

**EXPLORING THE PERCEPTIONS OF STUDENT NURSES ON PATIENT-  
CENTERED CARE PROVIDED IN PSYCHIATRIC INSTITUTIONS IN  
PIETERMARITZBURG, KWAZULU-NATAL.**

**A Dissertation submitted to**

**The School of Nursing**

**The Faculty of Health Sciences**

**College of Nursing**

**University of KwaZulu-Natal**

**In Partial fulfillment of the requirements for the  
COURSE WORK MASTERS DEGREE IN NURSING  
(MENTAL HEALTH NURSING)**

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## Declaration

I, Luntukazi Matanzima, declare that this is my own account of my research and has not been submitted before for any other degree at any other institution and all the sources that I have used or quoted have been indicated and acknowledged by means of complete references.

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Date

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Ms C.Engelbrecht

**(Research Supervisor)**

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Date

## **Dedication**

I dedicate this study to my parents, my late father, Superman Monwabisi Matanzima, how I wish he was here to see me developing academically, and my beloved mom, Mandisa Matanzima, who gave me the foundation of love and good life.

## **Acknowledgements**

I thank and praise the Almighty God for giving me the opportunity, wisdom and strength to complete this study. I wish to extend my sincere thanks and appreciation to the following people who contributed to this study.

1. Ms C. Engelbrecht, my supervisor, for her constructive criticism.
2. Mrs. N.C. Majola, the Principal of the Campus, for permitting me to undertake the study on the campus, and for her support and encouragement.
3. Dr L.L.NkonzoMthembu, the Principal of the College, for permitting me to undertake the study.
4. The Department of Health, for granting me the permission to conduct the study.
5. The research participants, for their willingness, understanding and cooperation during the course of this research study.
6. My sincere gratitude and appreciation goes to a strong network of colleagues, especially R.T.Zondi for her patience and advanced computer skills, and W.D. Cele for her guidance and support and friends who have weathered and calmed the storms with me over the past three years.
7. I am eternally grateful to my family, especially my mother, Mandisa, and my sisters, Lusanda, Vuyolwethu and Nwabisa, for their continuous prayers, love, support and encouragements. Thank you for being the pillars of my strength
8. Finally I would like to acknowledge my only child and son, Songo. Thank you for being my inspiration Boy!

## **Abstract**

The purpose of the study was to explore and describe how student nurses perceive patient-centered care in their allocated units in the uMgungundlovu district.

The main objectives of this study were to:

- Explore the student nurses 'perceptions of patient – centered care provided.
- Describe the student nurses' perceptions of patient-centered care provided.
- Describe where the working environment in the psychiatric institution is supportive of patient-centered care.
- Explore and describe what factors could hinder the provision of patient-centered care according to the student nurses' perceptions.
- Explore and describe what factors could promote the provision of patient-centered care according to the student nurses' perceptions.

The researcher used the qualitative , explorative and descriptive approach. Focus group interviews were used to collect data from fourth year psychiatric nursing students who were doing the four year course diploma programme at two psychiatric institutions in the uMgungundlovu district, where student nurses from other campuses were allocated. The interviews were tape recorded and later transcribed to facilitate easy analysis. Thematic data analysis was used.

The findings suggest that inconsistent practices are the biggest hindrances to patient-centered care. Patients and relatives are not often involved in their own care and there is a lack of information given to patients by health providers which contributes to patients' inability to make decisions and choices for themselves. Their rights in this regard are violated. The lack of resources interferes with the goal of promoting patient centered care.

A number of recommendations for psychiatric nursing practice, education, policy making and nursing research based on the data from the study were made. If accepted and implemented, patient-centered care in the psychiatric institutions might improve.

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# **CHAPTER ONE**

## **Background to the Study**

### **1.1 Introduction**

This chapter presents the background to the study and problem statement, describes the purpose of the research and then details the objectives and questions. It also briefly explains why the study is significant to the nursing profession.

Respect for a human being or person is the basis of all that is truly nursing. The respect of patients' values, preferences and needs, and taking individuals as unique human beings when caring for them, shows appreciation of the self and others (Freshwater, 2002).

The underlying philosophy of patient-centered care is providing patterns of care that recognize each person as a unique and worthy individual. According to Edvardson, Sandman and Rasmussen (2008), patient-centered care is widely described as a preferred model of care as it uses the individual person's perspective as a point of departure.

Patient-centered care takes the personal weaknesses and strengths of patients into consideration and provides individualized care to each patient. Joffe, Macocchia, Weeks, and Cleary (2003) found that patients in hospital value trust, respect and autonomy. They emphasize that ethical models of health care should give attention to these issues. Respect and dignity are the cornerstones of a relationship and when health care providers foster a relationship with their patients and are considerate about their needs, patients will realize that health care providers respect them. Patient-centered care encompasses the physical, emotional, social and spiritual

needs of the patients (Millers & Koop, 1994). The basic principles of patient-centered care are encompassed in legislation relating to the provision of health care in South Africa.

The White Paper on Transformation of the Public Service (Government Gazette NO. 18340, 1997) proposed that the delivery of public services, including the health service, be improved and, in accordance with this, the health care system is currently undergoing major changes, including organizational restructuring and quality improvement.

The Batho Pele Principles relate directly to the concept of patient-centered care. Batho Pele means '*people first*' and the eleven Batho Pele Principles (Government Gazette NO.18340, 1997) cover the following areas of public service (health care) delivery:

- Consultation: Clients or patients should be consulted about the level of service they receive and be given choice of services offered.
- Service standards: People should be told what level and quality of service they will receive so that they can know what to expect.
- Access: All people should have equal access to services.
- Courtesy: Patients deserve dignity, courtesy, consideration and respect.
- Information: Full information should be given to clients or patients regarding the service they are entitled to receive.
- Openness and Transparency: All information and reports should be available for the patients or clients.

- Readiness: If care or service that is promised is not available, an explanation should be given and people's complaints should be responded to.
- Value-for-money: Consideration of efficiency in order to give the people the best possible value-for-money.
- Encouraging Innovation and Rewarding Excellence: Innovation can be new ways of providing better service, cutting costs or improving conditions. It is also about rewarding the staff who go the extra mile in making it all happen.
- Customer Impact: Impact means looking at the benefits that are provided for the customers both internal and external. It is also about making sure that all the customers are aware of their rights in terms of the Batho Pele Principles and exercise them.
- Leadership and Strategic Direction: Good leadership is one of the most critical ingredients for successful organizations.

Also relating to the concept of patient-centered care, the National Department of Health introduced the Patients' Rights Charter in 1999. This charter lists the rights of patients with respect to participation and decision making. Every citizen has the right to participate in the development of health policies and everyone has the right to participate in decision-making on matters affecting their health (Department of Health, 1999).

