple societal-level socio-economic risk factors for mental illness and disability (DoH, 2007). It ranks 13th highest in the world in terms of the proportion of the population living under the poverty line (50%); is second highest in terms of income inequality (GINI coefficient is 65); has the 19th highest unemployment rate (24%); and has a high rate of urbanization, lying 41st with a rate of 1.4%. In addition, South Africa has extraordinary high rates of crime and violence, one of the highest road accident death rates in the world, and lies 99th out of 121 countries in a 2007 *Economist* rating using a “Global Peace Index”. It has the 4th highest rate of drug offences and, according to the United Nations Office on Drugs and Crime (UNODC), South Africa now ranks within the top 30% of countries in terms of rates of opiate addiction. South Africa is also located at the epicentre of the HIV pandemic in Sub-Saharan Africa with the 4th highest prevalence rate (18%) and the greatest number of people living with HIV worldwide. HIV is associated with a significantly increased burden of neuropsychiatric disease and disability including depression, anxiety, psychosis and dementia. Furthermore, the mortality due to AIDS affects children, hundreds of thousands of whom have been orphaned. Child-headed households are now a common phenomenon in South Africa. There is substantial evidence that poverty, inequality, urbanization, unemployment, trauma and violence and substance abuse are major environmental risk factors for mental illness and therefore increases the burden of mental illness and disability within a society (DoH, 2007; Pauw,
Table 4-2: Socioeconomic and health indicators for South Africa (Department of Health, 2007; Burns, 2011:102)

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Unit</th>
<th>Ranked in the world (total no. of countries)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Proportion of the population living under the poverty line</td>
<td>50%</td>
<td>13th highest (100)</td>
</tr>
<tr>
<td>Index of income inequality (GINI coefficient)</td>
<td>65</td>
<td>2nd highest (134)</td>
</tr>
<tr>
<td>Unemployment rate</td>
<td>24%</td>
<td>19th highest (131)</td>
</tr>
<tr>
<td>Urbanization rate</td>
<td>1.4%</td>
<td>41 highest (63)</td>
</tr>
<tr>
<td>Murder rate (per 100 000 population)</td>
<td>47.5</td>
<td>3rd highest (121)</td>
</tr>
<tr>
<td>Rapes (per 100 000 population)</td>
<td>1.2</td>
<td>1st highest (65)</td>
</tr>
<tr>
<td>Assaults (per 100 000 population)</td>
<td>12.1</td>
<td>1st highest (57)</td>
</tr>
<tr>
<td>Burglaries (per 100 000 population)</td>
<td>8.9</td>
<td>10th highest (54)</td>
</tr>
<tr>
<td>Total crimes (100 000 population)</td>
<td>77.2</td>
<td>10th highest (60)</td>
</tr>
<tr>
<td>Drug-related offences (per 100 000 population)</td>
<td>53.8</td>
<td>4th highest (60)</td>
</tr>
<tr>
<td>Incarceration rate (per 100 000 population)</td>
<td>335</td>
<td>18th highest (155)</td>
</tr>
<tr>
<td>Road traffic deaths (per 100 000 population)</td>
<td>33.2</td>
<td>24 highest (178)</td>
</tr>
<tr>
<td>Opiate drug abuse (per 100 000 population)</td>
<td>0.38</td>
<td>47 highest (133)</td>
</tr>
<tr>
<td>Global Peace Index</td>
<td>2.4</td>
<td>22nd lowest (121)</td>
</tr>
<tr>
<td>HIV prevalence</td>
<td>18%</td>
<td>4th highest in the world</td>
</tr>
<tr>
<td>Number of people living with HIV/AIDS</td>
<td>5.7 million</td>
<td>1st highest in world</td>
</tr>
<tr>
<td>HIV/AIDS deaths per year</td>
<td>350,000</td>
<td>1st highest in the world</td>
</tr>
<tr>
<td>Tuberculosis incidence (per 100 000 population)</td>
<td>600</td>
<td>9th highest (200)</td>
</tr>
<tr>
<td>Life expectancy at birth (years)</td>
<td>48.9</td>
<td>16th lowest (221)</td>
</tr>
<tr>
<td>Death rate (per 100 000 population)</td>
<td>17</td>
<td>12 highest (220)</td>
</tr>
<tr>
<td>Infant mortality rate (per 1 000 live births)</td>
<td>44.4</td>
<td>59th highest (221)</td>
</tr>
<tr>
<td>Suicide rate-total (per 100 000 population)</td>
<td>15.4</td>
<td>22nd highest (106)</td>
</tr>
<tr>
<td>Suicide rate- male (per 100 000 population)</td>
<td>25.3</td>
<td>17th highest (103)</td>
</tr>
<tr>
<td>Suicide rate- female (per 100 000 population)</td>
<td>5.6</td>
<td>26th highest (103)</td>
</tr>
<tr>
<td>Physicians (per 1 000 population)</td>
<td>0.77</td>
<td>119th highest (202)</td>
</tr>
<tr>
<td>Psychiatrists (per 100 000 population)</td>
<td>0.28</td>
<td></td>
</tr>
<tr>
<td>Psychologists (per 100 000 population)</td>
<td>0.32</td>
<td></td>
</tr>
<tr>
<td>Indicator</td>
<td>Unit</td>
<td>Ranked in the world (total no. of countries)</td>
</tr>
<tr>
<td>--------------------------------------------------------------------------</td>
<td>----------</td>
<td>----------------------------------------------</td>
</tr>
<tr>
<td>Social workers in mental health (per 100 000 population)</td>
<td>0.4</td>
<td></td>
</tr>
<tr>
<td>Occupational therapists in mental health (per 100 000 population)</td>
<td>0.13</td>
<td></td>
</tr>
<tr>
<td>Nurses in mental health (per 100 000 population)</td>
<td>10</td>
<td></td>
</tr>
<tr>
<td>Psychiatric beds in mental health facilities (per 100 000 population)</td>
<td>24</td>
<td></td>
</tr>
</tbody>
</table>

There was little in the way of epidemiological data on mental illness in South Africa. However, the South African Stress and Health Study (SASH) (DoH, 2007), which was part of the WHO World Mental Health (WMH) Survey Initiative conducted between 2002 and 2004, reported results of a population-based survey of 4 351 adults. The 12-month prevalence of any Diagnostic and Statistical Manual (DSM-IV) disorder was 16.5%, with the most common disorders being agoraphobia (4.8%), major depressive disorder (4.9%) and alcohol abuse or dependence (4.5%). The authors of the SASH study note that the prevalence rate of common mental disorders are significantly higher in South Africa than in another WMH African country, Nigeria, and are in fact similar to the rates reported from Colombia and Lebanon (DoH, 2007). Interestingly, both of these countries have a number of socioeconomic features in common with South Africa and likewise have experienced chronic conflict. The SASH study authors also observe that the estimated prevalence of substance abuse in South Africa (5.8 %) was at least about twice as high as that in other WMH countries, with the exception of the Ukraine. With a national suicide rate of 15.4 per 100 000 population, South Africa is ranked 22nd in the world (DoH, 2007). According to Uys and Middleton (2010:393), suicide accounted for 7.7% of all non-natural deaths in South Africa. In the WHO Mental Health Action Plan 2013-2020, WHO members have committed themselves to work towards the global target of reducing the suicide rate in countries by 10% by 2020 (WHO, 2014). The issue of mental health gap and human rights are also a matter of concern in South Africa and are discussed in the following paragraphs.

The mental health gap and human rights issues

The gap that exists between the burden of mental illness and disability and the relative lack of mental health resources in South Africa is a human rights issue. The state has an obligation to provide services for the health needs of its people and it is clear that services for those with mental illness and disability are woefully inadequate and, for many people, inaccessible (DoH, 2007). South Africa is by no means the only country characterized by a mental health gap. In fact, most countries fall short of meeting the mental health needs of their citizens. However,
South Africa is a nation that has publicly declared its commitment to upholding the rights of the mentally ill and disabled, both in enacting one of the most progressive pieces of mental health legislation in the world. In making these commitments, the government of South Africa has affirmed its belief that all members of the society have a fundamental constitutional right to care. They also have a right to be taken care of by members of their family (Mokgothu et al., 2015:1). Emerging from decades (if not centuries) of racism and discrimination based on ethnicity, the new regime has been both passionate and vocal in addressing the rights of minority and previously discriminated groups in society. The South African Constitution guarantees these rights and it is clear that discrimination on the basis of race, gender, sexual orientation or physical disability is punished severely within the new dispensation (DoH, 2007).

This is not the case, however, regarding those with mental illness or disability. As is still the case in many countries around the world, people with mental disabilities face multiple forms of inequity and discrimination in their daily lives (Cady, 2010:117). Both outside and within the health system, patients encounter discrimination and prejudice in the form of reduced work opportunities and social opportunities, disenfranchisement and restriction of civil liberties, inferior treatment of co-morbid physical illnesses and social stigma. This is reflected, as we have seen, in the state’s failure to close the mental health gap through the provision of resources. This means that people with mental disabilities experience a fundamental violation of their basic right to care by the state. This calls for a human rights approach to the mental health gap in South Africa and in other nations (DoH, 2007).

Just like any other human being, psychiatric patients have rights as well. They have the right (Burns, 2011) to respect for inherent dignity and individual autonomy, including the freedom to make one’s own choices. There should be independence of persons, non-discrimination, full and effective participation and inclusion in society, respect for difference and acceptance of persons with disabilities as part of human diversity and humanity. All citizens should have equal opportunity, accessibility, equality between men and women, and respect for the evolving capacities of children with disabilities and respect for the rights of children with disabilities to preserve their identities. There should be equal recognition before the law, access to justice and legislative reform to abolish discrimination in society, to educate the society, combat prejudices and promote awareness of the capabilities of persons with disabilities. Everyone has the right to life, liberty and security of person, including freedom from degrading treatment, abuse, exploitation and violence, the right to movement, mobility, independent living and full inclusion within the community, including full access to and participation in cultural life, recreation, leisure and sport. Citizens should have freedom of expression and opinion, access to information and full participation in political and public life, respect for privacy, for the home and the family, including the freedom to make decisions
related to marriage and parenthood. They have the right to equal education, work and employment, including the full accommodation of individual requirements, the right to health, habitation and rehabilitation; and the right to an adequate standard of living, suitable accommodation and social protection (Burns, 2011).

The next discussion is on international perspective of psychiatric nursing.

4.7.3 Psychiatric nursing: an international perspective

According to a coalition of professional groups (American Nurses Association [ANA], American Psychiatric Nurses Association [APNA] and the International Society of Psychiatric-Mental Health Nurses (ISPHN), psychiatric nursing is committed to promoting mental health through the assessment, diagnosis, and treatment of human responses to mental health problems and psychiatric disorders. It is a specialised area of nursing practice and a core mental health discipline that employs explanatory theories of and research on human behaviour as its science and the purposeful use of self as its art. Essential components of the specialty practice of psychiatric nursing include health and wellness promotion through identification of mental health issues, prevention of mental health problems, care of mental health problems and treatment of persons with psychiatric disorders (APNA, 2011). On a more personal level, this speciality is the only one in which your voice, face, body language, and what cannot be seen- the mind, neurotransmitters, self-esteem and the like shape your work.

The role of the psychiatric nurse has changed over the years from that of custodian to a multifaceted role and the settings in which the psychiatric nurses practice have expanded from inside the hospital to all of the communities in which people live (Kneisl & Trigoboff, 2009:15). Although nursing functions have existed since ancient times, the profession of nursing, particularly psychiatric nursing, is a product of the late 19th and 20th centuries. Theodor and Friederick Fliedner founded the first systematic school of nursing in Germany in 1836. It was this school at Kaiserwerth that Florence Nightingale visited in 1851 before organizing a school to educate nurses in England after the Crimean War. Her school, Saint Thomas Hospital in London, stressed the importance of providing an optimum environment for clients. Although it is true that in the context of her time she emphasized the physical environment, Nightingale was among the first to note that the influence of nurses on their clients goes beyond physical care and has psychologic and social components (Kneisl & Trigoboff, 2009:15).

During World War II, 43% of all people discharged from the army were classified as having a psychiatric disability, creating a sharp increase in the demand for psychiatric services (Kneisl & Trigoboff, 2009:16). The National Mental Health Act, enacted in 1946 to cope with the surge in the need for psychiatric services, provided for the following: establishment of the National Institute for Mental Health (NIMH) to be added to the National Institutes of Health in Bethesda,
Maryland, development of programmes to train professional psychiatric personnel, including psychiatric nurses, support for psychiatric research and assistance in developing mental health programmes. With the establishment of the NIMH, psychiatric nursing was added to psychiatry, psychology, and social work as a field in which the highest priority became the preparation of clinically capable persons for positions of leadership. Before this time, fewer than a dozen psychiatric nurses held master’s degrees in the United States. The psychiatric nursing education gave most students consisted of a few weeks of observation on a psychiatric ward.

Because of new funding, nine universities received grants to expand and improve graduate programmes in 1948. The number increased gradually and steadily. These programmes prepared many of the nursing leaders who later developed theoretical frameworks for one-to-one relationship work. The National Mental Health Act of 1946 is probably the most significant piece of legislation affecting the development of psychiatric nursing, because of its wide-raging effects, (Kneisl & Trigoboff, 2009:16).

In the United States, there are more than 800,000 hospital admissions each year for the treatment of schizophrenia at an aggregate cost exceeding 3 billion dollars (Olfson et al., 2011:1138). According to Robertson et al. (2014:92), schizophrenia is a severe disorder that often has a significant impact on the lives of the individual sufferer. It occurs in an estimated one percent of the population, usually starting in the late teenage years or early adulthood. The average length of stay for inpatients for schizophrenia exceeds that for other major psychiatric disorders. Several factors seem to influence the risk of psychiatric hospital admission among individuals diagnosed with schizophrenia. The risk tends to increase with non-adherence to antipsychotic medication, reoccurrence of substance use disorders, and poor global functioning. Patients with previous psychiatric admissions and past suicidal attempts are also at high risk of future hospital admission. In addition, younger adults with schizophrenia are at higher risk than older adults. Consistent differences in hospital admission rates for schizophrenia patients have not been shown to be related to the marital status or gender of the patient, though men with schizophrenia appear to spend more time in the hospital than women with schizophrenia (Olfson et al., 2011).

According to the Substance Abuse and Mental Health Service Administration (SAMHSA), 19.1% of adults in the United States (45.1 million people) experienced a mental illness over the previous years. Across the nation, the number of psychiatric patients’ out-numbered the beds available to treat those requiring admission (Plant & White, 2013:240). This is the result of cuts in mental health benefits, psychiatric beds (in-patient, hospital) closures as well as
shrinking budgets for community-based psychiatric health services. This has also placed the burden of treating and often housing psychiatric patients on the emergency care system.

Medication administration errors have been reported in several psychiatric hospitals in the United Kingdom (UK). Prescribing, dispensing, transcribing and administration errors are associated with patient mortality and morbidity (Haw et al., 2005:1610). An estimated one out of every two inpatients in the United States of America (USA) is injured as a result of such errors. Administration errors are one of the most common types of medication errors. On the basis of the findings of a number of UK observational studies in general hospitals, administration errors accounted for approximately five percent of all administered doses. However, in a USA study of 36 healthcare facilities, the reported frequency was nineteen percent. Much of the research on administration errors has paid attention to general hospitals and to errors involving intravenous drugs and infusions. Few studies of medication errors have been conducted in psychiatric institutions and fewer have concentrated on administration errors. A USA study of medication errors, based on a retrospective review of records in a state psychiatric hospital, showed that administration errors were more frequent than prescribing, dispensing and transcribing errors combined.

Internationally, psychiatric hospitals have been confronted with various incidences of violent behaviours, such as patients attacking another patient or patients attacking staff members. For the second time in just over a year, a patient at the maximum security Clifton Perkins government psychiatric hospital has been charged with killing another patient (Kilar & Fenton, 2011) and a 22-year old patient at the Howard County facility was pronounced dead by an emergency room doctor, and his 24-year-old roommate has been charged for the killing. In another incident, the estate of a 40-year-old patient killed at a state psychiatric hospital sued the man accused of the killing and has started the process to sue the Department of Health and Mental Hygiene (Duncan, 2012). In-patient units at Spring Grove Hospital in Catonsville have become troubled environments where serious assaults on hospital staff are common, according to a report from a consultant for the Maryland Health Department. The chaos at the state’s largest psychiatric hospital, the consultant found, is worsened by a few patients who “prey upon patients and staff with relative impunity” after being ordered by courts to the hospital for psychiatric assessment (Rector, 2013). According to the Department of Justice, every year about 1.3 million women in the United States are assaulted by an inmate. One in every six women is a victims of rape, and there is an incidence of abuse against women in nearly 80% of inmate partner homicides (Rhine, 2010). This pattern of violence against women is an exhibition in psychiatric hospitals where over 80% of the residents have experienced sexual or physical abuse. Victims of abuse should receive treatment that focuses on trauma and recovery.
In order to address challenges associated with mental illness internationally, a mental health plan has been designed with the purpose of coming up with strategies to address these challenges.

**Mental Health Action Plan 2013–2020**

The vision of Mental Health Action Plan (WHO, 2013) is to have a world in which mental health is valued, protected and promoted, mental disorders are prevented and persons affected by these disorders are able to exercise their human rights and to access high quality, culturally sensitive health in time to promote recovery, to attain the highest possible level of health and to take part in work free from stigmatization and discrimination. The action plan outlines the following objectives and targets (WHO, 2013):

### Table 4-3: Action plan objectives and targets

<table>
<thead>
<tr>
<th>Action Plan Objectives</th>
<th>Action Plan Targets</th>
</tr>
</thead>
<tbody>
<tr>
<td>• To strengthen effective leadership and governance for mental health</td>
<td>• 80% of countries will have developed or updated their policies or plans for mental health in line with international and regional human rights instruments by the year 2020.</td>
</tr>
<tr>
<td></td>
<td>• 50% of countries will have developed or updated their law for mental health in line with international and regional human rights instruments by the year 2020.</td>
</tr>
<tr>
<td></td>
<td>80% of countries will be routinely collecting and reporting at least a core set of mental health indicators every two years through their national health and social information systems by the year 2020.</td>
</tr>
<tr>
<td>• To strengthen information systems, evidence and research for mental health</td>
<td>Service coverage for severe mental disorders will have increased by 20% by the year 2020.</td>
</tr>
<tr>
<td>• To provide comprehensive, integrated and responsive mental health and social care services in community-based settings</td>
<td>80% of countries will have at least two functioning national, multi-sectoral mental health promotion and prevention programmes by the year 2020.</td>
</tr>
<tr>
<td>• To implement strategies for promotion and prevention in mental health</td>
<td>The rate of suicide in countries will be reduced by 10% by the year 2020.</td>
</tr>
</tbody>
</table>

The current practice in psychiatric nursing may have future implications in psychiatric hospitals.