In addition, the Government supports primary health care and promotes the education of nurses and other health care workers in an endeavor to change their attitudes and switch from a non-consultative approach to a more considerate, information laden patient-centered approach. The provision of holistic client-centered care requires evidence-based knowledge and the related

skills of nursing, and is implemented by the adoption of a caring and responsible attitude, effective communication and interpersonal skills, as well as ethical principles (The Nursing Council of Hong Kong, 2005). The practice of nursing is client-focused (The Nursing Council of Hong Kong, 2005) and is carried out at the primary, secondary and tertiary levels of health care. The functions of a client centered service should include problem solving and collaboration with the client as well as other health care professionals to define and achieve mutually agreed upon health goals.

Koivisto, Janhonen and Vaisanen (2004, as cited in O'Donovan, 2007) reported that some individuals are restrained without being told why, or being offered an alternative, leaving them feeling humiliated and fearful. These researchers found that individuals with psychosis wanted the right to be involved with decisions concerning their treatment and not to be coerced by compulsory methods. This was supported by Hem and Heggen (2004), who reported that individuals with psychosis distrusted nurses and felt rejected by them. They wanted to be told the truth about their condition and be involved in decisions. Another study conducted by Olofsson and Jacobson (2001) highlighted the plight of service users, saying that they have inadequate knowledge about their rights as involuntary patients, their treatment and even the reasons why they had been admitted without having been consulted. These patients described feelings of inferiority, unworthy of care, of being changed to another person by medication, of not being allowed to express emotion as normal people and of not being accepted. They stated, furthermore, that since staff believed that they were involuntary, they didn't have to provide them with answers (Olofsson & Jacobson, 2001). Hem and Heggen (2004) reported that psychiatric nurses have complained that they lack the time to spend with individual patients because they are burdened with complex problems.



In some instances, the nature of the units where nurses work prevents them from practicing in a patient-centered way and although nurses working in the medical wards may try to approach care in a patient-centered way, they find it difficult to work in that way because of the structure, nature and function of the units (Barker, 2000). Johns (1999) suggested that nurses are not free to fulfill moral obligations to the patient without considering organizational and professional implications. Koivisto et al (2004) reported the ward atmosphere may also impede patient-centered care as a turbulent insecure ward environment can leave clients feeling frightened. According to Thistlethwaite and Jordan (1999), students were rarely introduced, either through training or observation, to the idea of patient-centered consultation during their hospital training and were only exposed to this concept when allocated to community clinics where it was promoted. Findings of a study conducted by Twinn (1995), at a university hospital in Finland, observed that clients in the medical wards where students received practical training were more relaxed when they were being cared for by student nurses because they were more supportive than permanent staff.

Other factors, such as the mutual prejudices and attitudes of both student and patients have been found to influence the student-patient relationship (Morin, Patterson, Kurts and Brzowski, 1999; Granskar, Edberg and Frilund, 2001; Patterson and Morin, 2002). By getting to know each individual patient better, students can gain insight into their circumstances, needs and desires, and thus provide better nursing care (Seed, 1994; Fagerberg and Kihlgren, 2001; White 2003). It would also seem that patients benefit from these therapeutic interactions with students (Richard, 1993; Twin, 1995). According to Johns (1994), students' awareness of their own feelings is just as important in creating a helping relationship

## **1.2 Problem statement**

Patient-centered care is an approach which has gained considerable attention in nursing literature. However, although patient-centered care is a term that is widely used term in both theoretical and research literature, it seems that in practice it is a poorly understood concept and that little is known about the factors which hinder or promote this approach to health care.

Students find themselves in a dilemma because they are taught about patient-centered care at college, but discover that it is not commonly practiced when they come into the clinical situation. They, therefore, end up not implementing the patient-centered care they have been taught. The researcher, therefore, saw it imperative to conduct this study.

## **1.3 Purpose of the study**

The purpose of the study was to explore and describe how student nurses perceive patient-centered care in their allocated psychiatric units at two institutions in the uMgungundlovu district, KwaZulu-Natal.

## **1.4 Research objectives**

The objectives of the study were to:

1. Explore the student nurses' perceptions of patient – centered care.
2. Describe the student nurses' perceptions of patient-centered care.
3. Describe whether the working environment in the psychiatric institution is supportive of patient-centered care.

4. Explore and describe the factors identified by student nurses that hinder the provision of patient-centered care in the institution.
5. Explore and describe the factors identified by student nurses that could promote patient-centered care in their working environment.

### **1.5 Research questions**

1. What are the student nurses' perceptions on patient centered care?
2. Do the students perceive the working environment in the psychiatric institution as therapeutic and supportive of patient-centered care?
3. According to the student nurses' perceptions, what are the factors that hinder the provision of patient-centered care in their working environment?
4. According to the student nurses' perceptions, what factors could promote patient-centered care in their working environment

### **1.6 Significance of the study**

This study is significant for nursing practice as the findings will be used to make recommendations that might improve the delivery of patient-centered care services in psychiatric institutions in KwaZulu-Natal. The objectives of this study are for student nurses to identify the factors that hinder or promote patient-centered care and once these have been identified and assessed, various solutions to the problem will be looked at.

The findings can assist the Department of Health, representatives from relevant health professionals (psychiatric trained health service managers and nurses), educationalists, relevant

stake holders and officers of patient bodies to formulate policies for patient-centered care that will guide nurses in their practice to ensure that the patients' needs are met (Hills and Mullet, 2002). Nurses will get more support from the management as the management will also be more involved in policy formulation (Hau, 2004).

Since student nurses will be involved in this study, gaps in the nursing education curriculum might be identified, and these can be addressed. I believe that this research will encourage mental health nursing students to foster better relationships with their patients and that the resulting positive perceptions and attitudes will increase their self-esteem and confidence, thus making them more competent in undertaking the tasks assigned to them which will lead to more effective patient-centered care (Stickley, Stacey, Pollock, Smith, Betinis and Fairbank, 2010).

Where educational or managerial factors have been identified as hindering patient-centered care, research based evidence may initiate changes to address the shortcomings. Moving from tradition to evidence based practice will be of importance to future mental health nurses (Zauszniewski, Suresky, Bekhet and Kidd, 2009).

## **1.7 Operational definitions**

### **1.7.1 Patient-centered care**

Redman (2004:11) describes patient-centered care as treating the patient as a unique individual. This requires taking each patient's needs and preferences into account when deciding what interventions are necessary to meet those needs. This takes into account that the first consideration is the patient who is at the center and whatever mode of intervention prescribed has to adhere with this consideration, bearing in mind that the core of nursing is caring, meaning being with and dealing with persons in this case the patient.