**4.7.4 Implications for the future**

There are three macro and five micro-influences that will continue to have a major effect on psychiatric nursing and mental healthcare in the future (Shea *et al.*, 1999:26; Robertson *et al.*, 2014:425). The macro-influences are the economics and financing of healthcare, information technology, and the new millennium. The micro-influences, those particular to psychiatric nursing, are managed behavioural healthcare, the psychobiologic paradigm shift,
accountability in practice, education trends, and mental health research. The macro and micro-influences are discussed in relation to implications for future advanced practice, education and research.

The economics and financing of healthcare was front-page news throughout the 1990s. Despite the failure of the healthcare reform movement, the effort to contain healthcare costs took on a life of its own (Robertson et al., 2014:427). As the “mainstream method of financing healthcare”, managed care now dominates every aspect of healthcare services. Managed care financing affects who gets care, who provides care, what care may be provided, how care is paid for, what and how data are collected, how clinical effectiveness is determined, how quality is measured, how satisfied patients are with the care they receive, and so on. The essence of managed care financing is the link between the cost services and the clinical effectiveness or outcomes of treatment. Today’s clinicians must learn to function using evidence-based practices, clinical pathways and guidelines, treatment protocols, standard formularies, and other methods designed to standardize practice at a quality level while remaining cost-effective. Many health insurance schemes discriminate against psychiatric patients by not taking into account the recurrent, long-term nature of their illness, by reimbursing different mental health professionals inequitably, and by excluding major groups of disorders such as alcohol-related disorders from their schemes (Tran et al., 2010:149; Robertson et al., 2014:427).

People have always viewed mental illness as distinct from physical illness in terms of areas for scientific research, causal attribution, disease process, symptom manifestation, treatments, practices, care facilities, providers, health policies and their effects on society itself (Shea et al., 1999:27). As a result, the psychiatric specialty discipline, psychiatric care systems, mental health policies and regulations, and even the mentally ill patients, to some extent, remained outside the mainstream of modern medicine and medical care. The stigma of mental illness is so pervasive that it is an uphill battle to obtain parity for mental healthcare. The advent of managed care systems has helped address the long-standing disparity between mental healthcare and physical healthcare. Managed care organisations emphasize ambulatory primary healthcare, access, cost-effective outcomes and quality measures (Baumann, 2015:791).

The second macro-influence is information technology in its broadest sense. Without information technology, managed care could not have developed so quickly or spread into so many arenas (Shea et al., 1999:28). Technology has provided all kinds of new information, often described as the “knowledge explosion”. Technology has allowed the use of traditional types and sources of information in new ways. For example, it is forecasted that “info medicine
will inexorably become the mainstream method of making medical decisions”. By this he means that physicians and patients will communicate through computers and satellite link-ups, and physicians will access a clinical algorithm database to decide about the diagnosis and treatment of the patient. Although this is occurring in several locations, it is not yet the main method of diagnosis and treatment (Baumann, 2015:790).

A micro-influence that has had a transforming effect on the discipline of psychiatric nursing is the shift in the basic paradigm from psychodynamic perspective to the comprehensive biopsychosocial model (Robertson et al., 2014:358). Signalling the integrated philosophy, there is renewed interest in biologic, psychopharmacologic, spiritual, and complimentary therapies, which are often used in combination with psychosocial interventions (Linda et al., 2015:1). Advances made in neuroscience, especially in the later years of the twentieth century, have overturned the exclusive reliance on practices such as long-term, insight-oriented psychotherapy and set aside psychoanalytic concepts in the treatment of most serious mental disorders. The emphasis has shifted in recent years to a consideration of how physical, psychological and social factors interact to predispose, precipitate and perpetuate physical disorders. This is called the bio-psychosocial model of Engel.

Accountability in practice is another important factor influencing changes in psychiatric nursing. Accountability can take many forms, but it is most evident in the shift from process to outcome by advanced psychiatric nurses who have especially treasured the process and processing aspects of their practice (Shea et al., 1999:29). Advanced psychiatric nurses are in the forefront of improving access to mental healthcare by delivering quality services when and where they are needed, such as in crisis mobile units and home care. Their use of practice guidelines, best practices, critical pathways, professional standards of clinical care, and quality indicators are examples of how advanced psychiatric nurses take account of their responsibilities in practice. They also take responsibility when they take the lead to promote mental health and prevent mental illness by developing and evaluating programmes that are sensitive to the community’s needs and responsive to epidemiologic trends. Accountability means to answer for one’s acts, including the act of supervision. The professional nurse is expected to recognize and understand the legal implications of accountability by knowing what accountability is and what it means in terms of nursing practice (Huber, 2014:154).

Is practice driving changes in education, or is education influencing how advanced psychiatric nurses practice? The answer is both (Baumann, 2015:606). Just as the healthcare industry is transforming itself to be effective, consumer-oriented, and accountable, nursing education programmes and academia itself are adapting to new ways to deliver innovative, student-centred programmes and product-oriented outcomes (Uys & Treadwell, 2014: 2). Nursing
education programmes have always responded to the needs of the community and the profession, although not always in time. In today's fast-paced environment, the development and revision of curricula is proceeding at a high speed. Master's programmes are proliferating, and specialty offerings, including psychiatric nursing, are on the rise (Baumann, 2015:607).

All the macro and micro-influences come to bear on research, which is the scholarly investigation of phenomena from the cellular to the societal level. In psychiatric nursing, the phenomena of interest have behavioural manifestations or organisational features, such as depressive reactions, management of negative symptoms, crisis intervention techniques, brief therapies, psychopharmacologic strategies, mental health services, patient outcomes and effective communication (Shea et al., 1999:30). Research is the profession's greatest need and its greatest hope. Advanced psychiatric nurses are perfectly positioned to identify the pivotal research questions that can improve care and advance the profession. They have the knowledge and skills to collaborate on multidisciplinary studies seeking to answer fundamental but complex system research problems. Medical research involves a wide variety of research designs and types of research (Baumann, 2015:77).

In summary, a psychiatric hospital is a health establishment where individuals with mental illness are treated and cared for. In order to ensure a positive practice environment in psychiatric institutions, professional nurses and other mental health professional should take measures to prevent medication errors and prevent the risks associated with violence and injury, thereby ensuring a healthy safe environment for both patients and staff. The conclusion statements from the literature related to the context follows below.

4.7.5 Conclusion statements on the context: psychiatric nursing and psychiatric hospital

In conceptualising the context, the following statements were deduced:

- Deinstitutionalisation has not yet been fully achieved because of inadequate mental healthcare providers in psychiatric settings.

- A shift from curative healthcare to community psychiatric care is important to make services more accessible to the community.

- There is a need for collaboration between traditional medicine and western medicine as patients consult with traditional healers when experiencing psychiatric problems and this approach will assist in the provision of integrated psychiatric service.
The Department of Health should increase or improve resources, like budgets and human allocation for psychiatric services as psychiatric institutions continue to experience inadequate budgets and are understaffed.

The green paper on National Health Insurance (NHI) does not mention psychiatric services as part of district health services and mental health professionals should be included as part of the specialist district teams to ensure services are rendered.

Safety in psychiatric hospitals must be ensured so that patients and health professionals can function in a risk-free environment.

Conceptualisation of the context is depicted in Figure 4.4

![Figure 4-4: Conceptualisation of the context](image)

The above figure shows that psychiatric nursing involves three levels, namely the micro level, meso level and macro level. At the micro level (psychiatric hospital) psychiatric patients are admitted, assessed, diagnosed and treated. The meso level (psychiatric practice in South Africa) shows how psychiatric nursing is viewed in South Africa. The macro level (international perspective) reflects how psychiatric nursing is viewed at international level. The next discussion focuses on the goal that addresses improved staff outcomes.

**4.8 GOAL: IMPROVED STAFF OUTCOMES**

A substantial body of literature, mostly from North America and increasingly from other countries, shows that nurse staffing differs across hospitals, and that the difference in staffing
has significant implications for the recruitment and retention of nurses, the quality of care they render and the outcomes they produce for the patients (Aiken et al., 2011:357). Nurse staffing and nursing skill mix measures and sometimes physician hospital staffing, seem to be the only organisational variables in many countries. This is why research literature on staffing is more common than literature on how other features of hospitals influence patient outcomes. While nurse staffing has been shown to be related to nurse and patient outcomes, research indicates that nurse staffing is sometimes difficult to measure. The impact of nurse staffing on patient outcomes has been viewed as controversial in the United States and as contentious in the United Kingdom (Rafferty et al., 2007:176). Staffing is a critical concern in all healthcare organisations as 60 to 80% of the budget goes to staffing (Finkelman, 2012:298). With the increasing costs of healthcare, this is an expense that must be considered daily. It is also important to remember that staffing is both a process and an outcome. It is inextricably linked to leaders’ accountability to stay within budget and control costs, regulatory and legal mandates, staff competency, quality of care and versatility of staffing levels and assignments based on census and acuity. According to Huber (2014:367), nurse staffing methodology should be an orderly, systematic process based on sound rationale, applied to determine the number and kinds of nursing personnel required to provide nursing care of a predetermined standard to a group of patients in a particular setting. The end result is the prediction of the kind and number of staff required to give care to patients. The prediction of the number and kinds of personnel to give patients nursing care 24 hours a day, 7 days a week, is no small task. The major goal of staffing management is to provide the right number of nursing staff with the right qualifications to deliver safe, high quality and cost effective nursing care to a group of patients and their families, as evidenced by positive clinical outcomes, satisfaction with care and progression across the care continuum. For some time now, economics has been the primary driver in dictating changes in the registered nurse skill mix in hospitals (Hustin, 2010:165). As a result, the trend for at least the last decade has been to reduce registered nurses in the staffing mix and to replace them with less expensive alternatives. Empirical research increasingly concludes, however, that the number of registered nurses in the staffing mix has a direct effect on quality care, in particular, patient outcomes. In response, legislators, healthcare providers and the public are increasingly demanding adequate staffing ratios of registered nurses in acute care settings. According to Blegen et al. (1998), studies in nursing have shown that nursing care delivery changes affect institutional and staff outcomes, though the effects on patient outcomes have not been studied adequately.

Numerous studies in the last decade have examined the link between staffing mix and patient outcomes. Much, but not all, of the research has suggested a link between the increased representation of professional nurses in the staffing mix and improved patient outcomes.
In research conducted by Aiken et al., it was found that staffing at six patients per nurse rather than four would result in an additional 2.3 deaths per 1 000 patients and an additional 8.7 deaths per 1 000 patients with complications. Staffing at eight patients per nurse rather than six would incur an additional 2.6 deaths per 1 000 patients and 9.5 deaths per 1 000 patients with complications. Uniformly staffing at eight patients per nurse rather than four was expected to entail five excess deaths per 1 000 patients and 18.2 complications per 1 000 patients. Within days of the study’s release, Aiken’s study results were summarised, repeated and analysed in detail in almost all relevant public forums and by most professional healthcare organisations. The message was clear: there is a direct link between nurse-to-patient ratios and mortality rates and having an inadequate number of professional nurses places the public at risk (Hustin, 2010:167).

Ensuring proper professional nurse staffing levels for inpatient psychiatric hospitals is important given the increasing severity of psychiatric patients with mental illness and the increasing evidence that nurse staffing levels influence outcomes (American Psychiatric Nurses Association, 2011). There is sufficient evidence that the risk for adverse outcomes increases as the ratio of patients to nursing staff goes up. Subsequently, the American Psychiatric Nurses Association (APNA), as the biggest professional organisation representing psychiatric nurses, made recommendations for determining staffing needs of inpatient psychiatric units that will protect the quality of care and the safety of both the staff and patients (Bae et al., 2010:41). In this research staff refers to the nurse and specific nurse outcomes are subsequently discussed.

4.8.1 Nurse outcomes

Nurse outcomes include the vacancy rate, job satisfaction, turnover rate, retention rate and burnout levels (Yoder-Wise, 2011:282). In 2004, California became the first state to implement minimum nurse-to-patient staffing requirements in acute care hospitals, and for decades nurses have reported that there are not enough nurses in hospitals to provide care of a high standard (Aiken et al., 2010:904). Kane et al. (2007) note that while patient outcomes are the ultimate concern, nurse outcomes can interact with nurse staffing to affect patient outcomes. In addition, patient outcomes will, in turn, affect length of stay (LOS), and greater complication rates may increase the length of stay for patients. A number of studies evaluated by Kane et al. (2007) focus on the impact of nurse satisfaction on patient outcomes. In a survey of 8 760 nurses, Sochalski, as described by Kane et al. examined the relative risk of adverse events among Medicare patients in relation to perceived quality of care. Nurses responded to the survey question, “How would you describe the quality of nursing care delivered to patients in your unit on your last shift?” A reduction by 16% in the relative risk of patient falls and
medication errors corresponded to a 30 percent increase in nurses satisfied with the care provided (Yoder-Wise, 2011:282). Various strategies can be employed to improve nurse outcomes.

4.8.2 Interventions to improve nurse outcomes

Over 150 years ago, Florence Nightingale conducted the first nursing outcomes research and documented unsanitary and unsafe conditions in hospitals (Cheung et al., 2010:35). She introduced basic measures for improving sanitation and hygiene. The effect on the mortality rate was shocking. Within six months, the death rate at the military hospital in Scutari, Turkey went down from 43% to 2%. Her focus on outcomes as a method to measure quality was a major contribution to health research. She was of the opinion that highly trained nurses make a difference in creating a safe practice environment that significantly improves patient care.

Staffing is the method used to ensure that the appropriate staff, qualifications and quantity are available to provide the care that is needed for patients to meet their needs and therefore provide quality safe care. This is not easy to accomplish with patients changing and the ever-unstable nursing workforce (Finkelman, 2012:298). Factors that must be considered in staffing are: types of patients and care required, number of patients, workload patterns such as when patients are admitted and discharged, times of procedures and other treatment, average daily census, hours of work, for example an inpatient psychiatric unit is operational 24 hours a day, 7 days a week, types of nursing staff used, for example registered nurses or psychiatric nurses, the use of support staff such as a unit secretary and staff to transfer patients to examinations and procedures can make a big difference, as does the communication system for example use of pagers, cellular phones and handheld computers. The documentation system is also a critical factor, with computerized systems typically providing effective communication and effective use of time (Finkelman, 2012:298). The effects of nursing characteristics on patient outcomes have been studied in the past. Evidence suggests that higher proportions of nurses with a baccalaureate degree, better work environment for nurses and lower patient-to-nurse ratios are associated with lower mortality and failure to rescue (MedCare, 2011).

Staffing management is complex and challenging because of the numerous dependencies and interrelated organisational processes. A conceptual framework provides logic and order to complex processes for administrators and scientists to consider (Huber, 2014:369). A conceptual framework for staffing management proposes that the following staffing terminology should be kept in mind: human resources staffing strategy, nurse staffing management plan, nurse staffing, skill mix, staffing pattern, scheduling, staffing effectiveness, nurse-to-patient ratio, skill level, nursing workload, nursing direct care hours, average daily
census, admission, discharges and transfers, and average length of stay. This conceptual framework is intended for the evaluation of quality care, relating various structures (e.g. hospital characteristics) that impact various processes (e.g. actual staffing) and subsequently influence various outcomes (e.g. patient quality, patient satisfaction, and staff satisfaction) (Churchill & Warden, 2014:18). In the proposed framework, structures represent the various nursing strategies, both internal and external to the organisation, which directly influence an organisation’s ability to manage processes for staffing effectively. The processes are a series of defined stages with outputs that directly affect subsequent stages of staffing. Finally, the outcomes of staffing management are multidimensional and measured in terms of organisational outcomes, including patient, fiscal and staff outcomes (Huber, 2014:369).

The staffing management plan provides the structured process to identify patient needs and then to deliver the staff resources as efficiently and effectively as possible (Calvan, 2010:1). An effective plan first focuses on stabilising the psychiatric unit core staffing. A staffing pattern or core coverage is determined through a forecasted and a recommended care standard (Huber, 2014:375). Hiring to the associated position complement and developing balanced and filled schedules, without holes, are essential building blocks for efficient and cost effective daily routine allocation. Daily staffing allocation requires managing a variable staffing plan, measuring and predicting demand, and then providing balanced workload assignments to ensure that the correct caregivers are best matched to patient needs. A successful staffing management plan incorporates the policies inherent to the organisation, patient care unit and nurse population, including union and contracting affiliates. Nurse staffing policies should address both patient care units and organisations, such as shift rotation, overtime, full-time/part-time mix, and weekend staffing (Huber, 2014:375).

Data indicate that there is increased enrolment in doctoral programmes that will help increase number of faculty; however, more will be needed American Association of College of Nursing (AACN, 2010). Along with the education problems, there is the problem of staff turnover. Reported turnover rates of newly registered nurses vary from 13% - 70%. Job burnout and dissatisfaction are causing retention problems, with nurses leaving the profession or taking extended time off from work. This leads to high turnover rates, which affects costs, healthcare quality and safety, and the image of nursing, leading to problems with attracting people into the profession (Bae et al., 2010:47; Finkelman, 2012:300). The present, complex shortage is primarily lack of supply (not enough nurses). It is believed that past strategies, such as sign-on-bonuses and premium packages, only redistribute nurses from employer to employer, rather than increase the number of nurses. In addition to not having enough nurses under usual circumstances, researchers and professional organisations have identified multiple interrelated factors that affect the demand for nurses that should still be considered. These
factors are: cost containment pressures within healthcare organisations, resulting from managed care and an increasingly competitive healthcare environment, hospital consolidation, downsizing and reengineering, reduction in inpatient hospitalisation rates, increased acuity of hospital patients and a shift of outpatient care from hospital to ambulatory and community-based settings (Finkelman, 2012:300).

In summary, improved staff outcomes will result in job satisfaction, increased patient outcomes, decreased levels of burnout and decreased turnover for professional nurses working in psychiatric institutions, thereby creating positive practice environments.

After discussing literature relating to staff outcomes, the following conclusion statements were deduced:

4.8.3 Conclusion statements on the goal: improved staff outcomes

- There is a correlation between staff outcomes and patient outcomes in that when staff outcomes are improved, the patient satisfaction level is increased.
- When staffing numbers are increased, the nurse–patient ratio is increased in health establishments and the level of burnout among staff members decreases.
- When employees experience job satisfaction and are satisfied with their work environment, the turnover rate decreases.
- A high staff turnover affects the overall budget of the health establishment.
- Daily staffing allocation requires a staffing management plan that should be incorporated in the institutional internal policies.