### **1.7.2 Perceptions**

For the purpose of this study, perceptions are ways of seeing and understanding patient-centered care.

### **1.7.3 Student nurse**

The South African Nursing Council regulations R425 of 22 February 1985 define a student as a person following a course of study in a school, college or university, and a nurse a person, often a woman, who is trained to attend the sick and infirm and assist doctors. For the purpose of this study, a student nurse, is a person, either male or female, who is undergoing a four year diploma programme in nursing for the purpose of helping the sick.

### **1.7.4 Psychiatric institution**

Usually called a hospital, a psychiatric institution is where mentally ill people are placed for the purpose of diagnosing and treating them.

## **1.8 Summary**

This chapter discussed the background to the study, the purpose of the study, the research objectives, the research questions and the significance of the study. It highlighted the fact that patient-centered care encompasses the physical, emotional, social and spiritual needs of the patients. It also highlighted the need to respect patients' values, preferences and needs and that each individual should be seen as a unique human being.

## **CHAPTER 2**

### **Literature Review**

#### **2.1 Introduction**

This chapter discusses the literature review conducted by the researcher on patient-centered care. The search key words used during the on line literature review were: patient-centered care; student nurse-patient relationship; and psychiatric institution. The following data bases were consulted: Cinahl; Ebscohost; Google scholar; and Science direct.

Service user dissatisfaction with mental health services has led to the exploration of alternative methods of service delivery (Felton & Stickely, 2004). As people have become more aware that mental health care users are entitled to the same rights as normal human beings, patient-centered care has become a recommended method.

#### **2.2 Patient-centered care**

Gillespie, Florin, and Gillian, (2004) believe that various definitions exist to define patient-centered care. They believe it to be a range of activities from patient involvement in individual care to public involvement in health policy decisions. Barker (2003) suggests that within psychiatric nursing, patient-centered care involves putting people at the centre of nursing care. Watkins (2001) proposes that it is about understanding the person's outer and inner worlds from their frame of reference. Brown, McWilliams and Griffin (2006) believe that client driven is defined as both client-centered (focused on the client) and client empowering (engaging clients to their optimal potential as partners in care). McCabe (2002) suggests that patient-centered care involves patient communication which is a basic component of nursing and facilitates the

development of a positive nurse patient relationship which, along with other organizational factors, results in the delivery of quality nursing care. This means that a person is a unique, holistic being with the potential to learn and develop through interacting with the changing environment. Each person has intrinsic worth and has a right to participate in the decision making process which affects his or her own life and dignity, and must always be treated with respect.

The environment consists of external and internal components, which change constantly and generate both positive and negative stressors. The internal environment of a person, comprising of biological, psychological, spiritual and intellectual components, interacts with the external that encompasses social, cultural and situational influences. This continual interaction affects the person's functioning as an individual, as well as part of a family, group and community. The level of wellbeing depends on the maintenance of equilibrium within the person, and between the person's interactions with the changing environment (Watkins, 2001).

A recent policy document in Ireland (Mental Health Commission, 2006) has recommended that a partnership approach to mental health care delivery be adopted. The partnership approach is possible if the Department of Health can really see the need for the involving of representatives from relevant health professionals i.e. trained health service managers, nurses, educationalists, relevant stake holders and officers of patient bodies in the formulation of policies for patient centered-care that will guide the nurses in their practice to ensure that the patient's needs are met. Leighton (2002) has argued that individualized person-centered care may be inaccessible or inappropriate for certain service users because it conflicts with their values and beliefs. In South Africa, Barker (2000) suggests that psychiatric nursing is about identifying what needs to be performed now to address the needs of the person. This information is sought through the use of

holistic assessment where an intimate conversation will take place with the person where trust must be developed. He focuses on issues such as mutuality, respect, collaboration and gaining an understanding of how persons understand their experience.

In summary, while much theoretical literature exists on the concept of patient-centered care, few studies have been undertaken to explore how this is translated and used in practice. Within the mental health services, many studies have suggested that it remains at a tokenistic level (Felton and Stickely, 2004) which others reported is increasing (Cook, Phillips and Sader, 2005). Peplau's theory (1997), however, focuses on the interpersonal processes and therapeutic relationship that develops between the nurse and client. According to this theory, the needs of the clients must be assessed in order to deliver comprehensive care.

Byrne and Long (1976), cited in Thistlethwaite and Jordan, 1999), identified two contrasting styles of consultation which they found to be relevant; doctor-centered and patient-centered. They recognized that the more holistic, patient-centered approach defines problems in their physical, psychological and social components. The doctor will not only be aware of the nature and cause of the problem, but also investigates the patient's ideas, concerns and expectations as part of the management process. Students should also be involved in the consultations by taking notes of the patient's history in order to formulate a diagnosis and become familiar with the patient's concerns. In this way, students will become exposed to the practice of patient-centered care.

Many models of patient-centered care exist, particularly where the care of elderly people is rendered. Models include Mc Cormack's (2003) 'Authentic consciousness model'; Barker's (2000) 'Tidal model'; Titchen's (2001) 'Skilled companionship model'; Nolan, Davies and



Brown's (2004) 'Senses framework'; Kitwood's (1990) 'Positive person's work model'; and John's (1994) 'Burford model'. According to Dewing (2004), however, there is a failure to evaluate their effectiveness in practice so there is still a need for more research to be done. A study was undertaken utilizing Barker's (2000) 'Tidal model' and findings revealed many issues on the use of a patient-centered mode of care delivery. This model focused on developing an understanding between the care giver and the service users, with the service users being the major stakeholders in their care. An assessment tool was also developed which assessed how the problem began, their past experiences, what brought them to hospital, how were they feeling at that present moment, what their expectations were, their strengths, family support and the person involved in outlining the interventions.

Titchen (2001) presents mutuality as a requirement of 'Skilled companionship' framework of patient-centered care, suggesting that when the practitioner involves the patients in their care, the sharing of responsibility contributes to a better understanding of their difficulties. A study by McCann and Barker (2001) revealed that even when psychiatric nurses attempt to see the situation from their patient's eyes by engaging in a mutual relationship with them, they can never really understand what they are experiencing.

Latvala (2002) identified that shared awareness between the nurse and service user is needed, meaning that each one of them must be able to recognize personal resources, limitations and constraints. According to Trnobranski (1994), the nursing literature widely promotes the importance of a nurse patient relationship which fosters the involvement of the patient in negotiation and decision making regarding his or her care. Patients need to be aware of what is being discussed in relation to them. Latvala, Janhonen and Moring (2000) suggested that psychiatric nurses need to listen carefully to the patient to understand their needs concerning

their daily life and believed that this is performed through participatory dialogue. Studies by Thorne and Robinson (1988), Jewell (1994) and Ricketts (1996) indicated that nurses often base the patient's decisions on their own values, not considering that their values are not the same as those of the patients.