Refer to figure 4-5

![Figure 4-5: Conceptualisation of improved staff outcomes](image-url)
In order to improve staff outcomes, the problem of shortage of professional nurses should be addressed, including nurse–patient ratio to decrease nurses’ workload. Consideration should be given of the ever changing or unstable nursing workforce due to high incidences of professional nurses resigning and retiring, resulting in high staff turnover. High levels of burnout and decreased levels of job satisfaction result in more negative and toxic practice environments.

The next discussion focuses on the procedure that is the creation of positive practice environments.

**4.9 PROCEDURE: CREATION OF POSITIVE PRACTICE ENVIRONMENTS**

The work environment of nurses is receiving international attention because there is growing agreement that identifying opportunities for improving work conditions in hospitals is important to maintain adequate staffing, high quality care, nurses’ job satisfaction and therefore their retention (Hinno *et al*., 2011:133). Identifying factors that lead to satisfaction of professional nurses is important to attract and keep them in the workforce (Zori *et al*., 2010:306). According to Roche *et al*. (2010:195), research has established that factors in the practice environment influence nurse and patient outcomes, and the link between positive practice, nurse satisfaction and retention has been identified in a number of studies. Positive practice environments (PPEs) are settings that support excellence and decent work (ICN, 2008). In particular, they strive to ensure the health, safety and personal well-being of staff, support quality patient care and improve the motivation, productivity and performance of individuals and organisations. In almost every country, nurses provide the majority of health services – up to 80 percent in some cases (Baumann, 2007:2). The reasons for the healthcare and nursing crisis are varied and complex, but evidence underlines that unhealthy work environments are key among them. Unhealthy environments affect nurses’ physical and psychological health through the stress of heavy workloads, long hours, low professional status, difficult relations in the workplace, problems carrying out professional roles, and a variety of workplace hazards. Evidence (ICN, 2008) indicates that “long periods of strain affect personal relationships and increase sick time, conflict, job dissatisfaction, turnover, and inefficiency” (ICN, 2008). Nurses who are stressed because of heavy workloads, friction with colleagues, inappropriate tasks, insufficient skills and knowledge, poor management or unsafe working conditions are challenged to provide the highest standard of care. PPEs affect not only nurses, but also other healthcare workers and support excellence in services, ultimately improving patient outcomes. A discussion on PPE related to elements, benefit and cost of unhealthy and unsafe workplaces follows.
4.9.1 Elements of positive practice environments

PPE are characterised by ICN (2008) as the presence of:

- occupational health, safety and wellness policies that address workplace hazards, discrimination, physical and psychological violence and issues pertaining to personal security;
- fairness and manageable workloads and job demands/stress;
- an organisational climate reflective of effective management and leadership practices, good peer support, worker participation in decision making and shared values;
- work schedules and workloads that permit healthy work-life balance;
- equal opportunity and treatment;
- opportunities for professional development and career advancement;
- professional identity, autonomy and control over practice;
- job security;
- decent pay and benefits;
- safe staffing levels;
- support, supervision and mentorship;
- open communication and transparency;
- recognition programmes; and
- access to adequate equipment's, supplies and support staff.

Attributes of the PPE that significantly influence staff nurse satisfaction are participation in hospital affairs, staffing and resource adequacy, nursing foundations for quality care nurse manager ability and support, and collegial nurse–physician collaboration (Zori et al., 2010:306).

There is a growing understanding of the relationship between nurses’ work environments, patient/client outcomes and organisational and system performance. Numerous studies have shown a strong link between nurse staffing and patient/client outcomes, Registered Nurses Association of Ontario (RNAO, 2008a:13; RNAO, 2008b:19). Work environment is influenced by various factors such as the availability of equipment, the physical environment, the role of management, peer relations and patient acuity (Duffield et al., 2010:24). The evidence shows
that healthy work environments yield financial benefits to organisations with respect to reductions in absenteeism, lost productivity, organisational healthcare costs, and costs arising from adverse patient/client outcomes. Achievement of PPEs for nurses requires transformational change, with interventions that target underlying workplace and organisational factors. It is with this intention that guidelines have to be developed. It is believed that full implementation will make a difference for nurses, their patients/clients and the organisations and communities in which they practice. It is anticipated that a focus on creating healthy work environments will benefit not only nurses, but also other members of the healthcare team. We also believe that best practice guidelines can be successfully implemented only where there are adequate planning processes, resources, organisational and administrative supports, and appropriate facilitation. A PPE is a practice setting that maximizes the health and well-being of nurses, quality patient/client outcomes, organisational performance and societal outcomes (Baumann, 2007:3). A healthy work environment for nurses is complex and multidimensional, comprised of numerous components and relationships among the components. A comprehensive model is needed to guide the development, implementation and evaluation of a systematic approach to enhancing the work environment of nurses (Papastavrou et al., 2014:3).

The Comprehensive Conceptual Model for Healthy Work Environments for nurses presents the healthy workplace as a product of the interdependence among individual (micro level), organisational (meso-level) and external (macro level) system determinants as shown below in the three outer circles (RNAO, 2008a:15). At the core of the circles are the expected beneficiaries of healthy work environments for nurses—nurses, patients/clients, organisations and systems and society as a whole, including healthier communities. The lines within the model are dotted to indicate the synergetic interactions among all levels and components of the model. The model suggests that the individual’s functioning is mediated and influenced by interactions between the individual and her/his environment. Therefore, interventions to promote healthy work environments must be aimed at multiple levels and components of the system. Similarly, interventions must influence not only the factors within the system and the interactions among these factors, but also influence the system itself (RNAO, 2008a:15). See the figure below.
Figure 4-6: Conceptual model for healthy work environments for nurses (RNAO, 2008a:14)

The model has the following assumptions (RNAO, 2008a:15):

Healthy work environments are essential for quality and safe patient/client care. The model is applicable to all practice settings and all domains of nursing. Individual, organisational and external system level factors are the determinants of healthy work environments for nurses.

Factors at all three levels affect the health and well-being of nurses, quality patient/client outcomes, organisational and system performance, and societal outcomes, either individually or through synergistic interactions. At each level, there are physical or structural policy components, cognitive/psycho/social/cultural components, occupational components and professional/occupational components. The professional/occupational factors are unique to each profession, while the remaining factors are generic for all professions/occupations.

4.9.1.1 Physical/structural policy components

At the individual level, the physical work demand factors include the requirements of the work, which necessitate physical capabilities and effort on the part of the individual. Included among these factors are workload, changing schedules and shifts, heavy lifting, exposure to
hazardous and infectious substances and threats to personal safety (RNAO, 2008a:16). At the organisational level, the organisational physical factors include the physical characteristics and the physical environment of the organisation and the organisational structures and processes created to respond to the physical demands of the work. Included among these factors are staffing practices, flexible and self-scheduling, access to functioning lifting equipment, occupational health and safety policies and security personnel. At the system or external level, the external policy factors include healthcare delivery models, funding, and legislative, trade, economic and political frameworks (e.g. migration policies, health system reform) external to the organisation (RNAO, 2008a:16). Refer to the figure 4.7.

![Figure 4-7: Physical/structural policy components (RNAO, 2008a:16)](image)

4.9.1.2 Cognitive/psycho/socio/cultural components

At the individual level, the cognitive and psychosocial work demand factors include the requirement of the work, which necessitates cognitive, psychological and social capabilities and effort (e.g. clinical knowledge, effective coping skills, communication skills) on the part of the individual. Included among these factors are clinical complexity, job security, team relationships, emotional demands, and role clarity and role strain (RNAO, 2008a:17). At the organisational level, the organisational physical factors include the physical characteristics
and the physical environment of the organisation and the organisational structures and processes created to respond to the physical demands of the work. Included among these factors are staffing practices, flexible and self-scheduling, access to functioning lifting equipment, occupational health and safety policies, and security personnel. At the system or external level, the external policy factors include healthcare delivery models, funding, legislative, trade and economic and political frameworks (e.g. migration policies, health system reform) external to the organisation. At the individual level, the cognitive and psychosocial work demand factors include the requirements of the work, which necessitates cognitive, psychological and social capabilities and effort (e.g. clinical knowledge, effective coping skills, communication skills) on the part of the individual. Included among these factors are clinical complexity, job security, team relationships, emotional demands, role clarity, and role stain (RNAO, 2008a:17). At the organisational level, the organisational social factors are related to organisational climate, culture and values. Included among these factors are organisational stability, communication practices and structures, labour/management relations, and a culture of continuous learning and support. At the system level, the external socio-cultural factors include consumer trends, changing care preferences, changing roles of the family, diversity of the population and providers, and changing demographics all of which influence how organisations and individuals operate (RNAO,2008a:17). See the figure below.
Figure 4-8: Cognitive/psycho/cultural components (RNAO, 2008a:17)

4.9.1.3 Professional/occupational components

At the individual level, the individual nurse factors include the personal attributes and/or acquired skills and knowledge of the nurse, which determine how she/he responds to the physical cognitive and psychosocial demands of work (RNAO, 2008a:18). Included among these factors are commitment to patient/client care, the organisation and the profession; personal values and ethics; reflective practice; resilience, adaptability and self-confidence; and family work balance, including the prevention of sexual harassment at work (Philadelphia Employment Law News, 2012:1). At the organisational level, the organisational professional/occupational factors are characteristic of the nature and the role of the profession/occupation. Included among these factors are the scope of practice, level of autonomy and control over practice and interdisciplinary relationships. At the system or external level, the external professional/occupational factors include policies and regulations at the provincial/ territorial, national and international level, which influence health and social
policy and role socialisations within and across disciplines and domains (RNAO, 2008a:18). Refer to the figure below.

![Diagram](image)

**Figure 4-9: Professional / occupational components (RNAO, 2008a:18)**

### 4.9.2 Benefits of positive practice environment

The beneficial effects of positive practice environments on organisation performance in general and on health service delivery, health worker performance, patient outcomes and innovation in particular, are well documented (ICN, 2008). Positive changes in the work environment result in a higher employee retention rate, which leads to better teamwork, increased continuity of patient care and ultimately improvements in patient outcomes. A review of performance in more than 3 000 UK businesses identified high performing organisations having the following characteristics: value quality rather than quantity; focused on long-term outcomes; established a climate of employee relations characterised, but not codified by pride, innovation and strong interpersonal relations; and understanding that collective mechanisms
support this. The WHO identified an enabling work environment as one of the four components in strengthening management and leadership of health systems delivery. PPEs demonstrate a commitment to safety in the workplace, leading to overall job satisfaction. When health professionals have job satisfaction, rates of absenteeism and turnover decreases, staff morale and productivity increases, and work performance as a whole improves. Maintaining a level of autonomy over their work allows staff to feel that they are respected and valued members in their places of employment. Research demonstrates that nurses are attracted to and remain at their place of employment when opportunities exist that allow them to advance professionally, to gain autonomy and participate in decision making, while being fairly compensated. A richer mix of qualified nurses is linked to reduction in patient mortality, rates of respiratory, wound and urinary tract infections, number of patient falls, incidence of pressure sores and medication errors. Physicians get high satisfaction from their work if they have good working conditions, can help patients and when they can utilize advances in health technology. Effective teamwork is essential in healthcare organisations and improves the quality of work life and patient care (ICN, 2008). A healthy work environment helps to create a desirable workplace and provides the infrastructure that positively impacts on the effectiveness of the work itself, where there is autonomy and control over practice (Ditomassi, 2012:270). Furthermore, a nursing manager who consults with staff, provides positive feedback and displays good leadership is instrumental in increasing job satisfaction among nurses (Duffield et al., 2010:30). As the discrepancy between nursing demand and supply decreases, job satisfaction is likely to be increased, the perception of adequacy of resources and the level of control over practice increased (Duffield et al., 2011:250). In a study by Tourangeau and others, it was found that psychological and global empowerment and perceived organisational support have a direct effect on promoting increased job satisfaction and therefore an indirect effect on turnover intention (Tourangeau et al., 2010:9). According to the results of research conducted in the United Kingdom, workplace has a large positive correlation with “Collegial nurse physician relations” (r = 0.472; p = 0.000), “Nurse manager ability, leadership and support of nurses” (r = 0.453; p = 0.000), “Nursing foundations for quality of care” (r = 0.548; p = 0.000) and “Nurse participation in hospital affairs” (r = 0.475; p = 0.000). It also has a medium positive correlation with “Staffing and resource adequacy” (r = 0.381; p = 0.000) (Tourangeau et al., 2010:9). Yet practice environment can also be unhealthy and unsafe as described in the following section.

4.9.3 Cost of unhealthy and unsafe workplaces

It is the responsibility of the employer to provide a safe workplace for employees by abiding to workplace safety standards and to provide a workplace that is free of health and safety hazards to prevent injuries and death (Findlaw, 2013:1). Employees have the right to a safe
workplace and if the workplace becomes unsafe, they should report it to the employer (Findlaw, 2016:1). Unhealthy workplaces such as failure by the institution to pay overtime to employees could result in stress and conflict (Tanner, 2010:1). Unhealthy environments affect health professionals’ physical and psychological health through the stress of heavy workloads, long hours, low status, difficult relations in the workplace, problems carrying out professional roles, and a variety of workplace hazards (ICN, 2008). The costs of these unhealthy and unsafe workplaces for health professionals have been well documented by the ICN (2008). However, this not only affects nurses, but also all healthcare professionals. Dissatisfaction with opportunities for advancement and dissatisfaction with educational opportunities were expressed by the majority of nurses (Aiken et al., 2012:146).

Evidence (ICN, 2008) indicates that long periods of job strain affect personal relationships and increase sick time, conflict, job dissatisfaction, turnover and inefficiency. A survey of Swiss primary care practitioners reported that one third presented a moderate or a high degree of burnout, which was mainly associated with work-related stressors (ICN, 2008). A study in Finnish hospitals reported that workplace bullying of staff is related to an increase in absence due to sickness (ICN, 2008). Another by the same research team (ICN, 2008) reported that poor teamwork seems to contribute to physicians’ sickness absence rates. Research on pharmacists in South Africa reported that stressors that had high severity ratings included the unavailability of medicine, frequent interruptions, high levels of workload and insufficient salaries (ICN, 2008). A study of nurses in the USA, Canada, England, Scotland and Germany showed that 41% of hospital nurses were dissatisfied with their jobs and 22% planned to leave them in less than one year. Findings confirmed the relationship between workplace stress and nurses’ morale, job satisfaction, commitment to the organisation and intention to quit (ICN, 2008). A study of emergency care physicians in Canada reported that the resource factors that have the greatest impact on job satisfaction include availability of emergency room physicians, access to hospital technology and emergency beds, and stability of financial (investment) resources (ICN, 2008). A study of physiotherapy interns in Nigeria (ICN, 2008) reported that while most were satisfied with the support of their senior colleagues, many were grossly dissatisfied with their salaries (91%), the available equipment (79%), and the office environment (58%). A survey of physiotherapists in Zimbabwe (ICN, 2008) highlighted that 78% reported experiencing work-related musculoskeletal disorders (WMSDs), and that one in four physiotherapists took sick leave or required treatment because of WMSDs. Overworked nurses may display slower reaction times, less alertness to changes in patients' conditions, and medication errors, which translate into adverse risks to patients (ICN, 2008). Physicians express dissatisfaction when facing high levels of bureaucracy and loss of self-regulation (ICN, 2008). The demand on health professionals' time is being challenged by various non-clinical
factors, (i.e. indirect services such as arranging community resources, travel to/from the patient, case management, documentation, tracking statistics and other administrative duties), which compete with direct hands-on therapy time required to achieve positive patient and system outcomes (ICN, 2008). High turnover, a symptom of a poor work environment, is likely to lead higher provider costs, such as in recruitment and training of new staff and increased overtime and use of temporary agency staff to fill gaps. Turnover costs also include the initial reduction in the efficiency of new staff and decreased staff morale and group productivity (ICN, 2008). One study of turnover costs in the USA estimated that total turnover costs for a hospital system employing 5 000 employees was between $US17 and $29 million (ICN, 2008).

In a study by Aiken et al. (2012) it was found that hospitals face problems associated with hospital quality, nurse burnout, safety and dissatisfaction. In another study by Mayeng and Wolvaardt (2015:6) in South Africa, it was found that patient safety incidents were not investigated and there was lack of commitment to issues related to quality. This is of concern when viewed in light of the need to identify, report, analyse and prevent any unexpected incidents that could cause harm to the healthcare user (Mayeng & Wolvaardt, 2015:6). Medication errors have direct and indirect consequences, and are usually the result of breakdowns in a care system. Studies indicate underreporting of medication errors by nurses (Swart et al., 2015:6).

In summary, a PPE can be established in psychiatric institutions by allowing professional nurses to participate in hospital affairs, ensuring that staffing and resources are adequate, when nurse managers provide support to nurses by making opportunities for advancement possible, and when nurse–physician collaboration or relationship and communication is good. After reviewing the literature related to positive practice environments, the following conclusion statements can be deduced:

4.9.4 Conclusion statements on the procedure: creation of positive practice environments

In conceptualising the procedure, which in this research refers to establishing and maintaining positive practice environments, the following statements can be deduced:

- Negative work environment such as difficult relations among health professionals could affect nurses holistically and increase levels of burnout.

- Heavy workload increases job dissatisfaction among nurses, resulting in high staff turnover.

- Policies that address workplace hazards must be in place to ensure that the practice environment is safe for both patients and staff.
• It is important that opportunities for professional development and career advancement are made available to all health professionals as it promotes job satisfaction and good leadership.

• Support, supervision and mentorship of new employees are important to make them feel welcome in the institution.

• Access to adequate equipment, resources and supplies by the professional nurse and other health professionals enables the rendering of quality care delivery and better nurse physician relationships.

• Positive practice environments have beneficial effects on staff, patient and organisational outcomes. In response, unhealthy work environments can be detrimental to all the role players in healthcare organisations.

Conceptualization of the procedure is represented in Figure 4.10

![Figure 4.10: Conceptualisation of positive practice environments](image)

The above figure shows that positive practice environments are characterised by the availability of the following in a psychiatric hospital: adequate resources, policies, training opportunities, orientation programmes for new employees, fair workloads, teamwork among personnel and effective supervision by supervisors. The sixth classification by Dickoff et al. (1968), namely dynamic (motivation) is discussed next.