A new approach to organizing health services, which is called patient and family centered care, is sweeping across North America, and this is an approach that could also work very well in the South African setting (Uys, 2010). Patient and family centered care is a radical approach to ensuring the quality of care by putting patients and their families in the center of the care. According to Uys (2010), evidence has supported that the implementation of this approach greatly improves outcomes for the service, the staff , patients and their families. This author maintains that such an approach should be the philosophy and system of care for all health service settings. It is based on four core concepts:

- People are treated with respect and dignity
- Health care providers should communicate and share completely unbiased information with patients and families in ways that are affirming and useful.
- Individuals and families build on their strengths through participation in experiences that enhance control and independence.
- Collaboration among patients, families and providers occurs in policy and programme development and professional education, as well as in the delivery of care. This means the patients should be given all the information that they need so that they will be able to make informed decisions and be self directed.

The service should focus on treating patients and their families as respected collaborators in care with their own dignity, preferences and opinions. The information given to them should be accessible and easily understood. Whatever is written in connection with health education should be with the patient's input. The aim of the care is to make the patient and family as self sufficient and knowledgeable as possible. The patient and family should be involved in the care from day one, take part in team meetings and ward rounds and should be part of discussions about treatment options.

### **2.3 Activities that reflect patient and family based care.**

**2.3.1 Bedside level** - The patient and family should have accessibility to the patient's record. The planning should be shared with the patient and family. The patient should be allowed any visitors of their choice, not only those who are known to be family members.

**2.3.2 Ward level** – There should be open visiting times for designated family members. Family members and staff should be available to the patient whenever necessary in order to support, inform and give advice. Patients and their family members should be incorporated in the patient's routine and participate in rounds so that they can have input. The staff should always display respect, even when nobody is watching

**2.3.3 Institutional level** – The vision and mission of the institution should address the experience of patients and families as core. Family and patients should be members of all committees in the service e.g. quality and clinical committees. A member of the family should be trained as one of the members of the council. Patient and family experience surveys should be done regularly and form the basis of service planning. A culture of patient and family centeredness should be reflected in the environment (Uys, 2010). Good or bad stories about the

service provider should be taken into consideration because it can be used as the motivation for improvement.

## **2.4 What does patient-centered care mean?**

According to Lewis (2009), patient-centered care involves respect for patient's values, preferences and expressed needs and leads to shared responsibility and decision making. Patient-centered care is best expressed by the phrase *"through the patient's eyes"* (Lewis, 2009). Freshwater (2002) supports the above statement saying that *"in nursing , respect for a human being or person is the basis of all that is truly nursing and the respect of patient's values, preferences and needs is the appreciation of self and the other taking individuals as unique human beings in caring for them."* There should be 'team medicine' to give patients support as they move through different care settings for prevention as well as treatment. The patients should be supported by giving them the right information about the advanced technical machinery that is being used to help them. The patient's physical comfort should be taken into consideration at all times. In a holistic approach, empathy and emotional well-being are as important as evidence based medicine. A larger community of caregivers should be considered which would include more people than just the health professionals who are treating the patient. The implementation of a delivery system would provide time off for the different care providers during the various phases of care.

## **2.5 What patients want**

According to Lewis (2009), patients expect the following: all of their needs should be addressed; the person in charge must know the patients well and be able to be contacted to help when needed; the patients should get care whenever they need it and whatever service is required

should be given to them; all information regarding the patient should be accessible to those who need it, whenever they need it; and patients should have access to their records and be given the opportunity to add information if they wish to do so.

Uys (2010) is in agreement with the above statement that patients should have the right to access their records and their questions be answered by a knowledgeable health provider. This author adds, however, that the health givers should be able to listen, explain and clarify, ensuring that they are on the same level as the patient, thus maintaining consistency. Patients should also have access to a telephone at all times. They should be listened to when they want to give feedback about quality. When they have fears or hopes they should be understood. All patients should be given fair treatment at all times, regardless of sex, colour, race and creed. This is again supported by the Batho Pele principles as laid down in the Government Gazette NO. 18340, 1997, which states that they must be given time to express needs and be heard effectively.

## **2.6 Provider attributes that promote patient-centered care**

According to Lewis (2009), achieving genuine patient-centered care requires a cultural adjustment according to the following attributes:

- Recognition that health care is an integrated service industry designed to respond to the people's needs.
- The organization should be responsible for the processes and outcomes of care, especially communications and follow up.

- The health providers should be willing to participate in non-hierarchical teams to ensure that patients get comprehensive, well integrated care from the most appropriate caregivers.
- Incentives should be given to staff to encourage them to spend more time with the clients.
- Trust and encouragement should be given to those patients who are willing to be actively involved in their own care.
- The service provider must be willing to admit their own failures and pursue remedies.

Morrison (1997) states that nurse' values, education, family life, health perceptions and financial status are often very different from the people they serve, which results in a lack of cultural consideration of patients. Patients, on the other hand, often regard the health providers as superior because they are well educated people in control of their lives. These opposites in perception can lead to creating a divide, rather than a confluence as implied by patient-centered care. Latvala, Janhonen and Moring (2000) suggest that psychiatric nurses need to listen carefully to the patient to understand their needs concerning their daily life. This can only be achieved through communication in a language accessible to the relevant parties.

## **2.7 Governance and management for patient-centered care**

Managers and governors are not directly involved in care, but their mandates, values and policies create a framework that influences the relationship between patients and providers. Managers deal more directly with care providers, while governors, especially government, are responsible mainly for the public, who are the patients. If patient-centered care is to be realized within the

health system, governors and managers have to make it a top priority and implement policies to support it. According to Lewis (2009), the focus should be on the following:

- Indicators that capture patient-centered care should be accurate and comprehensive.
- Goals and targets for achieving various elements of patient-centered care should be clearly stated.
- Regular patient surveys should be done so as to monitor patient-centered care and identify strengths and weaknesses.
- Regular surveys to monitor the provider's attitudes, expectations and behaviors should also be done.
- There should be organizational changes that promote systems thinking, collective accountability and team based care.
- A culture of patient-centered care that refuses to tolerate behaviors that do not put patients first should be ignored.

These concepts of patient-centered care are in line with the Batho Pele Principals in the Government Gazette No.18340, (1997) which aimed at introducing and improving the delivery of public services, including the health service .

## **2.8 Potential policy measures to advance patient-centered care.**

- Accelerate the implementation of a patient accessible, patient-friendly health system where patients should be made the cornerstone of public reports and accountability, and incentives and innovation should be part of the planning.