4.10 DYNAMIC: MOTIVATION

Work motivation influences the content and the quality of work-related outcomes in healthcare (Toode et al., 2010:246). However, a comprehensive understanding of nurses’ work
motivation as a response to the increasing challenges and demands in healthcare is still lost (Toode et al., 2010:246). The term motivation is derived from the Latin word for movement, *movere* (Latham, 2012:3). Lambrou et al. (2010:2) define motivation as the processes responsible for an individual’s direction, intensity and persistence of effort towards the achievement of a specific goal. Motivation according to Finkelman (2012:339) is the intensity of a person’s desire to engage in some activity. Its importance in the workplace is captured in the equation: job performance = ability x motivation. This equation succinctly explains why the subject of motivation is a cornerstone in the fields of human resource management, industrial and organisation psychology and organisational behaviour (Finkelman, 2012:339). Motivation is an integral aspect in the work environment, such as in psychiatric institutions (Latham, 2012:3). The time, money and resources an organisation devotes to ways of increasing a person’s abilities are wasted to the extent that an employee chooses not to learn what is being taught or chooses not to apply newly acquired knowledge and skills in the workplace. Therefore, the purpose of performance appraisal/performance management is to focus not only on identifying the requisite abilities an individual requires to be able to perform effectively, it is also to coach the person so as to inculcate a desire for continuous improvement. To facilitate the coaching process, researchers in the area of selection/staffing focus on the identification and development of tests that predict who is predisposed to being highly motivated in a work setting (Latham, 2012:3). It is difficult to discuss any work issue without considering motivation. Motivation relates to individual staff members, teams, management, components of the organisation (units, divisions, departments) and the department as a whole. Theories of leadership and management often address motivation. According to the work system model, nurses may experience satisfaction or dissatisfaction because of their individual characteristics, their tasks, preferences, different tools and technologies used, organisational and physical environment (Hoonaker et al., 2013:315.e13). When a person is a team leader or a team member, he should display motivation because his level of motivation will determine whether the team works effectively or not. Given this, it is important to understand motivation and how it affects work. The following aspects relating to motivation are discussed in the paragraphs below: historical development of motivation theory, intrinsic versus extrinsic motivation, assessment of the motivational climate and strategies for motivation.

4.10.1 Historical development of motivation theory

The question about employee motivation has played a central role in management practice and theory since the 20th century (Toode et al., 2010:247). The “golden age” of work motivation theories and researches began in the mid-1960s. Nevertheless, before the 1990s, this topic got recognition in nursing literature. At the start of the 21st century, the framework of modern
work motivation research integrated all the theories addressing the personality, values, cognition, needs, affect, behaviour and the environment (Toode et al. 2010:247). Traditional management theory is based on McGregor’s Theory X. Traditional theory addresses itself to Maslow’s primary physiological and safety needs and employs the monistic theory for reinforcement (Toomey, 2009:108). The latter helps meet some of the hygiene needs, but did not provide motivation.

4.10.2 Intrinsic versus extrinsic motivation

According to Natan and Becker (2009:308), intrinsic motivation is a motivational behaviour aimed at achieving a feeling of control and competence. It includes seeking challenges, inquisitiveness and looking for opportunities to be excellent. On the other hand, extrinsic motivation is a motivational behaviour aimed at achieving rewards or avoiding punishment. When the activity is the means of achieving another goal, the motivation to act is seen as extrinsic, though work commitment theories and their relationships to work-related behaviours have been a great force for debate and research. Theories present usually as internal and external motivating variables that cause changing levels of commitment. Identifying these variables and the type of commitment that best foresee behaviours and attitudes has been the ground for research in almost every social science discipline (Gambino, 2010:2533). In most cases, motivation comes from a need that must be fulfilled, and this leads to a specific behaviour. Fulfilment of needs end up with some kind of reward, which can either be extrinsic or intrinsic (Lambrou et al., 2010:2). Empirical research conducted by the University of Michigan’s Survey Research Centre (Latham, 2012:106) led to the conclusion that the use of external sanctions, of pressuring for production, may work to some degree, but not to the extent that the internalised motives do. Similar to the claim regarding the negative effect of money on behaviour, it is believed that professional nurses judge their motivation on the basis of the circumstances in which they behave. If nurses perform activities for external rewards, such as money, they infer a lack of personal interest, but when nurses perform without external inducement, they judge themselves to be in control and therefore become intrinsically motivated. It could be concluded that extrinsic incentives reduce intrinsic motivation, creating the impression for people that their behaviour is externally precipitated. This in return weakens nurses’ feelings of competence and self-determination. This inference was drawn by comparing the amount of time a person spends on a task after the experiment had allegedly ended (“free time”) and no reward was given, versus the amount of time spent on the task prior to the administration of the reward.

Bandura in Latham (2012:107) argued that the deficiencies of this reasoning are at least fourfold. First, intrinsic motivation is an elusive concept. It is usually defined as the
performance of activities for no apparent external reward. Identifying the existence of intrinsic motivation on the basis of persistence of behaviour in the absence of noticeable extrinsic incentives is no easy task. It is all but impossible, he said, to find situations that completely lack external inducements (e.g., situational, physical, and social structures, the materials they contain, and expectations of others). The activation of behaviour is the result of a continuous interaction between personal and situational sources of influence. Second, Bandura pointed out that the methodology used in the experiments may be flawed. The abrupt withdrawal of a monetary reward is not a neutral event. Not rewarding behaviour after it has been rewarded consistently functions as a punisher that reduces performance. Moreover, satiation and tedium affect one’s level of activity. When incentives are used to get professional nurses to perform the same behaviour repeatedly, they eventually tire of it. Decreases in performance often reflect reactions to how incentives are presented rather than to the incentives themselves. Incentives can be used coercively (e.g., “you will not get performance bonus until you are assessed”), as an expression of appreciation (e.g., “this is in recognition of the good you are doing”), or to convey evaluative reactions (e.g., “this is what this performance is worth to us”). In short, the same incentive can have differential effects on an individual’s behaviour depending on the message conveyed. As Bandura noted, it is unlikely that the professional nurse loses interest in her work just because they are offered high performance bonuses.

The following assumptions related to motivation in the workplace in general can be applied to professional nurses (Latham, 2012:107):

- If a professional nurse is rewarded for completing a task or attaining a goal for quality, and if that reward is abruptly stopped, the person still spends as much time on the activity as was spent prior to the reward being introduced in the experiment (i.e., baseline performance).

- Verbal praise positively affects professional nurses’ performance. When the reward is verbal praise, professional nurses spend more time on a task, despite the cessation of the praise, than they did prior to the introduction of praise in the experiments.

- Moreover, nurses reported that they like the task more after receiving praise or money.

- Reward for high creativity in one task enhances creativity in an entirely different task.

- A reward having a detrimental effect on a nurse’s performance occurred when an anticipated reward was presented on a single occasion without regard for quality of performance or task completion.
Joining the nursing profession requires that an individual is intrinsically motivated. According to McLaughlin et al. (2009:406), friends and parents can affect people’s intention to join the nursing profession both negatively and positively. Having a relative who is also a nurse does not necessarily result in encouragement, and relatives may either encourage or discourage one to become a nurse. Furthermore, individuals may choose nursing because they identify themselves with other nursing role models such as Florence Nightingale, the woman who carried the lamp at night to care for the sick. She also cared for the soldiers in the Crimean War and changed the position of nurses during the 19th century (Rhodes et al., 2011).

4.10.3 Assessment of the motivational climate

According to Miulli and Nordin-Bates (2011:5), the motivational climate is the psychological atmosphere in which there are training and rehearsing opportunities for personnel and personnel are performing according to expectation. It is the structure of the social environment that influences the individual’s motivation and motivational processes and the extent to which the environment is structured towards promoting mastery of the task and the learning goals (Livingstone, 2008:1). Duda and Balaguer (2012:120) are of the opinion that motivational climate is dimensional and consists of different structures such as the evaluation of the system, the type and the basis for recognition, the nature of the interaction between the groups and the identification of authority.

Understanding a person’s motivation is helpful in developing strategies to increase a person’s motivation and to understand the team’s motivation better (Finkelman, 2012:340). The critical questions are what makes a person work and want to improve work performance? Methods that might be used to increase motivation include observation, asking professional nurses, and comparing and contrasting outcome results with rewards that they receive. When professional nurses are identified as having poor motivation, how are they usually described? Typical descriptors are lack of energy, lack of initiative, poor communication, lack of follow-through, low socialization at work, and no “get up and go”. It is helpful to watch for changes in self and others. Motivation at work is also affected by personal problems and therefore may interfere with the nurses’ motivation. In a study conducted at a government hospital in Nigeria, it was found that nurses were poorly remunerated and poorly motivated in correlation with the extent of their work performance and poor working conditions (Awosusi & Jegede, 2011).

4.10.4 Strategies to improve motivation

Motivation among professional nurses can be improved by understanding generational differences among nurses. Generation can be defined as a group that can be identified that shares birth years, location and important life events at critical developmental stages, divided into five to seven years into the first wave, core group and last wave (Wong et al., 2008:2;
Tolbize, 2008:1). There are two views concerning generational differences at the workplace (Tolbize, 2008:1). The first assumes that shared events influence and define each generation and that while people in different generations differ, they share thoughts, behaviours and values because of shared events. The other view is that although there might be differences throughout an employee’s career stage, they may be generic in what they want from their jobs. According to Adcox (2016:1), a generation gap refers to the differences between generations that can make communication difficult and cause conflict among people. Numerous articles have reported that Generation Y (persons born between 1982 and 2001) employees have work values that are different from previous generations. They are more concerned about recognition, rewards and status when compared to previous generations (Shea, 2012:1). Therefore, institutions have to focus more on transforming their work environments to motivate their employees to participate in behaviour that is consistent with their goal. Institutions need not only understand the importance of employees’ motivations, they should also understand the differences in preferences of motivation factors between employees’ generations. Failure by management of the institution to understand this difference would result in institutional ineffectiveness (Yusoff & Kian, 2013:97). Today’s multi-generational workplace may pose a challenge to nurse managers because of age differences in teams. Generational differences in job expectation could cause conflict, making productivity in the workplace difficult (Goldbeck, 2015:1). Therefore, nurse managers should recognize the generational differences so that individualized approach to motivation could be applied.

Rewarding professional nurses for achieved outcomes and effective performance is critical in developing the team and improving and supporting motivation. Recognising effort should never be taken for granted (Finkelman, 2012:341). There will be times when professional nurses in psychiatric institutions will excel in their practice environment and it is particularly important to recognize these times. There will also be times when things do not go well, and these times require some form of intervention. The focus should be on improvement and moving forward, not on dwelling on errors (although they do need to be analysed if improvement is to take place). The most common strategies used to motivate staff are pay for performance, merit raises, spot rewards, skill-based pay, recognition awards, job redesign that results in greater job satisfaction, empowerment, goal setting, because when people set goals they are more motivated to reach them, positive reinforcement, and lifelong learning that improves skills and demonstrates that the organisation is committed to the employees. The decision to use the reward method depends on the individual, situation, policies and procedures, roles and responsibilities, and timing. Work meaningfulness, good interpersonal relationships and respect have been shown to have a positive outcome on the quality of service provided (Lambrou et al., 2010:15). This would imply that hospital management should
consider taking an effort to motivate its health professionals by arranging regular goal setting meetings with them, identifying, analysing and solving work-related problems to improve the performance of the health establishment. Other strategies to improve motivation include evaluation of normative commitment and feelings of obligation and loyalty among professional nurses, as well as implementing transformational changes in the practice environments (Gambino, 2010:2538). Engin and Cam (2006:268) believe that psychiatric nurses who do not suppress their anger and can control their anger, and who can verbalise difficult feelings such as desires and anger, have a high level of job motivation. It is also believed that the establishment of a mastery motivational climate will increase enjoyment, perceived competence and intrinsic motivation among professional nurses working in psychiatric institutions (Theeboom et al., 2014:294).

According to the results of this research, opportunity for advancement as a way of motivating personnel was found to have a large positive correlation with “Nurse foundations for quality of care” \( (r = 0.505; p = 0.000) \) and nurse participation in hospital affairs \( (r = 0.558; p = 0.000) \). It also has a medium positive correlation with “Staffing and resource adequacy” \( (r = 0.395; p = 0.000) \), “Nurse physician relations” \( (r = 0.270; p = 0.000) \) and “Nurse manager ability, leadership and support of nurses” \( (r = 0.441; p = 0.000) \).

To summarise, professional nurses working in psychiatric institutions have to be rewarded for providing nursing care of a high standard. In a working environment, individuals are either intrinsically or extrinsically motivated as they execute their responsibilities and functions. In order to ensure a PPE, hospital management should involve professional nurses in goal setting and consider generational differences so that professional nurses could feel that they form part of the psychiatric institution. This action would improve the performance of the institution.

After discussing literature relating to motivation as the dynamic in this study, the following conclusion statements are made:

4.10.5 Conclusion statements on dynamics: motivation

In conceptualising the dynamics, the following statements were deduced:

- Employees in general are motivated to work if management makes training opportunities available to them.

- External factors such as financial rewards are not the only determinants of motivation as seen by professionals who have a passion for their chosen career that continue to do their best in the absence of external motivators.
- The degree of motivation among staff members will be increased if members are involved in decision making within the institution.

- Nurse managers can observe employees' performance behaviour related to motivation and should intervene appropriately by considering generational differences.

- The decision to choose the reward method for staff members depend on the institutional policies and procedures and verbal praise.

Conceptualization of the dynamic is presented in Figure 4.11.

![Figure 4-11: Conceptualisation of motivation](image)

The above figure shows that at their workplace, individuals are either intrinsically or extrinsically motivated. Individuals are motivated when training opportunities are made available to them, are included in goal setting, are rewarded for the good work that they are doing, are respected by management and other health professionals such as physicians, are satisfied with their jobs and when they are involved in institutional policy development.

4.11 SUMMARY

The purpose of this chapter was to describe a conceptual framework for the research, which addresses Objective 3 of Step 3 in Chapter 1. Concepts were identified and systematically classified to the categories: agent (nurse manager), recipient (professional nurse), context (psychiatric hospital), goal (staff outcomes), procedure (positive practice environments) and dynamic (motivation). Conclusion statements were deduced to serve as inferences for the construction of practice theory. In the next chapter (5), a discussion on theory construction follows.
5.1 INTRODUCTION

A nursing theory is a set of concepts, definitions, relationships and assumptions or propositions derived from nursing models or from other disciplines and project as a purposive, systematic view of phenomena by designing specific inter-relationships among concepts for the purposes of describing, explaining, predicting and/or prescribing (De Vos et al. 2013:37; Masters, 2015:6). It is further defined as a group of related concepts that propose action that guide practice (Polit & Beck, 2014:133).

In the previous chapters the reader was introduced to aspects that are related to the construction of a theory (Chapter 2 Phase 2 step 2) for positive practice environment for professional nurses working in selected psychiatric institutions. Following the identification of the main concepts and the review of the literature in Chapter 4, I present the practice theory for professional nurses working in selected psychiatric institutions in South Africa. The chapter provides the visual overview of the initial practice theory (refer to Figure 5.1). Evaluators who gave comments and suggestions evaluated the initial practice theory. Thereafter a final practice theory was constructed (refer to Figure 5.2) after considering the comments. The following is discussed: description of the theory, assumptions of the theory, purpose of the theory, context of the theory, structure of the theory, definition of concepts, summary of statements derived from the conceptual work and relational statements.

5.2 DESCRIPTION OF THE PRACTICE THEORY

Theory description is related to the accomplishment of Objective 3 Step 5 in Chapter 1, namely to describe the practice theory. The objective specified the description of the concepts in constructing a practice theory for professional nurses working in psychiatric institutions and the development of relational statements between the concepts. In describing the theory showed in Figure 5.2, positive practice environment was situated at the centre of the structure because it forms the core of the practice theory.

The nurse manager should provide leadership and act as a change agent to bring about transformation in a psychiatric hospital. He/she should have clinical expertise and business sense to execute his/her management function, thereby ensuring quality management in the psychiatric hospital.
The professional nurse is expected to have the necessary skills and knowledge that would make him/her a competent practitioner as he/she carries out his/her daily duties. He/she is expected to function within the legal framework, which governs the practice as a nurse.

Improved staff outcomes resulted in increased job satisfaction, decreased burnout and decreased turnover rate among professional nurses working in psychiatric hospitals. Improved staff outcomes also brought about improved patient outcomes.

When positive practice environments are created, the workload among professional nurses becomes fair. Adequate staff members should be employed, which would result in job satisfaction. A positive practice environment will exist when there are policies that guide the practice of professional nurses, when there are training opportunities for professional nurses, when there is teamwork between professional nurses and other health professionals, when there is supervision of new professional nurses and there is opportunity for professional advancement.

Within a working environment individuals are either intrinsically or extrinsically motivated. Professional nurses will be motivated to work in psychiatric hospitals when there are set goals that indicate what is expected from them, when there are training opportunities for them, when they are rewarded for the good work that they are doing, when they are respected by other health professionals, when they are satisfied with their job and there are policies that guide their practice.

When positive practice environments are created, the more the nurse manager provides good leadership in psychiatric hospitals, the more the professional nurse is able to utilize his/her knowledge and skills in the practice environment, the staff outcomes improve, which promotes job satisfaction among professional nurses and the level of motivation is improved among nurse managers and professional nurses.

5.3 ASSUMPTIONS OF THE THEORY

One assumption that appears to have received approving nods from members of the discipline was that disciplines develop through scientific discoveries, and scientific discoveries are useful when they are organised into some coherent wholes. These wholes could be theories or theoretical statements. Theories provide the frameworks that help in describing, explaining, predicting, and prescribing (Meleis, 2012:392). Therefore, theory construction and development are activities that are essential in all disciplines. In fact, the progress of any discipline is measured by the scope and quality of its theories and the extent to which its
community of scholars was engaged in theory construction. Completing isolated research projects that were not cumulative or that did not lead to the construction or corroboration of theories had limited usefulness. Since no explicit theoretical framework was used as point of departure, the research was approached with openness to accommodate other views from other researchers. Assumptions may take the form of factual assertions, or they may reflect value positions. Factual assumptions are those knowable or potentially knowable through experience. Value assumptions asserted or implied what was right, good, or ought to be (Chinn & Kramer, 2008:115). Often an empirically knowable assumption contains important underlying value assumptions. The following assumptions were made in relation to the theory:

- An effective manager is a person who should possess leadership skills, act as a change agent to promote transformation within psychiatric institutions, should have clinical expertise and business sense and should be aware of his/her management functions as he/she strives towards quality management.

- Professional nurses should possess the necessary skills and knowledge when carrying out their duties and should operate within the legal framework.