- Develop, publicize and disseminate checklists and other tools for patients to use in clinical encounters to ensure that their needs are being met.
- Address financial cutbacks that restrict patients' means of communication so that telephones and e-mails can be made available to them.

## **2.9 What constitutes patient-centered care?**

According to the Ontario Medical Association (2010), patients should be at the center of the health care system, and this has become the topical issue. Patient-centered care seems to encompass all that is associated with good care and good communication. The system constitutes the individual needs of patients and treats them with respect and dignity. It recognizes that patients differ according to their desires and their ability to participate in decision making, where in some situations they may want to participate fully, but in others prefer to rely upon the doctor's advice. The attitude and behavior of doctors and other health professionals determine whether the care is patient-centered or not.

## **2.10 Principles of patient-centered care for health professionals**

Optimal care is achieved when accountability of health care outcomes is shared between health providers and patients (Ontario Medical Association, 2010). Health providers should share decision making about all aspects of their health care, including treatment, options, risks, benefits and evidence with patients. The information of all relevant aspects of health care should be communicated to the patients in a manner that can be understood by them. Health providers, however, should continue to act as advocates for their patients so as to meet their health care needs. They should take the lead in promoting compassion and empathy for patients and in promoting behaviors that are patient-centered and positive for the patient.



## **2.11 Core components of comprehensive patient- centered care**

According to Carroll, Alteras and Stepnick (2006), the following components for patient-centered care should be considered: A welcoming environment - a physical space and an initial personal interaction that is welcoming, familiar and not intimidating should be provided; Respect for patients' values and expressed needs - information about patients' care, preferences and priorities should be obtained and the patient should be involved in the decision making within a consistent, mutually respectful patient-provider relationship; Patient empowerment - the patients should be educated and be encouraged to expand their role in decision making, health related behaviors and self-management; Socio cultural competence - the culture, economic and educational status, health literacy level family situation and traditions of the patient should be considered and understood. Proper communication can only be achieved in a language accessible to the relevant parties. Information should be communicated at a level that the patient can understand. Latvala, Janhonen and Moring (2000) suggest that psychiatric nurses need to listen carefully to the patient to understand their needs as they go about their daily life; Physical and emotional support and the involvement of family and friends should be emphasized. The patient and family members should be involved in the planning, design and ongoing functioning of the organization, and the patient to be considered as a member of his or her team. The patient and family should be kept advised at all times and appropriate referrals must be made to ensure patients experience a smooth transition between phases of care. If the patient needs to consider an institution, a facility be provided, and waiting times kept to a minimum. The institution should have convenient service hours, promote patient access and help them to attain skills to better navigate the health care system; and the suggestions and complaints from patients and family

should be noted. Data measuring patient-centered care should be evaluated and feedback should be provided.

Barker (2003) suggests that patient-centered care involves putting people at the centre of nursing care. This is supported by Trnobranski (1994) who argues that the relationship between nurses and patients should be fostered in that the patients should be involved in decision making regarding their care. The organization should employ staff who appreciate and celebrate the diversity of the communities and cultures that the organization serves, and such staff should be given training and support. The staff should be empowered to be part of patient-centered teams and should be recognized and rewarded for exhibiting patient-centered principles. The top management, board and department heads should make a clear, explicit commitment to patient-centeredness and act as role models. According to Latvala (2000), patients become dissatisfied with the health care services because, in many cases, nurses, who attempt to implement patient-centered care are impeded by system and organizational barriers which have been put in place by the top management. In order to incorporate patient-centered care practices into daily operations and culture, patient-centered care should be tied to other priorities such as patient safety and quality improvement.

## **2.12 Outcomes of patient-centered care**

It has been noticed that patients seem more satisfied if they are part of the decision making process and a shared understanding of the problem is reached. One of the outcomes of patient-centered care is that there is higher incidence of patients taking an interest in their own physical health status. If patients receive warmth and respect, they open up and become responsive, thus alleviating their anxiety and fear and lessening the burden of disease. In this way patients not

only have input in improving the quality of health care by participating and having a responsible role in decision making, but communication and relationships with the care providers are greatly improved (Ward, 2004). This is supported by the Batho Pele Principles that aim at improving the delivery of the public service, including the health services (Government Gazette 388 -18340).

What became apparent from the literature review is that although there is consensus among researchers in their understanding of the term patient-centered care, it is all theory, and there is very little evidence of patient-centered care having been put into practice. There is evidence, however, that patients are dissatisfied with the health care services (Latvala (2000)). Even if nurses attempt to implement patient-centered care, they often encounter barriers created by system and organizational procedures of service delivery. According to Brown, William & Griffin (2006), at the system level, the financial constraints of the government impeded the adoption of the patient-centered approach. At organizational level, barriers associated with centralized allocation and control of service delivery hampers nurses' efforts to incorporate client-centered and client empowering care (Chiovitti, 2008). An ongoing struggle around resources takes place between nurses and care managers, with nurses trying to get more for the patients and managers trying to save for the service (Hau, 2004). This impedes partnering in client-centered care. According to Brown, William & Griffin (2006), managers who continue to exercise allocation and centralized control of scarce service resources appeared to send mixed messages to the nurses, undermining their ability to confidently enact a client-centered empowering partnership. Hiscock and Shuldham (2008), suggest that managers should support staff and take risks in order to empower nurses to implement initiatives which improve patient care. Psychiatric mental health nursing is currently practiced in the face of competition among

health care providers, nursing shortages, access and financial problems in the delivery of care to very ill and poor individuals, and developments in science and technology (Stockman, 2005).

Nurses seem particularly pre-occupied with personal concerns about remuneration, workload and working conditions, which distracts them from partnering with patients. The patients are depersonalized and little thought is given to their dignity. They can be seen wearing torn hospital attire and, sometimes, wearing no gowns at all. When requests for new gowns are made, the unit manager makes it clear that the government does not have the money.

Thus, in order for patient-centered care to take place, support is needed from the most senior managers as there is a relationship between leadership and quality of care. This relates also to the senior staff who should be role models to the students. If senior staff are not practicing quality service, one cannot expect students to do so. The implementation of patient-centered care into the health system can bring about better outcomes.

### **2.13 Peplau's framework**

Peplau's, (1997) theoretical framework was used as a guide for this study. It focuses on the interpersonal processes and therapeutic relationships that develop between nurses and clients. Interpersonal processes include the nurse client relationship, communication, pattern integration and roles of the nurse. This theory stresses the importance of nurses having the ability to understand their own behavior in order to help others identify perceived difficulties (Peplau, 1997). Nursing is viewed as an interpersonal process because it involves interaction between two or more individuals with a common goal. The nurse and patient respect each other as individuals, both of them learning and growing as a result of the interaction. Each individual may be viewed as a unique biological, psychological, spiritual, sociological structure who will not react the same

as any other individual. Both the nurse and the patient have learned their unique perceptions from different environments, and the customs and beliefs of their particular culture. Peplau (1997) identified four interrelated, sequential phases in interpersonal relationships; orientation, identification, exploitation and resolution.

#### **2.13.1 Orientation phase**

During this phase the individual has a felt need and seeks professional assistance. The nurse helps the individual to recognize and understand his or her problem and determines the need for help (Peplau, 1997).

#### **2.13.2 Identification phase**

The patient identifies with those who can help him or her. The nurse encourages the patient to ventilate so that she can explore the feelings and help where she can.. Patient participates in goal setting, has feeling of belonging and selectively responds to those who can meet his or her needs (Peplau, 1997).

#### **2.13.3 Exploitation phase**

Patient actively seeks and draws knowledge and expertise of those who can help. The nurse projects new goals to be achieved through personal effort (Peplau, 1997).

#### **2.13.4 Resolution phase**

The patient gradually puts aside old goals and adopts new goals. This is a process in which the patient frees himself from the nurse and leads to termination of the relationship (Peplau, 1997).

## **2.14 Summary**

This chapter described what is really meant by patient-centered care and what is expected by the patients, family and also the public from the service providers and policy makers.

## **CHAPTER 3**

### **Research methodology**

#### **3.1 Introduction**

This chapter describes the methods and procedures used to conduct this research study. The research design, research paradigm, research setting, population, sample selection, trustworthiness and data collection are explained, and ethical considerations are outlined at the end of this chapter.

#### **3.2 Research design**

This study was conducted within the interpretive paradigm, using a qualitative exploratory descriptive design (Cormack, 1991).

A qualitative approach is used when researchers want to explore the meaning of a phenomenon and get an in-depth or deeper understanding of the phenomenon (Cormack, 1991). In this study the researcher wanted to explore the meaning of how student nurses understand patient-centered care.

Exploratory studies aim to make some kind of investigation about the unknown or new insights about a phenomenon. According to TerreBlanche, Durkheim and Painter (2006), exploratory studies employ an open, flexible and inductive approach to research. This exploratory study seeks new insights in the form of how patient-centered care is perceived by student nurses.

The goal of a descriptive design is to describe the phenomenon of interest accurately. In this study, student nurses describe their perceptions about patient-centered care during focus group interviews (Cormack, 1991).

### **3.3 Research paradigm**

An interpretive paradigm underpinned this study. It aimed to create meaning by explaining and describing perceptions in order to make sense. Methodologically, there was interpretation and interaction between the researcher and the participants. Within this paradigm, intersubjectivity (mutual recognition) between the researcher and the participants was fostered and valued. The underlying assumption of an interpretive paradigm is that the whole needs to be examined in order to understand a phenomenon. Interpretivism seeks to collect and analyze data from parts of a phenomenon (Weaver & Olson, 2005). This paradigm was chosen because neither the researcher nor participants could conclude whether patient-centered care was rendered or not without examining the situation.

### **3.4 Research setting**

The research study was conducted at two different psychiatric institutions situated in the uMgungundlovu district in KwaZulu-Natal. The two institutions were specifically chosen because they are where the students from various campuses are placed to do their practical psychiatric training. The two institutions differ in that one is an ordinary psychiatric institution and the other is the only forensic psychiatric hospital in the province. The interviews were conducted in the halls of each psychiatric institution.



### **3.5 Target population**

The target population consisted of fourth year psychiatric nursing students who were doing the four year course diploma programme at the psychiatric institutions in the uMgungundlovu district. This target population was chosen because they are exposed to the theoretical instructions in mental health nursing and should therefore have an understanding of what is required in the wards in which they have been placed. For the interviews, the participants were allocated randomly to groups A, B and C.

### **3.6 Sample selection**

Purposive sampling was done. This was based on the belief that the researcher's knowledge can be used to hand pick sample members (Polit and Beck, 2004). The researcher decided to purposely select 24 subjects who were judged to be typical of the population, or particularly knowledgeable about the issues under the study (Polit and Beck, 2004). There were three focus groups with eight student nurses in each group. In selecting participants for a focus group, the researcher selected a homogeneous group because the goal was to encourage individuals to share their ideas and perceptions (Polit and Beck, 2004). The participants in this study were homogeneous in the sense that they were all fourth year students doing the same psychiatric module and allocated to psychiatric institutions. The participants did differ in some respects, however, in that there were both males and females, although there were more females, and they came from different race groups and had been allocated to different wards. Because the participants had been allocated randomly to the groups, the groups were made up of both sexes and participants from different institutions.

### **3.7 Data collection and tool**

According Krueger (1994), focus group interviews were born the late 1930s by social scientists who had doubts about the accuracy of traditional methods of information gathering. This method was useful and of practical advantage because it allowed participants to share their thoughts with each other. New ideas were generated and a range of ideas were considered before the research questions were answered. The interviews were tape recorded with the permission of the participants. Krueger (1988) suggests that the researcher must encourage one participant to speak at a time to avoid garbling the tape. The recorder was set up prior to the interview and was visible to the participants. As soon as possible after the completion of an interview, the tape was replayed, with the researcher listening carefully to the content as well as to the questions asked and the participants' responses (Morse and Field, 2002). The tapes were transcribed to avail a text to assist with the data analysis of the interviews.

### **3.8 Collecting and recording data**

Data collection began immediately after ethical clearance had been received from the Ethics Review Committee of the University of KwaZulu-Natal, the Principal of KwaZulu-Natal College of Nursing, the Principal of the campus and the Research Committee of the Department of Health. Because I had chosen purposive sampling, it did not take long to get all the participants ready.

Three groups of eight were interviewed to increase the researcher's confidence in data saturation. In-depth interviews were conducted which lasted about forty five minutes. The purpose of the study was discussed with the participants and their consent to participate obtained. Participants were given a research study information sheet (AppendixA) with detailed information about the

purpose of the study and contact details of the researcher and supervisor. This took place before the interviews and they were given time to think about the purpose of the research before the interview. A guide with questions relating to the research objectives was on hand. Interviews were then tape recorded. It was ensured that the record tapes were the correct length for the interview and labeled with the date and time to prevent recording over data, and as a reference point for transcribing (Bramley, 2004).