- Improved staff outcomes are characterized by increased job satisfaction, decreased burnout, decreased turnover rate among professional nurses working in psychiatric institutions and improved patient outcomes.

- Positive practice environments in psychiatric institutions is attributed to fair workload to professional nurses, adequate staffing, job satisfaction among professional nurses, the availability of policies to guide them, adequate resources, availability of training opportunities and professional advancement for staff members, teamwork and supervision of new professional nurses.

- Professional nurses will be motivated in their work environment when training opportunities are made available, when they work in a goal-directed environment, are rewarded for the good work that they are doing and when there is mutual respect among health professionals.

- There is a correlation between positive practice environments and motivation among professional nurses working in psychiatric institutions.

5.3.1 Purpose of the theory

Theory was constructed for the purpose of creating positive practice environments for professional nurses working in psychiatric institutions. Positive practice environments can be achieved by ensuring the availability of job satisfaction, advancement of professional nurses,
fair workload, teamwork, supervision of nurses, development of policies, orientation of new employees, adequate staffing and resources and training opportunities. The nurse manager should display good leadership at all times, act as a change agent, should have clinical expertise and business sense including management functions and quality management. The professional nurse is expected to function within the legal framework and should have skill, knowledge and be competent. Improved staff outcomes should bring about increased job satisfaction, decreased burnout, decreased turnover rate and improved patient outcomes. Individuals would be motivated to work when the following are available: training opportunities, goal setting, rewards, respect, job satisfaction and policies. The purpose of this theory was to identify the elements of a positive practice environment in psychiatric institutions, which are:

- The nurse manager.
- The professional nurse.
- Psychiatric hospital.
- Improved staff outcomes.
- Creation of positive practice environments.
- Motivation.

5.3.2 Context of the theory

In achieving the theoretic purpose of the practice theory, the context in this study involves three levels namely: the macro context, meso-context and micro context. The macro-context refers to the international perspective of psychiatric nursing, the meso-context refers to psychiatric nursing in South Africa and the micro-context refers to the psychiatric hospital where professional nurses practice psychiatric nursing in Gauteng and North West provinces in South Africa. These three levels may or may not be interrelated.

5.3.3 Structure of the theory

The structure of the theory was determined by bringing together concepts or ideas and seeing how these concepts related to one another. These relationships would determine the direction and the quality of the elements of the theory. Therefore, it was important when presenting the structure of the theory that all the elements that constituted a structure (concepts, related concepts and relational statements) were described. The structural form of the theory was the graphic illustration of how the concepts of a theory are related to one another. According to Chinn and Kramer (2008:112), the structure of a theory gives overall form to the conceptual relationships within it. Determining the structure of theory would be difficult if the network of
relationships was unclear or very complex. Structural forms were powerful devices for shaping our perceptions of reality. As relationships are explored, the overall theoretic structure and the structure of individual components began to merge.

The structure of the theory is reflected predominantly on two graphic forms, namely linear and circular. The arrows show how one element relates to another. The rectangles represent the different levels in psychiatric nursing. The broken lines of the inner rectangle show how the psychiatric hospital is related to the identified concepts. The different colours used in the diagram are meant to simplify the distinction between concepts and there is no other significant meaning attached to the colours.

The structure comprises of three levels namely the macro, meso, and the micro level. The outer rectangle (macro level) represents the international perspective of psychiatric nursing where the following are reflected: economics and financing healthcare, information technology, support for psychiatric research and psychiatric patients' rights within a new millennium. The second rectangle (meso level) represents psychiatric nursing in South Africa where deinstitutionalisation and decolonisation are in process. The inner rectangle (micro level) represents psychiatric hospitals where the following concepts are prevalent: nurse manager, professional nurses, positive practice environments, improves staff outcomes and motivation.

To address questions of structure, the following questions may be asked:

- What were the most central relationships?
- What was the direction, strength and quality of relationships?
- What was the order of appearance of relationships within the narrative?
- Do relationships appeared to move toward or away from the theoretic purpose?
- Did relationships come together and formed concepts or differentiated them?
- Did the theorist show the structure in a form of a diagram?

Once the major or central relationship was identified, other aspects of structure could be described. Figure 5.2 shows the structural form of the theory.
Figure 5-1: Presentation of the initial practice theory for positive practice environments for professional nurses working in selected psychiatric institutions in South Africa
Figure 5-2: Presentation of the final practice theory for positive practice environments for professional nurses working in selected psychiatric institutions in South Africa.
5.3.3.1 Definition of the concepts

- **Nurse manager**
  The nurse manager is an internal stakeholder who plays an essential role in managing change, cultural integration, retention and the direction of staff attitudes in a nursing unit towards changing the healthcare structure. They have to be prepared to deal with staff stress, low morale, staff uncertainty, staff turnover, inadequate quality care outcomes and the decreasing budget.

- **Professional nurse**
  A professional nurse is a person who is qualified and competent to practice comprehensive nursing independently in the manner and to the level prescribed, who is capable of assuming responsibility and accountability for such practice and who is registered with the regulatory and registering nurse authority.

- **Psychiatric hospital**
  Psychiatric hospital is a hospital specializing in the treatment of serious mental disorders. Patients are admitted according to the Mental Health Care Act No.17 of 2002. The emphasis is the treatment of mental disorders, the promotion of mental health and the prevention of mental illness.

- **Positive practice environment**
  Positive practice environment is a setting that supports excellence and decent work and that strives to ensure the health, safety and personal wellbeing of staff. Such an environment supports quality patient care and improves the motivation, productivity and performance of individuals and organisations. The work environment is the unit in which the nurses work, such as wards or programmes, and the organization (hospital or community) that employs them and the social context of government, profession and public opinions. Problems with nurses’ work and work environment include stress, heavy workloads, long hours, injury and poor relations with other professions that can affect their physical and psychological health. Research across occupations shows that long periods of job strain affect personality relationships and increase sick time, turnover and inefficiency.

- **Improved staff outcomes**
  Improved staff outcomes are results that ensure that the appropriate staff, qualifications and quantity are available to provide the care that is needed for patients to meet their needs. It is
the provision of quality safe care and includes job satisfaction, retention rate and burnout levels.

- **Motivation**

Motivation is the process responsible for an individual’s direction, intensity and persistence of effort towards the achievement of a specific goal and related to individual staff members, teams, management, components of the organisation (units, divisions) and the department as a whole.

- **Psychiatric nursing**

Psychiatric nursing is an integrated process that promotes and maintains patient behaviour that contributes to integrated functioning. The patient may be an individual, family, group, organisation or community. It is a specialized area of nursing practice, employing the wide range of explanatory theories of human behaviour as its science and the purposeful use of self as its art.

- **Leadership**

Leadership is defined as a process through which a person influences others to accomplish an objective and directs the organisation in a way that makes it more cohesive and coherent.

- **Burnout**

Burnout is a state of emotional, mental and physical exhaustion caused by excessive and prolonged stress. It occurs when you feel overwhelmed and unable to meet constant demands. As the stress continues, one begins to lose the interest or motivation that led one to take on a certain role in the first place. It is further defined as a consequence of prolonged job stress and is most often characterized by exhaustion, cynicism and reduced professional efficacy. What follows is a summary of statements derived from the conceptual framework discussed in Chapter 4.

5.3.3.2 **Relational statements**

Relational statements (Chapter 2 Phase 2 step 1) were formulated through deductive reasoning from conclusion statements derived from the empirical data and the conceptual framework (Table 5.1). The relationship between concepts is described by means of relational statements, cross-referenced to Table 5.1. Each relationship statement underneath reflects one of the conclusion statement/s in Table 5.1. A synthesis of deductions is as follows:
• Effective and efficient management of an institution can be established by ensuring that there were adequate resources for professional nurses to make their work environment healthy to render quality patient care (Conclusion statements no. 1, 16, 29).

• Management is about making decisions and solving problems to make the work environment of professional nurses positive (Conclusion statements no. 2, 6, 33).

• Effective managers always ensure that staff members attend workshops and courses to improve their knowledge and skills to improve patient care, thereby encouraging professional nurses to be motivated at work (Conclusion statements no. 3, 4, 8).

• The shortage of professional nurses in psychiatric hospitals increases their workload, making the work environment negative (Conclusion statements no. 20, 22, 25).

• Effective managers plan institutional activities in consultation with other health professionals and this motivates them because they are made to feel that they form part of the institution (Conclusion statements no. 5, 23, 34).

• There is a correlation between staff outcomes and patient outcomes in that the more professional nurses are employed, the better the quality of care provided to patients (Conclusion statements no. 10, 19, 21, 24, 30).

• Deinstitutionalization of psychiatric services to primary healthcare is important with the aim of moving psychiatric hospital-based care to primary healthcare to ensure that psychiatric services are made available and accessible to the community. Curative healthcare is expensive and has serious cost implications (Conclusion statement no. 14).

• Collaboration of psychiatric services with other sectors such as traditional practice is important to provide comprehensive psychiatric services (Conclusion statements no.12, 15, 17).

• Positive practice environments enhance job satisfaction among professional nurses, and decrease the level of burnout among professional nurses (Conclusion statements no.13, 18, 26, 28).

• Professional nurses should always strive to provide care of a high standard and abide by the legislation that governs their practice (Conclusion statements no. 7, 9, 11).

• Personnel in a health establishment are motivated to work if management makes career opportunities available for them (Conclusion statements no. 27, 31).

• Financial means (money) is not the only determinant of motivation (Conclusion statements no. 32, 35).
<table>
<thead>
<tr>
<th>Nurse manager</th>
<th>Professional nurse</th>
<th>Psychiatric hospital</th>
<th>Improved staff outcomes</th>
<th>Creation of positive practice environments</th>
<th>Motivation</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Nurse managers are responsible for maintaining standards of care, ensuring the availability of adequate resources and providing direction and leadership in the management of a health facility.</td>
<td>7. Professional nurses are responsible and accountable for their practice/ actions and are expected to practice within the legislative framework.</td>
<td>14. Deinstitutionalization of mental healthcare to primary mental healthcare has not yet been fully achieved because of inadequate mental healthcare providers in psychiatric settings.</td>
<td>19. There is a correlation between staff outcomes and patient outcomes in that when staff outcomes are improved, the patient satisfaction is increased.</td>
<td>24. A negative work environment, such as difficult relations among health professionals, could affect nurses holistically and increase the level of burnout.</td>
<td>31. Employees are motivated to work if management makes training opportunities available to them.</td>
</tr>
<tr>
<td>2. Nurse managers are change agents who ensure that the objectives and goals of the institution are achieved.</td>
<td>8. Professional nurses are capable of exercising intellectual and moral judgement when executing his/her duties because of the knowledge and skills he/she acquired during training.</td>
<td>15. There is a need for collaboration between traditional practice and western medicine, as patients consult with traditional healers when experiencing psychiatric problems and this approach will assist in the provision of integrated psychiatric service.</td>
<td>20. When staffing numbers are increased, the nurse–patient ratio is increased in health establishments and the level of burnout among staff members decreases.</td>
<td>25. Heavy workload increases job dissatisfaction among nurses and this could result in high staff turnover.</td>
<td>32. External factors such as financial rewards are not the only determinants of motivation as seen by professionals who have a passion for their chosen career and who continue to do their best in the absence of external motivators.</td>
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<tr>
<td>3. Nurse managers motivate and communicate effectively, are responsible for team building, for managing staff turnover, improving stress levels and low morale among staff members.</td>
<td>9. Professional nurses have a responsibility to delegate tasks to their subordinates and to consider whether the subordinate is capable of carrying out the delegated task, but the professional nurse remains accountable.</td>
<td>16. The Department of Health should increase or improve resources, like budget, human allocation for psychiatric services as psychiatric institutions continue to experience inadequate budgets and are understaffed.</td>
<td>21. When employees experience job satisfaction and are satisfied with their work environment, the turnover rate decreases.</td>
<td>26. Policies that address workplace hazards must be in place to ensure that the practice environment is safe to both patients and staff.</td>
<td>33. The degree of motivation among staff members will be increased if members are involved in decision-making within the institution.</td>
</tr>
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<td>4. Nurse managers ensure that staff members are engaged in staff development on a continuous basis to maintain quality patient care.</td>
<td>10. When providing care to patients, professional nurses should always involve the patient because this could improve patient outcomes. Quality improvement should be maintained at health facilities to ensure that patients receive care that is of a</td>
<td>17. The green paper on National Health Insurance (NHI) does not mention psychiatric services as part of district health services and there is a need to</td>
<td>22. When the turnover rate in a health establishment is high, the budget is affected because more money is used for paying pension funds and for resignations.</td>
<td>27. Opportunities for professional development and career advancement should be made available to all health professionals to promote job satisfaction and good leadership.</td>
<td>34. Nurse managers can observe employees’ performance behaviours related to motivation and should intervene appropriately by considering generational differences.</td>
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<td>5. They are responsible for planning the activities of the institution.</td>
<td>11.</td>
<td>18.</td>
<td>23. Daily staffing allocation requires a staffing management plan. This plan should be incorporated in the institutional internal policies.</td>
<td>28. Support, supervision and mentorship of new employees should be carried out so that they can feel welcome in the institution.</td>
<td>35. The decision to choose the reward method for staff members depends on the institutional policies and procedures and verbal praise.</td>
</tr>
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<td>6. Managers should display self-confidence when interacting with staff.</td>
<td>12.</td>
<td>19.</td>
<td>24.</td>
<td>29. Access to adequate equipment, resources and supplies by the professional nurse and other health</td>
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<tr>
<td>Nurse manager</td>
<td>Professional nurse</td>
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<td>employees during decision making and problem solving.</td>
<td>high standard. Professional nurses need to work in collaboration with other health professionals to ensure quality patient care.</td>
<td>include mental health professionals as part of the specialist district teams to ensure services are rendered. Safety in psychiatric hospitals must be secured so that that patients and health professionals can function in a risk-free environment.</td>
<td></td>
<td>professional enables the rendering of quality care delivery and better nurse–physician relationships. Positive practice environments have beneficial effects on staff, patients and organisational outcomes. In response, unhealthy work environments can be detrimental to all the role players in healthcare organisations.</td>
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</table>
5.4 EVALUATION OF THE THEORY

A theory was evaluated with respect to each of the questions and the responses to the questions were used to form conclusions about how well the theory served its purpose. Since the practice theory was constructed based on empirical evidence, the researcher evaluated the theory by commenting on both the semantic and structural clarity. According to Chinn and Kramer (2008:126), when evaluating a theory, critical reflection contributes to understanding how well the theory relates to practice and research. Experts in theory evaluation such as Chinn and Kramer, Meleis and Fawcett offer different criteria. The criteria were discussed and compared to ultimately identify the criteria that is most suitable for the research.

5.4.1 Evaluation synopsis according to Chinn and Kramer (1991:129, 2008:237) (refer to appendix K)

Chinn and Kramer are of the belief that the questions for critical evaluation of the theory should be:

- How clear is the theory?
- How simple is the theory?
- How general is the theory?
- How accessible is the theory?
- How important is the theory?

Clarity refers to how well the theory can be understood and how consistently the ideas are conceptualised. The evaluators would be considering semantic clarity, semantic consistency, structural clarity and structural consistency. Semantic clarity and consistency primarily refers to the understand ability of theoretic meaning as it relates to concepts. Structural clarity and consistency reflect the understand ability of connection between concepts within the theory and the whole of the theory.

Simplicity means that the number of elements within each descriptive category, particularly concepts and their interrelationships, are minimal.

Generality of a theory refers to its breadth of scope and purpose. A general theory could be applied to a broad array of situations. Parsimony is sometimes used as a synonym to describe the trait of theoretic simplicity, but the concept of parsimony also includes the idea of generality. A parsimonious theory is conceptually simple, but accounts for a broad range of empiric experiences.
Accessibility addresses the extent to which empirical indicators can be identified for concepts within the theory and how attainable the projected outcomes of the theory are if a theory is used to explain and predict some aspect of the practice world. Concepts can move toward increased empirical accessibility through generating and testing relationships, deliberately applying the theory and clarifying conceptual meaning.

The importance of a theory is closely tied to the idea of its clinical significance or practical value. An important theory is forward-looking, useful and valuable for creating a desired future. The central question is “Does the theory create a reality that is important to nursing”? (Chinn & Kramer, 2008:127-134).

5.4.2 Evaluation synopsis according to Meleis (2012:182)

A critical review of evidence before and while translating it into practice and a critical assessment and evaluation of theories before and while utilising them in practice or research, are tasks that nurses have always engaged in (Meleis, 2012:179). Quality care and coherent research programmes require critical analyses and judgement of theories. Nurses evaluate theories to apply practice, to develop curricula, to operationalise research, or to use in daily decision making. These evaluations may be deliberate, systematic, criteria-based, objective, conscious, and elaborate, or they may be subjective, experimental, quick, and based on a limited set of criteria. Both types of evaluations are essential. Therefore, neither type is sufficient by itself.

Evaluation of theory is an important component of nursing practice and of knowledge development to:

- decide which theory was more appropriate to use as a framework for research, teaching, administration, or consultation;
- identify effective theories in exploring some aspect of practice or in guiding a research project;
- compare and contrast different explanations of the same phenomenon;
- enhance the potential of constructive changes and further theory construction;
- identify epistemological approaches of a discipline through attention to the socio-cultural context of the theorist and the theory;
- critically examine and question the ontological beliefs in a discipline;
- identify competing and complementary schools of thought in a discipline;
effect changes in clinical practice, define research priorities, and identify content for teaching and guidelines for nursing administration;

utilize coherent and integrative frameworks to communicate to the public the rationales and goals of nursing practice;

identify strategies that could be used to advance the development of theories;

define and articulate the discipline’s demand and perspective; and to

be a critical consumer of theories, and a critical consumer of evidence-based practice (Meleis, 2012:179).

5.4.2.1 Criteria for selecting theories

Meleis (2012:180) identified the following as the criteria for selecting the theory:

Personal: Individuals who use this criterion discuss their personal comfort using the theory, their intuitive choices, and the theory’s congruence with their philosophical view of life.

Mentor: People who use a theory for this reason use a theory because they were mentored by a theorist, or they were exposed to the teaching of a theorist who profoundly influenced and transformed them. They spoke of personal influence, respect, personal contact, and educational experience.

Theorist: Many selected and utilised a theory as a framework for their research or practice based on who the theorists were, their standing in the field, their status, and how they are recognised.

Literature support: Others identified the availability of extensive writings about the theory that gave them assurance of the level of significance of the theory and the status it holds.

Socio-political congruency: Another criterion used for selecting theory is the congruence between the theory implementation process and the socio-political and economic climate at the time of the choice. These people spoke of a climate that supported one theory over another because, for example, there was no need to institute structural changes in the organization, or the theory required minimal preparation of members of an organisation. Within this category were those who indicated that the theory was imposed by administration at that point in time.

Utility: The ease with which a theory was understood and applied prompted this group of users to indicate that utility was the prime factor.
5.4.3 Evaluation synopsis according to Fawcett (2000:504)

According to Fawcett, when evaluating a nursing theory, its content should be compared with certain criteria such as the explication of origins, comprehensiveness of content, logical congruence, generation of theory, credibility and contribution to the discipline of nursing. These criteria were evaluated in the following steps:

**Evaluation step 1: Explication of origins**

The first step of evaluation entails explication of origins of the nursing theory. The identification of the author’s beliefs and values gave information about the philosophical foundations of the theory and helps identify special points of emphasis in the view of nursing put forward by the nursing theory. The expectation was that those philosophical beliefs had been made clear by the author. The following questions are of paramount importance when evaluating the origins of the nursing theory:

- Are the scholars who influenced the theory author’s thinking acknowledged and are bibliographies indicated?
- Are the philosophical beliefs on which the nursing theory is based clearly stated?

**Evaluation step 2: Comprehensiveness of the content**

The second step of evaluation concerns with the comprehensiveness of the content. Here the emphasis is on the depth and breadth of the content. According to Fawcett, no well-established criterion for the depth of the content of a nursing theory has been established. It seems reasonable to expect that the content should entail the four meta-paradigm concepts and that the content is relatively unambiguous. Therefore, the expectation is that the nursing theory includes concepts and non-relational propositions that represent a description of a person, an identification of the person’s environment, a description of the author’s meaning of health, a definition of nursing, a statement of nursing outcomes, and a description of nursing practice, which may be in the form of a methodology for nursing practice. Furthermore, the practice methodology should have a base of scientific knowledge, permit dynamic movement between each component, and be compatible with ethical standards for nursing practice. The following questions should be asked when evaluating the depth of the content of a nursing theory:

- Did the relational statements of the nursing theory link the four meta-paradigm concepts?
- Did the nursing theory provide adequate descriptions of all the four concepts of nursing’s meta-paradigm?
Evaluation step 3: Logical congruence

The third step of evaluation of a nursing theory recognises the logic and its internal structure. Logical congruence is evaluated by an intellectual process that involves making a judgement of the congruence of the theory author’s philosophical beliefs with the content of the theory. The process required to make judgements regarding the congruence of the world view or views and category or categories of nursing knowledge reflected by the theory. Evaluation of logical congruence is of importance if the nursing theory incorporates more than one world view or category of nursing knowledge, because different schools of thought cannot be combined easily. The following questions would be relevant when evaluating logical congruence:

- Does the theory show characteristics of more than one category of nursing knowledge?
- Do the components of the theory show logical translation of diverse views?
- Does the theory show more than one world view?

Evaluation step 4: Generation of theory

The fourth step of the evaluation of a nursing theory indicates the relationship between a more abstract and general conceptual theory and a more concrete and specific theory. Grand theories and middle-range theories are derived from nursing theories. Therefore, the extent to which the nursing theory leads to generation of the theory should be judged. The abstract concepts and propositions of the theory should be clear so that the more concrete concepts and propositions of grand theories and middle-range theories can be deduced and testable hypotheses can be developed. The applicable question here would be:

- Which theories were constructed from the nursing model?

Evaluation step 5: Credibility of the nursing theory

The fifth step of evaluation pays attention on the credibility of the nursing theory. Credibility determination is necessary to avoid the risk of accepting and adopting the nursing theories without being critical. This could lead to their use as ideologies. It is important to critically review the evidence regarding the credibility of each nursing theory and not just accept them unchallenged. The goal of credibility determination is to ensure which nursing theories are appropriate for use in clinical settings and with which clinical populations. The determination of credibility would either support or not support the impression that any nursing theory can guide or explain any nursing intervention in any situation, and that all theories are equally relevant for guiding the nursing practice. The rejection or acceptance of that impression by means of a thorough evaluation of the credibility of each nursing theory is crucial if nursing is
to continue to proceed as a respected discipline characterized by excellence in clinical and scientific scholarship. In this step, the following questions are relevant:

- Are education and special skills training required before applying the nursing theory in nursing practice?
- Is it feasible to implement clinical protocols derived from the nursing theory and related theories?
- To what extent is the nursing theory actually used to guide nursing research, administration and practice?
- Does the nursing theory lead to nursing activities that meet the expectations of various cultures and in diverse geographic regions?
- Does the application of the nursing theory, when linked with relevant theories and appropriate empirical indicators, make important and positive differences in the health status of the society?

**Evaluation step 6: Contributions to the discipline of nursing**

The sixth and final step of evaluation of nursing theories, which is as general as the conceptual theories themselves, requires one to make judgement with reference to the contributions of the theory to the discipline of nursing. The judgement is made following a thorough review of all the available and applicable literature. Fawcett believes that judgement should not be made by comparing one nursing theory with another. Instead, each nursing theory should be judged on its own merits and based on its own philosophical beliefs. The expectation is that the nursing theory facilitates understanding of the phenomena of interest to nursing. The applicable question is: What is the overall contribution of the nursing theory to the discipline of nursing?

**5.4.4 Critical comparison of theory evaluation by Chinn and Kramer, Meleis and Fawcett**

It should be noted that the three above-mentioned theorists use different criteria for evaluating the nursing theory, though they all contributed to theory evaluation in nursing. Theory evaluation by Chinn and Kramer and Meleis share some similarities, such as asking how clear the theory that had been constructed is and if it can be understood without any difficulty by the reader or other researchers. All three theorists, when evaluating a nursing theory are interested in knowing what contribution the theory will make to nursing research and nursing practice. This implies that the three are interested in the growth of the nursing as a discipline.
5.4.5 Self-evaluation by the researcher

After analysing the different criteria used by the three theorists, the criteria for theory evaluation by Chinn and Kramer (2008:237) (see appendix K), was selected because the theory is based on empirical evidence. This is set out in Table 5-2 as follows:


<table>
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<th>Criteria</th>
<th>Researcher’s comments</th>
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| 1. Clarity of the practice theory             | • Aspects related to clarity and consistency were reviewed simultaneously.  
• The meaning of the theory and the way it related to concepts used in the study were understandable.  
• The concepts within the theory were well connected and easy to understand as illustrated in different diagrams.  
• The structural clarity was understandable and the relationship between concepts was clearly indicated as in Figure 5.1. The linear and arrow presentations indicated how the concepts were related to each other. |
| 2. Degree of complexity/simplicity            | • The description of the findings, diagrams and figures in Chapter 3 are complex and may not be simple to understand, unless the reader is familiar with quantitative research and statistics.  
• The description of the theory is simplified with reference to conclusion statements made in the study.  
• The number and differentiation of concepts is minimal, but sufficient to structure theoretic relations.                                                                                                                                                                                                 |
| 3. Generality of the practice theory          | • The practice theory can only be applied to psychiatric institutions in South Africa and cannot be used in other health facilities. This implies that the theory cannot be used in general settings.                                                                                                                                                                    |
| 4. Theory accessibility                       | • The definitions and meanings of the concepts, although implied to nursing practice, are specific to psychiatric institutions and are clear.  
• The empiric indicators are clearly identifiable.  
• The outcomes of the practice theory are achievable and can be implemented in a psychiatric practice environment.                                                                                                                                                                                                 |
| 5. Importance                                 | • This practice theory adds value to nursing science, nursing practice and nursing research.  
• The theory creates the opportunity for other researchers to do research when implemented in a psychiatric setting.                                                                                                                                                                                                                                             |

5.4.6 Theory evaluation by the evaluators

Four (4) independent evaluators who are experts with knowledge and experience in psychiatric nursing and theory construction were requested to evaluate the practice theory according to Chinn and Kramer’s criteria. Two are professors and the other two are PhD graduates. The evaluation instrument for practice theory evaluation according to Chinn and Kramer is attached as appendix K. Three evaluators submitted their evaluation report and one did not. The three evaluators’ comments were as follows:

<table>
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<th>Criteria</th>
<th>Researcher’s comments</th>
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| 1. Clarity of the practice theory | • The first evaluator indicated that the assumptions of the theory were provided, although it was not clear whether these assumptions are value assumptions or factual assertions. She further felt that the link between the assumption and the statements derived from the conceptual framework within the practice theory was not clear.  
  • The second evaluator was of the opinion that some of the concepts in the theory were not clear. She also felt that the diagram had to be revisited and should show the relationship between concepts.  
  • The third evaluator indicated that the theory had achieved a high level of clarity, but clarity was needed regarding the following:  
  • Assumption 1: to indicate what type of resources. Assumption 2: to indicate the type of support and by whom that support should be given.  
  • Figure 5.1 needed some formatting to enlarge the circles to increase readability. |
| 2. Degree of complexity/simplicity | • The first evaluator indicated that the purpose and the relevant concepts were explained, but the ‘predict’ function was obscured in that some of the conceptual and relational statements seemed to be general and its substantiation could be questioned. The relationship between the different concepts and the organisation were clearly outlined in Figure 5.1. The researcher should consider acknowledging the presence of collaborative relationships with the multidisciplinary team within the practice environment, as the nurse manager and professional nurse do not function in isolation. The relationship between concepts were also clearly outlined. The concepts were clearly differentiated, except the concepts practice environment and work environment.  
  • The second evaluator felt that the organisation of relationship of concepts needed some clarification. The differentiation of concepts was acceptable.  
  • The third evaluator reflected that the theory was simple in terms of the concepts and relationships were minimal, but sufficient. |
| 3. Generality of the practice theory | • The first evaluator was of the opinion that the practice theory could be applied within the context of a psychiatric hospital, but it could also be generalised to other work environments in nursing, e.g. a general hospital. The purpose of the practice theory was specific to nursing and justifiably a nursing purpose.  
  • The second evaluator agreed that the theory was discipline specific, but felt that it could be applied in other nursing settings. She also indicated that purpose specificity is acceptable, but felt that it needed a little refinement to ensure simplicity of the theory. She also indicated that there were not many interacting factors.  
  • The third evaluator reflected that although the theory is for psychiatric nursing, a collaborative relationship was expected to exist between nurses, physicians and other members of the multidisciplinary team. She also indicated that it was clear that the theory aimed to create the practice environments of professional nurses working in psychiatric institutions. However, perhaps one could rephrase it as “creating positive practice environments for professional nurses working in psychiatric institutions” as the environment is already there. |
| 4. Theory accessibility | • The first evaluator reflected that the definitions were specific to the purpose of the practice theory. The empirical indicators were clearly stated in the figure presenting the practice theory, but not densely described in the discussion of the practice theory.  
  • The second evaluator felt that some definitions are not specific. Some statements do not relate to empirical evidence. |
<table>
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<th>Criteria</th>
<th>Researcher’s comments</th>
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<tr>
<td>• The third evaluator reflected that the definitions were clearly outlined, but perhaps resources could be provided for the definitions. This commentator had no comments on empirical indicators.</td>
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5. Importance

• The first evaluator indicated that the theory had the potential to influence nursing science, specifically regarding the relationship between different concepts to create a positive practice environment. The theory was useful for nursing practice. It provided a good framework for creating a positive practice environment. She believed that future research on the implementation and the refinement of the practice theory may generate valuable information.

• The second evaluator believed the theory would be useful to nursing science. The theory would lead to positive changes to nursing practice. The theory made provision for more nursing research or studies.

• The third evaluator reflected that the theory was specific for psychiatric nursing practice. She further stated that the model was based on evidence and it could lead to further research, which could be further developed and tested.

5.5 GUIDELINES FOR OPERATIONALISATION

According to Dickoff et al., (1968), the utilisation of a survey list and the proposal of guidelines made it possible for the theory to be operationalised in practice. One should remember that not all theories are subjected to hypothesis testing. Proposing guidelines for operationalisation is in line with the research objective as indicated in Chapter 2, Phase 3 Step 2 of this research.

In order to ensure the successful operationalisation of the theory, the following assumptions are supported. They are derived from deductive and inductive thinking from the relational statements and the conceptual framework of this study:

• The Provincial Department of Health should be supportive of professional nurses and nurse managers who are placed in positions where political factors dominate their daily work.

• The National and Provincial Department of Health should design a human resource plan that will address the shortage of mental healthcare providers.

• Nurse managers should support the idea of preceptorship and mentoring of newly appointed professional nurses by experienced professional nurses.

• Hospital management should support the idea of establishing a collaboration between health professionals and traditional healers to provide a more comprehensive psychiatric service.

• Hospital management should promote inter-sectoral collaboration with other health professionals to provide integrated psychiatric healthcare services.
• Operationalisation of the practice theory for positive practice environments in psychiatric institutions is important.

• Deinstitutionalisation of psychiatric services to primary healthcare is important given the aim to move psychiatric hospital-based care to primary healthcare to ensure that psychiatric services are made available and accessible to the community.

• An adequate budget should be made available for the provision of psychiatric services from national and provincial governments.

• Support the importance of prioritizing safety by hospital management at the work environment for both professional nurses and psychiatric patients through policy development.

• Establish a platform such as workplace forum where needs identification and needs analysis of professional nurses are done to assess areas of concern.

• Nurse managers should encourage participative management style at all levels to promote the idea of shared governance in psychiatric hospitals.

• Hospital management should support the strategy of career advancement for professional nurses with the aim of promoting staff retention in health establishments.

• Hospital management should create an environment where professional nurses and doctors should work harmoniously and show respect for one another as they interact in the execution of their duties.

• Hospital management should engage professional nurses in decision making so that they feel that they form part of the organization.

• Hospital management should always ensure that there are adequate resources for professional nurses to enable them to do their duties as expected, thereby promoting job satisfaction and decreasing burnout.

• There should be effective communication between nurse managers and professional nurses and promotion of teamwork in psychiatric hospitals.

5.6 SUMMARY

Chapter 5 presented the practice theory in nursing and provided a description of the theory. This description discussed the assumptions, purpose, context and structure of the theory. The
Chapter paid attention to definitions of concepts, gave a summary of the statements derived from the conceptual framework and the relational statements and concluded with a discussion of the different theory evaluation criteria and guidelines for operationalisation.

Chapter 6 evaluates the practice theory for positive practice environments for professional nurses working in psychiatric institutions in South Africa. This is followed by a discussion of the limitations and recommendations for nursing science, nursing practice and nursing research.
CHAPTER 6: EVALUATION OF THE STUDY, LIMITATIONS AND RECOMMENDATIONS FOR NURSING SCIENCE, PRACTICE, AND RESEARCH

6.1 INTRODUCTION

To be useful, the evidence from data analysis should be carefully examined, organised and given meaning, and the statistical significance and clinical importance should be assessed with implications for practice and directions for further research (Grove et al., 2013:604). In this final chapter, I reflected on the evaluation of the research as described in Chapter 1. I also discuss the limitations of the research and suggest some recommendations for nursing science, nursing practice and nursing research.

6.2 EVALUATION OF THE STUDY

The aim of the research was to construct a practice theory for positive practice environments in selected psychiatric institutions in South Africa. This was achieved by utilising both inductive and deductive reasoning strategies in pursuit of the following objectives:

Objective 1 was to explore and describe the status of the practice environment in psychiatric institutions by allowing the participants to complete the RN4CAST questionnaire. The findings related to this objective were used to provide an understanding of concepts that are relevant to the phenomenon under investigation. Objective 2 was to discuss the prevalence of burnout among professional nurses working in psychiatric institutions by allowing the participants to complete the Maslach Burnout Inventory questionnaire to evaluate the level of burnout among professional nurses working in psychiatric institutions. Objective 3 was to describe the conceptual framework for the practice theory. Having used the empirical findings for objectives one, two and three, a practice theory for positive practice environments in psychiatric institutions was constructed with success.

It should be kept in mind that the researcher did not take into consideration any preconceived theoretical knowledge when describing the phenomenon under investigation. A reflection of the central theoretical argument was given earlier in the research and is utilised as a guideline to evaluate the research as indicated in Chapter 1.

It could be argued that the empirical research and description of embedded literature may lead to the identification of main and related concepts that, in turn, could develop into concept
identification, description, definitions and analysis. After main and related concepts have been analysed, relational meaning could be constructed between these concepts, which could be used to construct a theory of positive practice environment for professional nurses in selected psychiatric institutions in South Africa. With the input of a panel of experts, this constructed theory could be evaluated and refined into a valuable contribution. Such a contribution would be to assist professional nurses in nursing to facilitate the creation of a positive practice environment by utilising this theory.

In this research, a quantitative data collection method was used in the form of a questionnaire that was completed by the participants after they gave their permission for the research. Related concepts were identified and deductive and inductive conclusions were made based on how the concepts related to one another. Concepts relating to positive practice environments in selected psychiatric institutions such as work environment, leadership and burnout were discussed and an analysis of how they relate to one another was made in an attempt to construct a practice theory that can be utilised in nursing to improve the practice for professional nurses in psychiatric institutions in the North West and Gauteng provinces. The secondary literature review played a significant role in the study and was used for statement synthesis.

The one of a kind contribution in this research is that it identifies components of a positive practice environment in psychiatric institutions in South Africa. The research was intended to give an exposition of the positive practice environment in psychiatric institutions as described by professional nurses working in the said setting. The positive evaluation of the practice theory by the experts, supports the usability to ultimately improve practice.

6.3 LIMITATIONS OF THE RESEARCH

6.3.1 The research was limited by the following limitations related to the research:

- The research was conducted only in public psychiatric institutions in the North West and Gauteng provinces, thereby limiting the research findings to public psychiatric institutions.
- Although more than five hundred professional nurses were expected to complete the Practice Environment Scale of the Nursing Work Index questionnaires, the response rate of the participants did not have an impact on the reliability of the research findings.
- Some professional nurses were reluctant to participate in the research, therefore endangering the development of the nursing profession.
6.4 RECOMMENDATIONS

After having gone through the whole process of research, the following recommendations follow from the relational statements and conceptual framework pertaining to nursing practice, nursing science and nursing research:

6.4.1 Nursing practice

The following recommendations can be put forward for nursing practice:

- Quality assurance should be maintained at all times to ensure that patients get treatment of a high standard.
- Professional nurses should collaborate with other health professionals, including traditional healers, to provide comprehensive care to psychiatric patients.
- Professional nurse engagement in decision making should be increased so that nurses can feel that they are part of the organisation.
- Professional nurses should be encouraged to be part of the major decision committees within the institution such as budget committee and strategic planning.
- Management should ensure that there are adequate resources at the institution to provide nursing care.
- Management should encourage the establishment of team building to promote staff morale.
- Management should promote continuous staff development to ensure quality patient care in psychiatric institutions.
- Management should motivate for budget improvement for the provision of improved psychiatric services in psychiatric institutions.
- Support speciality certification in psychiatric nursing (Advanced Psychiatric Nursing) including salary improvements.
- The findings of the study should be presented to the management at psychiatric institutions in South Africa.
- Managers should be visible, accessible and responsive to the needs of professional nurses.
- Capacitate management at psychiatric institutions about the significance of positive practice environment.
• Experienced professional nurses should be retained so that they can give guidance and support to the newly qualified professional nurses.