### **3.9 Data analysis method**

According to Braun & Clarke (2006), thematic analysis is a useful and flexible method for qualitative research as it is suitable for identifying, analyzing and reporting patterns (themes) within the data. The following six prescribed steps were followed:

- Familiarizing self with the data, whereby the data is transcribed, read and re-read, noting down initial ideas.
- Generating initial codes whereby the interesting features of the data are noted in a systematic manner across the entire data set by collating data relevant to each code.
- Searching for themes whereby potential themes are collated by gathering all data relevant to each potential theme.
- Reviewing themes whereby a thematic map of the analysis is generated to check if themes work in relation to the coded extracts.
- Defining and naming the themes whereby ongoing analysis refines the specifics of each theme in the overall story the analysis tells, and clear definitions and names for each theme are generated.

- Producing the report, which is the final opportunity for analysis. It involves the selection of vivid, compelling extract examples, final analysis of selected extracts, relating back of the analysis to the research question, study objectives and literature, and finally producing a scholarly report of the analysis.

### **3.10 Trustworthiness**

Lincoln and Guba's model (1985) identified four aspects of trustworthiness. These are credibility, transferability, dependability and conformability.

#### **3.10.1 Credibility**

To ensure credibility the researcher spent some time in the institutions where the research was going to be conducted. The participants had developed a perception of the research topic, namely patient-centered care. The individual viewpoints and perceptions were verified against each other. Credibility was ensured by continuously listening to the interviews and comparing them to the verbatim transcripts to ensure that both were saying and meaning the same.

#### **3.10.2 Transferability**

Transferability is the extent to which the findings of study can be applied to other situations. However, since the findings of qualitative projects are specific to a particular environment and a small number of participants, it is impossible to demonstrate that the findings are applicable to other situations and populations. Lincoln and Guba (1985) suggest that it is the responsibility of the researcher to ensure that sufficient information about the research is provided to enable the reader to make such a transfer.

### **3.10.3 Dependability**

Dependability was ensured by employing techniques that if the same work is repeated in the same context, with the same methods and with the same participants, similar results will be obtained. Lincoln and Guba (1985) stress that the processes within the study should be reported in detail.

### **3.10.4 Conformability**

Conformability was ensured in that the findings of the study were the result of the perceptions and ideas of the participants, rather than the characteristic preferences of the researcher.

### **3.11 Ethical issues**

Polit and Beck (2004) point out that when humans are used as study participants, which is often the case in nursing research, care must be exercised in ensuring that the rights of those human are protected. In this study, a fair, proper, acceptable, human and accountable approach which considered the ethical responsibility of protecting the rights of the participants was followed. The following principles were considered: permission, informed consent, risk-benefit ratio, right to decide to participate, and right to privacy. The aims and purpose of the study were verbally explained in detail to the participants when they were first approached and they were informed that they could ask whatever questions they had concerning the study. They were invited to consult to my supervisor if they felt the need, but no one had any questions. All the participants were asked to sign an informed consent form. It was explained to them that participation in the study was voluntary and they had the right to withdraw at any time. Participants were assured of confidentiality. No one had access to the material with their information, except me and the research team. Their names did not appear on any information.

### **3.12 Data management**

Hard copy biographical data and transcribed interviews are stored in a locked cupboard in the researcher's office. This data will be stored for five years. Identifying names and places were removed from all transcripts. The tape recorder and cassettes are also stored in a locked cupboard and will remain there for two years before being destroyed if the results of the study are published and for five years if there is no publication from this study.

### **3.13 Data dissemination**

After the completion of the study, copies of these findings will be sent to the University of KwaZulu-Natal faculty, the University of KwaZulu-Natal library and the KwaZulu-Natal College of Nursing.

### **3.14 Summary**

This chapter outlined the methodology of the study. It described the design of the study, the research setting, the target population and how the sample was selected. The method of how the data was collected and recorded was also explained. Trustworthiness and ethical considerations ensured .

## **CHAPTER 4**

### **Findings and discussion**

#### **4.1. Introduction**

This chapter presents the results based on the three focus group interviews held at the selected psychiatric units in the uMgungundlovu district. The interviews took place at both institutions. This study seeks to explore and describe how student nurses perceive patient-centered care in the psychiatric units to which they've been allocated in the uMgungundlovu district. The results of the three interviews that were conducted indicate that all three groups had very similar perceptions of patient-centered care. For the purpose of clarity and easy identification, I have tagged the relevant groups A, B and C and will refer to them accordingly. The responses given by participants in the focus groups will be presented thematically. Excerpts from the focus group interviews are italicized.

#### **4.2. Safety and Security**

One of the themes that emerged from the focus groups is the role of safety and security in promoting patient-centered care.

##### **4.2.1 Cameras as security devices**

When asked about how they perceive patient-centered care, participants in focus group B stated that installation of security devices such as cameras were essential to ensuring that patients are cared for in a therapeutic environment. In affirming that security enhances a therapeutic

environment for the patients, one of the participants pointed out that “*there are cameras from which the security is watching the patients while they are in their dormitories which make it therapeutic for the patients as they are unstable. The staff is always there to guide them*” (Transcript B, lines 367–379). This extract can be interpreted as expressing the significance of cameras in providing a more secure environment in which patients feel comfortable, relaxed and confident. Thus, cameras not only enhance the overall safety of patients, but also contribute towards stabilizing their health. This finding is supported by Koivisto et al (2004), who maintain that a turbulent and insecure environment is a hindrance to patient-centered care.

The view of another participant captures how they have constant supervision in the dormitories. The participant pointed out that cameras make it possible for those in charge to keep a constant watch over the patients. According to Desai (2010), cameras that monitor patients are used as tools for managing safety within mental health hospitals as they make hospital environments safe and secure for patients, staff and visitors. Although the installation of cameras is a financial strain on the Department of Health and patients have been known to assault staff when realizing that they are being watched, there are definitely positive aspects. Cameras can pick up patients abusing each other, patients collapsing and patients dying.

One aspect about cameras that the staff did not like was that their activities were also being monitored while they were interacting with the patients. Line managers use cameras to observe their practices and it can be a perfect disciplinary apparatus which provides information on what is happening in the ward and the relationships between patients and staff.



#### **4.2.2. Locking of gates**

Another security measure at the hospital which the participants noted involves locking the gates. According to the participant, this practice *“is therapeutic too because the staff is always with the patients if they are there and they make sure that no patient going out without anyone knowing”* (Transcript C, lines 816–818). From the foregoing, it is ostensible that participants whose excerpts have been cited perceive that cameras in dormitories and the locking of gates contribute to the safety of patients, thus making the environment primarily patient-centered. According to Dickison (2010), however, the locking of gates can have some unintended consequences. The terrified staff in one Ipswich mental health hospital unit threatened to strike after the patients kicked down the security doors, threatened to kill the staff and trapped the nurses in locked rooms. Nurses were breaking down and crying. In this case, the locking of gates had a negative effect on the mental patients, confirming to them that others perceived them as dangerous, when in reality

the locked gates were merely protecting them from roaming around and getting lost.