• The green paper on National Health Insurance should include psychiatric services at district level.

• Design an assessment tool for the practice environment in various psychiatric institutions to ensure continuous evaluation of the work environment for professional nurses.

• The Provincial Department of Health should be supportive of professional nurses and nurse managers who are placed in positions where political factors dominate their daily work.

• The Provincial Department of Health should design a human resource plan that will address the shortage of mental healthcare providers.

6.4.2 Nursing science

The following recommendations can be put forward for nursing science:

• Promote the status of nurses as independent practitioners by clearly defining the roles of professional nurses and improving their conditions of service.

• Design a tool based on the conclusions from the empirical evidence that will be unique to South Africa.

• Support the idea of preceptorship and mentoring of newly appointed professional nurses.

• Promote inter-sectoral collaboration with other health professionals to provide integrated healthcare to psychiatric patients.

• Encourage policy development on positive practice environment so that all staff members should be conversant with the concept.

• Encourage the professional development of current professional nurses, including a career pathway that develops specific skills such as stress management and conflict resolution to decrease the prevalence of burnout.

• Doctors and professional nurses should participate in continuous professional development (CPD) to improve their knowledge and skills.

• Motivate for more nurse training and employment of nurse educators to increase the production of professional nurses at nursing education institutions.
Periodically review the scope of practice for professional nurses to evaluate its relevance to the current nursing practice.

Generalist nurses who are working in psychiatric units should receive guidance and education from mental healthcare providers to promote their confidence at work.

Strengthen the implementation of employee assistance programmes (EAP) to assist employees who are under performing at work due to family problems that could result in stress.

6.4.3 Nursing research

The following recommendations can be put forward for nursing research:

- Promote publication of research findings related to positive practice environment.
- Conduct an investigation of the influence that positive practice environment may have on the organisational objectives.
- Encourage professional nurses’ autonomy by supporting staff presentation at conferences, workshops on positive practice environments.
- Promote research and evidence-based practice in psychiatric institutions.
- Operationalisation of the practice theory for positive practice environments in psychiatric institutions.
- Do an investigation on the practice environment of nurses working in other institutions other than the psychiatric settings.
- Do a comparative study between the perception of professional nurses about their present practice environment in psychiatric institutions and psychiatric units in general hospitals.
- Encourage policy development about the implementation of positive practice environments in public psychiatric institutions in South Africa.

6.5 PERSONAL REFLECTION

In any given setting, research is done for a particular purpose. In this instance it was done to improve nursing practice and nursing as a science. One might say that the journey travelled as a researcher had been a challenging one. Constructing a practice theory for professional nurses working in selected psychiatric institutions in the North West and Gauteng provinces consumed a lot of energy from the researcher, considering the vastness of the institutions where the research was conducted. One of the challenges was the process of data collection,
during which the researcher had to travel from one psychiatric unit to another, distributing questionnaires to the participant and to collect them. During that exercise, the researcher had to wait for the night staff, distribute questionnaires and collect them. This exercise was done in two psychiatric institutions in Gauteng and two psychiatric institutions in the North West provinces.

Research findings are not meant for the shelves. The researcher had to take it upon himself to visit various psychiatric institutions in South Africa and share the findings with the professional nurses and management.

6.6 SUMMARY

The conclusion chapter provided an evaluation of the research, followed by a discussion of the limitations and recommendations related to nursing practice, nursing science and nursing research. This was followed by the personal reflection pertaining to the experience during the process of research. This research provides an opportunity for other researchers to gain a better understanding of positive practice environment in psychiatric institutions as reflected by professional nurses working in those institutions.
REFERENCE LIST


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South African Nursing Council. 1985. Regulation relating to the approval of and the minimum requirements for the education and training as a nurse (General, community, psychiatry) and midwife leading to registration. Regulation 425 of 1993. Pretoria.


APPENDIX A: ETHICAL CLEARANCE CERTIFICATE

APPENDIX A

Private Bag X2803, Pretoria 0001
Tel: (012) 392-9100
Fax: (012) 392-9110
Email: ethics@nwu.ac.za

Ethics Committee
Tel: +27 18 595 4460
Fax: +27 18 595 5204
Email: Ethics@nwu.ac.za

11 July 2008

Dear Prof Klopper,

ETHICAL APPROVAL OF PROJECT

The North-West University Ethics Committee (NWU-EC) hereby approves your project as indicated below. This implies that the NWU-EC grants its permission that, provided the special conditions specified below are met and pending any other authorization that may be necessary, the project may be initiated, using the Ethics number below.

Project title: Leadership and policy development improving the quality of nursing in South Africa through nursing education and patient safety

Ethics number: H1002

Approval date: 11 July 2008
Expiration date: 10 July 2013

Special conditions of the approval (if any): Note

General conditions:

1. Any attempt to change the project without prior approval from the Ethics Committee must be recorded in the amendment form of the NWU-EC.
2. The project leader must ensure that ethical approval is obtained from the Ethics Committee for any additional research to be conducted during the study.
3. The project leader must ensure that ethical approval is obtained from the Ethics Committee for any changes to the project protocol.
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18. The project leader must ensure that ethical approval is obtained from the Ethics Committee for any changes to the project protocol.
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20. The project leader must ensure that ethical approval is obtained from the Ethics Committee for any changes to the project protocol.
21. The project leader must ensure that ethical approval is obtained from the Ethics Committee for any changes to the project protocol.
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33. The project leader must ensure that ethical approval is obtained from the Ethics Committee for any changes to the project protocol.
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36. The project leader must ensure that ethical approval is obtained from the Ethics Committee for any changes to the project protocol.
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38. The project leader must ensure that ethical approval is obtained from the Ethics Committee for any changes to the project protocol.
39. The project leader must ensure that ethical approval is obtained from the Ethics Committee for any changes to the project protocol.
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41. The project leader must ensure that ethical approval is obtained from the Ethics Committee for any changes to the project protocol.
42. The project leader must ensure that ethical approval is obtained from the Ethics Committee for any changes to the project protocol.
43. The project leader must ensure that ethical approval is obtained from the Ethics Committee for any changes to the project protocol.
44. The project leader must ensure that ethical approval is obtained from the Ethics Committee for any changes to the project protocol.
45. The project leader must ensure that ethical approval is obtained from the Ethics Committee for any changes to the project protocol.
46. The project leader must ensure that ethical approval is obtained from the Ethics Committee for any changes to the project protocol.
47. The project leader must ensure that ethical approval is obtained from the Ethics Committee for any changes to the project protocol.
48. The project leader must ensure that ethical approval is obtained from the Ethics Committee for any changes to the project protocol.
49. The project leader must ensure that ethical approval is obtained from the Ethics Committee for any changes to the project protocol.
50. The project leader must ensure that ethical approval is obtained from the Ethics Committee for any changes to the project protocol.

The Ethics Committee would like to remain at your service as scientist and researcher, and wishes you well with your project. Please do not hesitate to contact the Ethics Committee for any further queries or requests for assistance.

Yours sincerely,

Prof MMU Lemon
Chair, NWU Ethics Committee
APPENDIX B: INFORMATION LETTER TO PARTICIPANTS

North West University: Potchefstroom Campus
Private Bag X6001
Potchefstroom
2520

CONSENT FORM

Research title: Positive practice environments for professional nurses working in selected psychiatric institutions in South Africa.

Dear participant

The researcher of the above mentioned title invites you to participate in the research study. Kindly be informed that your rights as the participant will be respected at all times, such as the right not to participate in the study, the right to withdraw at any time during the research or data collection and the right to confidentiality.

Yours Sincerely

Lekgetho M.M (PhD Candidate)

The Questionnaire

- Please answer all the questions from page one to eight.
- Use a black pen only.
- Do not remove any pages from the questionnaire.
- Please be honest when answering the questions.
- Tick with an X when selecting the most appropriate response.

Declaration by the participant

I ............................................. agree to participate voluntarily in the research study as entitled above. I further declare that information was explained to me in a language that I understand and was provided with an opportunity to ask questions which were answered by the researcher satisfactorily.

Signature of participant

Date: ........................................
APPENDIX C: APPLICATION LETTER TO NORTH WEST DEPARTMENT OF HEALTH

FROM: LEKGETHO M.M

DATE: 02.06.2011

TO:
THE DIRECTOR
DEPARTMENT OF HEALTH & SOCIAL DEVELOPMENT
POLICY, PLANNING AND RESEARCH
PRIVATE BAG X2068
MAFIKENG
8070

SUBJECT: PERMISSION TO CONDUCT RESEARCH

I am currently a PhD (Nursing Science) student at the North West University: Potchefstroom campus and I am requesting permission to conduct research at psychiatric institutions in North West province (Witrand in Potchefstroom and Bophelong psychiatric hospital in Mafikeng). My research topic is "A theory for a positive practice environments for professional nurses working in selected psychiatric institutions in South Africa". My target group is professional nurses working in a psychiatric institution and they will be requested to complete a questionnaire. Recommendations based on the findings will be made for research, education and practice.

For more information pertaining to this research, the researcher may be contacted at one of the following numbers:

018 4068600 (work)
082 400 7929 (mobile)
018 462 1039 (fax no.)

Thanking you in advance.

Yours Sincerely

M.M Lekgetho
PhD candidate

Supervisor
H.C Klopp (Prof.)
Director: School of Nursing Science: Potchefstroom
APPENDIX D: APPROVAL FROM NORTH WEST DEPARTMENT OF HEALTH

To: Mr. M.M. Lekgetho
North West University

From: Policy, Planning, Research, Monitoring & Evaluation

Subject: Developing a Theory for Positive Practice Environments for Professional Nurses Working in Selected Psychiatric Institutions in South Africa

The Subject matter above bears reference

Purpose

To inform your good selves that permission to undertake the above mentioned study has been granted by the North West Department of Health. The researcher is expected to issue this letter as proof that the Department has granted approval to the districts or health facilities that form part of the study.

Arrangements in advance with managers at district level or facilities shall be facilitated by the researcher and the department expects to receive the final research report upon completion.

Kindest regards

[Signature]
Director, Policy, Planning, Research, Monitoring & Evaluation
Mr B Redlinghys

[Stamp]
DEPARTMENT OF HEALTH
PRIVATE BAG X9988
2011 -08 - 02
SUPERINTENDENT GENERAL

Healthy living for All
APPENDIX E: APPLICATION LETTER TO GAUTENG DEPARTMENT OF HEALTH

TO: HEAD OF DEPARTMENT
DEPARTMENT OF HEALTH GAUTENG PROVINCE
PRETORIA
0001

FROM: MR. LEKGETHO M.M

DATE: 10.03.2010

SUBJECT: PERMISSION TO CONDUCT RESEARCH

I am currently a PhD (Nursing Science) student at the North West University: Potchefstroom Campus and I am requesting permission to conduct research at Sterkfontein Hospital and Weskoppies Hospital. My research topic is “A theory for positive practice environments for professional nurses working in selected psychiatric institutions in South Africa”. My target group is professional nurses working in a psychiatric institution and they will be requested to complete a questionnaire. Recommendations based on the findings will be made for research, education and practice.

For more information pertaining to this research, the researcher may be contacted at one of the following contact numbers:

018 4068600 (work)
082 400 7929 (mobile)

Thanking you in advance.

Yours Sincerely

Lekgetho M.M
(PhD candidate)

Promoter: Co-promoter:
H.C Klopper (Prof.) Dr. P Bester
Director: School of Nursing Science
North West University: Potchefstroom Campus
APPENDIX F: APPROVAL LETTER FROM GAUTENG DEPARTMENT OF HEALTH

SECTION D - RECOMMENDATION AND APPROVAL

Reviewed and recommended or not recommended for approval by:

Mr S Mokoena
Deputy Director; Policy, Planning and Research
Date: 26/03/10

Supported by:

Ms S Bux
Director, Policy, Planning and Research
Date: 21/01/2010

Recommended/not recommended by:

Dr A Ramoeng
COO: Gauteng Department of Health and Social Development
Date:

Approved/not approved by:

Dr K S Chetty
HOD: Gauteng Department of Health and Social Development
Date: 9/01/2010

ONLY FOR APPROVAL OF THE RESEARCH STUDY TO BE CONDUCTED BY PROF NO MOKOENA OF NORTH WEST UNIVERSITY. THE
STUDY IS ENTITLED "LEADERSHIP AND POLICY DEVELOPMENT: IMPROVING THE QUALITY OF NURSING IN SOUTH AFRICA
THROUGH NURSE STAFFING AND PATIENT SAFETY"
APPENDIX G: APPLICATION LETTERS TO PSYCHIATRIC HOSPITALS

TO: DEPUTY DIRECTOR: NURSING
WESKOPPES HOSPITAL
PRIVATE BAG X
PRETORIA
0001

FROM: MR. LEKGETHO M.M

DATE: 17.03.2010

SUBJECT: PERMISSION TO CONDUCT RESEARCH

I am currently a PhD (Nursing Science) student at the North West University: Potchefstroom campus and I am requesting permission to conduct research at the above mentioned institution. My research topic is “A theory for a positive practice environments for professional nurses working in selected psychiatric institutions in South Africa”. My target group is professional nurses working in a psychiatric institution and they will be requested to complete a questionnaire. Recommendations based on the findings will be made for research, education and practice.

For more information pertaining to this research, the researcher may be contacted at one of the following numbers:

018 4066600 (work)
082 400 7929 (mobile)

Thanking you in advance.

Yours Sincerely

MLM Lekgetho
PhD candidate

Promoter: H.C Klepper (Prof.)
Co-promoter: Dr. P.Bester
Director: School of Nursing Science

Healthy Living for All
APPENDIX G

EXCELSIUS NURSING COLLEGE

VISION
To facilitate physical, psychological, social and spiritual wellness for all people of the North West Province through the provision of innovative nursing education and training.

MISSION
This college will strive towards preparing a nursing student through innovative, dynamic nursing education and training in order to become a reflective, critical analytical thinker and a professional leader in striving towards wellness.

TO: CHIEF EXECUTIVE OFFICER
WITRAND HOSPITAL
PRIVATE BAG X253
POTCHEFSTROOM
2531

FROM: MR. LEKGETHO M.M

DATE: 17.03.2010

SUBJECT: PERMISSION TO CONDUCT RESEARCH

I am currently a PhD (Nursing Science) student at the North West University: Potchefstroom campus and I am requesting permission to conduct research at the above mentioned institution. My research topic is "A theory for a positive practice environments for professional nurses working in selected psychiatric institutions in South Africa." My target group is professional nurses working in a psychiatric institution and they will be requested to complete a questionnaire. Recommendations based on the findings will be made for research, education and practice.

For more information pertaining to this research, the researcher may be contacted at one of the following numbers:

018 4068000 (work)
082 400 7929 (mobile)

Thanking you in advance.

Yours Sincerely,

M.M Lekgetho
PhD candidate

Promoter: H.C Klopper (Prof.)
Co-promoter: Dr. P. Bester
Director: School of Nursing Science

Healthy Living for All
TO: DEPUTY DIRECTOR NURSING
BOPHELONG PSYCHIATRIC HOSPITAL
PRIVATE BAG X2031
MAFIKENG
8670

FROM: MR. LEKGETHO M.M

DATE: 17.03.2010

SUBJECT: PERMISSION TO CONDUCT RESEARCH

I am currently a PhD (Nursing Science) student at the North West University: Potchefstroom campus and I am requesting permission to conduct research at the above mentioned institution. My research topic is “A theory for a positive practice environment for professional nurses working in selected psychiatric institutions in South Africa”. My target group is professional nurses working in a psychiatric institution and they will be requested to complete a questionnaire. Recommendations based on the findings will be made for research, education and practice.

For more information pertaining to this research, the researcher may be contacted at one of the following numbers:

018 4068600 (work)
082 400 7929 (mobile)

Thanking you in advance.

Yours Sincerely,

M.M LEKGETHO
PhD candidate

Promoter: H.C KLOPPER (Prof.)
Director: School of Nursing Science

Co-promoter: Dr. P. Bester
EXCELSIUS NURSING COLLEGE

VISION
To facilitate physical, psychological, social and spiritual wellness for all people of the North West Province through the provision of innovative nursing education and training.

MISSION
The college will strive towards preparing a nursing student through innovative dynamic nursing education and training in order to become a reflective, critical analytical thinker and a professional leader in striving towards wellness.

TO : CHIEF EXECUTIVE OFFICER
STERKFONTEIN HOSPITAL
PRIVATE BAG X2010
KRUGERSDORP
1744

FROM : MR. LEKGETHO M.M

DATE : 17.03.2010

SUBJECT : PERMISSION TO CONDUCT RESEARCH

I am currently a PhD (Nursing Science) student at the North West University: Potchefstroom campus and I am requesting permission to conduct research at the above mentioned institution. My research topic is "A theory for a positive practice environments for professional nurses working in selected psychiatric institutions in South Africa". My target group is professional nurses working in a psychiatric institution and they will be requested to complete a questionnaire. Recommendations based on the findings will be made for research, education and practice.

For more information pertaining to this research, the researcher may be contacted at one of the following numbers:

018 4068600 (work)
082 400 7929 (mobile)

Thanking you in advance,

Yours Sincerely,

M.M Lekgetho
PhD Candidate

Promoter :
H.C Klopper (Prof.)
Director : School of Nursing Science

Co-promoter :
Dr. P.Bester

Healthy Living for All
APPENDIX H: APPROVAL LETTERS FROM PSYCHIATRIC HOSPITALS

BOPHELONG PSYCHIATRIC HOSPITAL

21 September 2011

Lekgetho M.M.
Excelsius Nursing College

DEVELOPING A THEORY FOR POSITIVE PRACTICE ENVIRONMENTS FOR PROFESSIONAL NURSES WORKING IN SELECTED PSYCHIATRIC INSTITUTIONS IN SOUTHERN AFRICA.

In line with the approval granted by the North West Department of Health, permission is granted for you to conduct your research at Bophelong Psychiatric Hospital.

Please contact the Deputy Manager Nursing to inform her of the date on which you will be visiting the institution.

SS MOSIMEGE
CHIEF EXECUTIVE OFFICER

CC: T.A. TYOLO
Deputy Manager Nursing

Healthy Living for All
To: M. M. Lekgetho
Fax No: 018 462 1039

From: Mrs. M. Mabena – CEO Weshoppies Hospital

Date: 2011/04/13

Subject: PERMISSION TO CONDUCT RESEARCH

Permission is hereby granted for you to conduct research at Weshoppies Hospital on a topic “A theory of positive practice environments for Professional Nurses working in selected psychiatric institutions in South Africa”.

Please feel free to contact Mrs. M. Liessner or Mrs. L. Mokwena for any enquiries or assistance.

The Management of Weshoppies Hospital wishes you success with your studies.

M. A. Mabena
ATTENTION: MR M M LEKGETHO

M M LEKGETHO
39 KOLONEL NEL STREET
KEPE-NERDHOI
KLD
2571
Fax: 018 – 462 1348

RESEARCH REQUEST: DEVELOPING A THEORY FOR A POSITIVE PRACTICE ENVIRONMENT FOR PROFESSIONAL NURSES WORKING IN PSYCHIATRIC INSTITUTIONS

1. Your presentation dated 08/04/2011 to the PSQ Witrand Hospital and the approval by the North West Department of Health on the above-mentioned request refers

2. You are hereby informed that your request is approved

3. Please make all further arrangements regarding the logistics with the Nurse Manager Witrand Hospital, contact particulars Mrs A de Bruin, 018 – 2949100

Kind regards,

MRS A DE BRUIN
NURSE MANAGER WITRAND HOSPITAL

DR T G OOSTHUIZEN
SENIOR MANAGER: MEDICAL SERVICES WITRAND HOSPITAL

MRS M. MOCWALEDI-SENYANE
PRO WITRAND HOSPITAL

WITRAND HOSPITAL
2011-04-11
Dr. M.R. Billa
Chief Executive Officer
Sterkfontein Hospital
KRUGERSDORP

Dear Dr. Billa,

STUDY: A THEORY FOR POSITIVE PRACTICE ENVIRONMENT FOR PROFESSIONAL NURSES WORKING IN SELECTED PSYCHIATRIC INSTITUTIONS IN SOUTH AFRICA
RESEARCHER: MR. M.M. LEKGETHO

The above study was discussed at the Research Committee meeting. We recommend that permission be granted that Sterkfontein Hospital be used as a site for the above research. However, since this is a research project involving voluntary participation, we cannot guarantee participation of individuals/patients.

Upon completion of the study, a copy thereof should be submitted to Sterkfontein Hospital.

Thank you.

DR. J.J. SUBRAMANENY
PRINCIPAL PSYCHIATRIST / CLINICAL HEAD
31/05/2011

Approved.

DR. M.R. BILLA
CHIEF EXECUTIVE OFFICER
APPENDIX I: RN4CAST QUESTIONNAIRE FOR THE PSYCHIATRIC PRACTICE ENVIRONMENT

PLEASE MARK AN “X” IN THE BOX CORRESPONDING TO YOUR ANSWER IN EACH QUESTION, OR SUPPLY THE REQUESTED INFORMATION.

A. ABOUT YOUR JOB

<table>
<thead>
<tr>
<th>Question</th>
<th>Strongly Disagree</th>
<th>Somewhat Disagree</th>
<th>Somewhat Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Adequate support services allow me to spend time with my patients.</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>2. Physicians and nurses have good working relationships.</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>3. A supervisory staff that is supportive of nurses.</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>4. Active staff development or continuing education programs for nurses.</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>5. Career development/clinical ladder opportunity.</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>6. Opportunity for registered nurses to participate in policy decisions.</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>7. Physicians value nurses’ observations and judgments.</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>8. Enough time and opportunity to discuss patient care problems with other nurses.</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>9. Enough registered nurses on staff to provide quality patient care.</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>10. A nurse manager who is a good manager and leader.</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>11. A nursing director who is highly visible and accessible to staff.</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>12. Enough staff to get the work done.</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>13. Physicians recognise nurses’ contributions to patient care.</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>14. Praise and recognition for a job well done.</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>15. High standards of nursing care are expected by the management.</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>16. A nursing director is equal in power and authority to other top level hospital executives.</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>17. A lot of team work between nurses and physicians.</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>18. Opportunities for advancement.</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>19. A clear philosophy of nursing that influence the patient care environment.</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>20. Working with nurses who are clinically competent.</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>21. Physicians respect nurses as professionals.</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>22. A nurse manager who backs up the nursing staff in decision making, even if the conflict is with a physician.</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>23. Management that listens and responds to employee concerns.</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>25. Registered nurses are involved in the internal governance of the hospital (e.g., practice and policy committees).</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>27. An induction program for newly hired nurses.</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>28. Nursing care is based on a nursing rather than a medical model.</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>29. Registered nurses have the opportunity to serve on hospital and nursing committees.</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>30. Physicians hold nurses in high esteem.</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>31. Written, up-to-date care plans for all patients.</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>32. Patient care assignments that foster continuity of care (i.e., the same nurse cares for the patient from one day to the next).</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>
2. How satisfied are you with your current job in this hospital?
   □ Poor    □ Fair    □ Good    □ Excellent

3. How would you rate work environment at your job in this hospital (such as adequacy of resources, relations with coworkers, support supervisor)?
   □ Very dissatisfied    □ A little dissatisfied    □ Moderately satisfied
   □ Very satisfied

4. How satisfied are you with the following aspects of your job?

<table>
<thead>
<tr>
<th>Aspect</th>
<th>Very Dissatisfied</th>
<th>A Little Dissatisfied</th>
<th>Moderately Satisfied</th>
<th>Very Satisfies</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Work schedule flexibility</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>2. Opportunities for advancement</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>3. Professional status</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>4. Wages</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>5. Educational opportunities</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>6. Annual leave</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>7. Sick leave</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>8. Study leave</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
</tbody>
</table>

5 a) If possible, would you leave your current hospital within the next year as a result of job dissatisfaction?
   □ Yes    □ No

b) If yes, what type of work would you seek?
   □ Nursing in another hospital    □ Nursing, but not in a hospital    □ Non-nursing

6. If you were looking for another job, how easy do you think it would be for you to find an acceptable job in nursing?
   □ Very difficult    □ Fairly difficult    □ Fairly easy    □ Very easy

7. Would you recommend your hospital to a nurse colleague as a good place to work?
   □ Definitely no    □ Probably no    □ Probably yes    □ Definitely yes
8. Would you recommend your hospital to your friends and family if they needed hospital care?

   1  Definitely no     2  Probably no     3  Probably yes     4  Definitely yes

9. Please mark the response that best describes how frequently you have a each in relation to your current job in this hospital.

<table>
<thead>
<tr>
<th></th>
<th>Never</th>
<th>A few times a year or less</th>
<th>Once a month or less</th>
<th>A few times a month</th>
<th>Once a week</th>
<th>A few times a week</th>
<th>Every day</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. I feel emotionally drained from my work</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>2. I feel used up at the end of the workday</td>
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<tr>
<td>I feel fatigued when I get up in the morning and to face another day on the job.</td>
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<tr>
<td>4. I can easily understand how my patients feel about things.</td>
<td></td>
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<td></td>
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</tr>
<tr>
<td>5. I feel I treat some patients as if they were impersonal objects.</td>
<td></td>
<td></td>
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<tr>
<td>6. Working with people all day is really a strain for me.</td>
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<tr>
<td>7. I deal very effectively with the problems of my patients.</td>
<td></td>
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<tr>
<td>8. I feel burned – out from my work.</td>
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<tr>
<td>9. I feel I’m positively influencing other people’s lives.</td>
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<tr>
<td>10. I’ve become more insensitive toward people since I took this job.</td>
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<tr>
<td>11. I worry that this job is hardening me emotionally.</td>
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<tr>
<td>12. I feel very energetic</td>
<td></td>
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</tr>
<tr>
<td>13. I feel frustrated by my job.</td>
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<tr>
<td>14. I feel I’m working too hard on my job.</td>
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<tr>
<td>15. I don’t really care what happens to some patients.</td>
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<tr>
<td>16. Working directly with people puts too much stress on me.</td>
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<tr>
<td>17. I can easily create a relaxed atmosphere with my patients.</td>
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</tr>
</tbody>
</table>
B. QUALITY AND SAFETY

1. In general how would you describe the quality of nursing care delivered to patients on your unit/ward?
   \[\begin{array}{c}
   1\square \text{ Definitely no} & 2\square \text{ Probably no} & 3\square \text{ Probably yes} & 4\square \text{ Definitely yes}
   \end{array}\]

2. How confident are you that your patients are able to manage their care when discharged?
   \[\begin{array}{c}
   1\square \text{ Not at all confident} & 2\square \text{ Somewhat confident} & 3\square \text{ Confident} & 4\square \text{ Very confident}
   \end{array}\]

3. How confident are you that hospital management will act to resolve problems in patient care that you report?
   \[\begin{array}{c}
   1\square \text{ Not at all confident} & 2\square \text{ Somewhat confident} & 3\square \text{ Confident} & 4\square \text{ Very confident}
   \end{array}\]

4. Please give your unit/ward an overall grade on patient safety.
   \[\begin{array}{c}
   1\square \text{ Failing} & 2\square \text{ Poor} & 3\square \text{ Acceptable} & 4\square \text{ Very good} & 5\square \text{ Excellent}
   \end{array}\]

5. In the past year would you say the quality of patient care in your hospital has...
   \[\begin{array}{c}
   1\square \text{ Deteriorated} & 2\square \text{ Remained the same} & 3\square \text{ Improved}
   \end{array}\]
6. The following questions ask for your opinion about patient safety issues in your employment setting.

<table>
<thead>
<tr>
<th></th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Neither</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Staff feel like their mistake are held against them.</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>2. Important patient care information is often lost during shift changes.</td>
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<tr>
<td>3. Things “fall between the cracks” when transferring patients from one unit to another.</td>
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<tr>
<td>4. Staff feel free to question the decision or actions of those in authority.</td>
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<tr>
<td>5. In this unit, we discuss ways to prevent errors from happening again.</td>
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<tr>
<td>6. We are given feedback about changes put into place based on even reports.</td>
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<tr>
<td>7. The actions of hospital management show that patient safety is a top priority.</td>
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</tbody>
</table>

7. How often would you say each of the following incidents occurs involving you or your patients?

<table>
<thead>
<tr>
<th></th>
<th>Never</th>
<th>A few times a year or less</th>
<th>Once a month or less</th>
<th>A few times a month</th>
<th>Once a week</th>
<th>A few times a week</th>
<th>Every day</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Patient received wrong medication, time, or dose</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td>2. Physical injuries after admission</td>
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<tr>
<td>3. Patient falls with injury</td>
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<td>4. Healthcare-associated infections</td>
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<tr>
<td>- Urinary tract infections</td>
<td></td>
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<tr>
<td>- Bloodstream infections</td>
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<tr>
<td>- Pneumonia</td>
<td></td>
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<td></td>
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<tr>
<td>5. Complaints from patients or their families</td>
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<td></td>
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<tr>
<td>6. Verbal abuse toward nurses</td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- By patients and/or families</td>
<td></td>
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<td></td>
<td></td>
<td></td>
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<tr>
<td>- By staff</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>7. I deal very effectively with the problems of my patients.</td>
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<tr>
<td>- By patients and/or families</td>
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<tr>
<td>- By staff</td>
<td></td>
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<tr>
<td>8. I feel burned – out from my work.</td>
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</tr>
</tbody>
</table>
C. ABOUT YOUR MOST RECENT SHIFT AT WORK IN THIS HOSPITAL

1. Which best describe the most recent shift you worked in this hospital?
   □ Day duty    □ Afternoon/evening    □ Night duty

2. Write in the box the number of hours you worked on your most recent shift in this hospital, e.g. 6, 12 hours?
   Hours: ________

3. On your most recent shift at this hospital did you work beyond your normal duty hours (e.g. more than 12 hours)?

4. How many patients were you directly responsible for on the most recent shift you worked, e.g. 1, 3, 10 patients?

5. Is the number of patients in preceding question (C4) typical of your workload everyday?

6. Of all the patients were you directly responsible for on your most recent shift,
   a. how many required assistance with all activities of daily living? ________
   b. how many required hourly or more frequent monitoring or treatments? ________

7. How would you describe your role in caring for most of the patients on your most recent shift?
   Mark the on option that fits best:
   □ I provided most care myself
   □ I supervised the care by others and provided some myself?
   □ I provided only limited care such as dressing changes or drug administration and most of care was done by others.

8. On your most recent shift how many patients in total were on your unit/ward? ________

9. How many registered nurses in total provided direct patient care on your unit/ward during the most recent shift you worked?
   Number of registered nurses: ________

10. How many other nursing care staff (staff nurses, nursing assistant and care workers) in total, provided direct patient care on your unit/ward during the most recent shift you worked?
   a. Staff nurses: ________
   b. Nursing assistants / care workers: ________
11. On your most recent shift, how often did you perform the following tasks?

<table>
<thead>
<tr>
<th>Task</th>
<th>Never</th>
<th>Sometimes</th>
<th>Often</th>
</tr>
</thead>
<tbody>
<tr>
<td>Delivering and retrieving food trays</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Performing non-nursing care</td>
<td></td>
<td></td>
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<tr>
<td>Arranging discharge referrals and transportation (including long term care)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Routine phlebotomy / blood draw for tests</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Transporting of patients within hospital</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cleaning patient rooms and equipment</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Filling in for non-nursing services not available on off-hours</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Obtaining supplies or equipment</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Answering phones, clerical duties</td>
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</tbody>
</table>

12. On our most recent shift, which of the following activities were necessary but left undone because you lacked the time to complete them? Mark all that apply

1. Adequate patient surveillance
2. Skin care
3. Oral hygiene
4. Pain management
5. Comfort / talk with patients
6. Educating patients and family
7. Treatments and procedures
8. Administer medications on time
9. Prepare patients and families for discharge
10. Adequately document nursing care
11. Develop or update nursing care plans / care pathways
12. Planning care
13. Frequent changing of patients position

D. ABOUT YOU

1. What is your gender?
   - [ ] Female
   - [x] Male

2. What is your age? Years: 

3. a. Did you receive your basic nursing education in the country where you currently work as a professional nurse?
   - [ ] Yes
   - [x] No
b. If no, in what country did you receive your basic nursing education? Country:

4. Not including the country where you currently work, list the last three countries, if any, (and years) where you have worked as a professional nurse.

Country / Years: ___________________________ Country / Years: ___________________________ Country / Years: ___________________________

5. What was your age when you first became a professional nurse (completed your training)?
Years: ___________________________

6. Do you have a baccalaureate degree in nursing?
   □ Yes  □ No

7. How satisfied are you with your choice of nursing as a career?
   □ Very dissatisfied  □ A little dissatisfied  □ Moderately satisfied  □ Very satisfied

8. Are you working in this hospital full time?
   □ Yes  □ No

9. How many years have you worked as a registered nurse….
   a. in your career  Years: ___________________________
   b. in this hospital  Years: ___________________________

10. Please write the name / number of the ward / unit that you work in (e.g. Ward 1A or Ward C): ___________________________

11. Do you have an additional qualification in psychiatric nursing science? If yes please indicate the type.
   □ Masters degree  □ Diploma  □ Advanced Psychiatric nursing

Thank you for taking the time to complete and return this survey.
APPENDIX J:  CERTIFICATE FROM STATISTICAL CONSULTATION SERVICES

Re: Thesis, Mr M Lekgetho, student number: 10899286

We hereby confirm that the Statistical Consultation Services of the North-West University analysed the data involved in the study of the above-mentioned student and assisted with the interpretation of the results. However, any opinion, findings or recommendations contained in this document are those of the author, and the Statistical Consultation Services of the NWU (Potchefstroom Campus) do not accept responsibility for the statistical correctness of the data reported.

Kind regards

Dr SM Ellis (Pr. Sci. Nat)
Head: Statistical Consultation Services

Original email: Monique van Derwerf(12205329)@ukzn.ac.za: “ke verslag suiwer” by telefoon: toon van hendrik_Vorwerk_ Org. dome
22 April 2014
APPENDIX K: CRITERIA FOR PRACTICE THEORY EVALUATION

CRITERIA FOR PRACTICE THEORY EVALUATION
(Adapted from Chinn & Kramer, 1991, 2008)

<table>
<thead>
<tr>
<th>CRITERIA</th>
<th>EVALUATOR'S COMMENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. CLARITY OF THE PRACTICE THEORY</td>
<td></td>
</tr>
<tr>
<td>2. DEGREE OF COMPLEXITY</td>
<td></td>
</tr>
<tr>
<td>2.1 Functions of the practice theory</td>
<td></td>
</tr>
<tr>
<td>(describe, explain &amp; predict)</td>
<td></td>
</tr>
<tr>
<td>2.2 Organization of relationships</td>
<td></td>
</tr>
<tr>
<td>2.3 Differentiation of concepts</td>
<td></td>
</tr>
<tr>
<td>3. GENERALITY OF THE PRACTICE THEORY</td>
<td></td>
</tr>
<tr>
<td>3.1 Discipline specificity</td>
<td></td>
</tr>
<tr>
<td>3.2 Purpose specificity</td>
<td></td>
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<td>-------------------------</td>
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</table>

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<thead>
<tr>
<th>4. THEORY ACCESSIBILITY</th>
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</thead>
<tbody>
<tr>
<td>4.1 Definition specificity</td>
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<tr>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>4.2 Identifiable empirical indicators</th>
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<tr>
<th>5. IMPORTANCE OF PRACTICE THEORY TO:</th>
</tr>
</thead>
<tbody>
<tr>
<td>5.1 Nursing Science</td>
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</tbody>
</table>

| 5.2 Nursing Practice                 |
|                                       |

| 5.3 Nursing Research                 |
|                                       |
APPENDIX L: TURNITIN REPORT

APPENDIX – L

Turnitin

11311738/thesis_2016.pd

by PETRA FESTER

Similarity Report

Similarity Index: 28%

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APPENDIX M: DECLARATION OF LANGUAGE EDITING

DECLARATION OF LANGUAGE EDITING

I, Christina Maria Etrecia Terblanche, hereby declare that I edited the following research study:

Positive practice environments for professional nurses working in selected psychiatric institutions in South Africa: a practice theory

for Mangena Lekgotla for the purpose of submission as a thesis for examination. Changes were suggested in track changes and implementation was left up to the author.

Regards,

CME Terblanche

Cum Laude Language Practitioners (CC)

SATI accreditation no: 1001066

Registered with PEG