Apart from the security cameras and the locking of gates, the participants also listed other efforts geared towards providing a safe environment for patients.

#### **4.2.3 Labeling of the different areas in the ward**

One of the participants explained that labeling all the rooms used by patients helped to make her ward a therapeutic environment. This included labeling all common rooms, as well as individualized rooms. She captured this view vividly: *“...I can say from my ward I’m working in an open ward. ... I can say the environment is therapeutic because I can speak about ... the levels ... like... each and every room is written room five or room one or room two... the*

*bathroom is written bathroom, TV room*” (Transcript B, lines 380–384). According to this participant, labeling the rooms is therapeutic in that patients will not become frustrated trying to locate where they want to go. This approach echoes the views of Watkins (2001) who believes that patient-centered care is about maintaining a balance within the individual and their interaction with the environment.

When asked to provide further explanation as to why the rooms are labeled, the following excerpt from one of the participants was quite illuminating: *“when the patients, are mentally unstable. Maybe he forgets where he is and his room or dormitory, it can be easy for him to identify his room, this is my room five, or where my dormitory is”* (Transcript B, lines 386–389). It seems that the main focus of the nurses is to make the patients stay in the wards as comfortable as possible and labeling rooms is one of the ways they deem appropriate to achieve this objective.

#### **4 .2.4 Marking individual property**

The excerpt above shows that a therapeutic environment involves labeling doors with patients’ names for easier identification or recognition. The nurses believe that labeling items such as towels and toothbrushes not only protects the health of the patients, but also makes it easier and more comfortable for them. This is explained by one of the participants, *“In my ward, during baths what I noticed is that the patients have their own bath towels and tooth brushes with labels so that they must not share with each other to prevent some of the cross infection”* (Transcript B, lines 453–455). Corroborating this point, another participant noted, *“Also my ward their towels are labeled with their names I think that is also therapeutic so that they don’t bath with somebody else’s towel. And also the tooth brushes are labeled and, when they have to be*

*transferred from their ward to another one they go with those things*” (Transcript C, lines 801 – 804).

The foregoing is supported by Barker (2003) when he suggests that within psychiatric nursing, patient-centered care involves putting people at the centre of nursing care. According to Watkins (2003), the level of wellbeing depends on the maintenance of equilibrium within the person, and the person’s interactions with the changing environment. In this study, the participants are suggesting that labeling of rooms and personal items enhances the wellbeing of patients, and therefore contributes to a therapeutic environment. (Watkins 2001). Clearly, through the labeling of rooms and other items, patients are able to achieve a certain level of equilibrium, not only within themselves, but also with their environment. Additionally, the practice of labeling also contributes towards creating an hygienic environment, which is a vital part of patient-centered care, as highlighted by one of the participants, *“There are, diseases which are transferred through those carelessness of sharing toothbrushes and towels”* (Transcript B, lines 457–458). According to this participant, the practice of labelling individual items mitigates the spread of diseases among patients.

#### **4 .2.5 Placement of patients**

Apart from the abovementioned practices which enhance the safety and security of patients and are thus central to therapeutic environment, the participants also highlighted some practices which do not promote a therapeutic environment, which may be very broadly dubbed unsafe practices. All participants in group B agreed that mixing patients of different ages in a single area is not therapeutic for patients and goes against the principles underlying patient-centered care. One of the participants, in particular, revealed that nurses were mixing older patients with

very young patients, a practice that the younger patients found very intimidating. She explained, *“I noticed that when giving treatment to the patient if you focus to the age ... we come across a person that, is said to be , above eighteen whereas the person is fifteen years and then they put that person of fifteen years to the people who are thirty-five and above. That means you are exposing that person to even sexual abuse because they have been loaded in the same room* (Transcript B, lines 569–574). In addition to mixing patients of different ages in the same room, patients who had been in the wards for a long time were being mixed with new patients. This practice, according to the participant, is unfair, mixing *“the people who are admitted for the first time and those who have been admitted for a long period of time is not therapeutic”* (Transcript B, lines 576–577). Perplexed by this practice, one of the participants asked, *“How come the actual age is not asked from the patient?”* (Transcript B, line 578). When the interviewer probed further on whether age is considered when wards are allocated, all participants in group B gave a chorus response that age is not considered when patients are allocated to wards.

## **4.3 Hygiene**

### **4.3.1 Clean linen**

Maintaining a clean environment for patients was another important concern raised. According to the participants, cleanliness is an important factor in maintaining a safe, therapeutic environment. The participants explained that it is important to keep the bathrooms clean and change the linen regularly, as these contribute to maintaining the general health of the patients. *“And also there are days that are allocated for the change of linen so that they don’t use the same linen throughout from Monday to Friday. So each and every week the linen is changed.”*

(Transcript B, lines 466–469). By providing these services, nurses are providing value-for-money services as specified in the Batho Pele principles (Government Gazette 388(18340)).

#### **4.3.2 Clean and dry floors**

Another participant further expressed how putting mats in bathrooms is important since it deters patients from encountering slippery floors which might be dangerous to their health. As one participant put it, *“In my ward, I saw that the ward is therapeutic because in their bathrooms there are mats, and sometimes they put something that will prevent the patients from slipping”* (Transcript B, lines 462–464). It is a patient’s right that they should be provided with a safe and clean environment. Therefore, it is imperative that their environment should be as safe and as clean as possible.

### **4.4 Habits**

#### **4.4.1 Smoking**

Another challenge to maintaining a therapeutic environment identified by the participants was the practice of mixing smokers with non-smokers in the wards. According to one of the participants, this practice constitutes a health hazard to non-smoking patients because they were becoming secondary-smokers, which is just as dangerous to their health as if they were smoking themselves. She explained it thus, *“and also something that is not therapeutic to the patients who are non smokers is put together with those that smoke. There is no smoking, nor non smoking area”* (Transcript C, 855–858).

According to Conway (2006), almost all mental health nurses do not want smoking banned in psychiatric wards because they fear that it would spark aggression from patients. Patients use

smoking as a de-stressor and many patients cannot cope without a frequent cigarette. The staff suggests that such a ban would cause mental deterioration and agitation leading to violence and aggression. Some staff favored the ban as it meant that nurses would no longer be exposed to passive smoking. It would also improve the wards' therapeutic environment as smoking is described as dirty, dark and miserable. Smoking kills and can cause physical health problems. According Brookes (2006), smoking is no different to self harm as it is maladaptive behavior that threatens one's health. As the aim of nursing professionals is to provide and promote health and health empowerment to their patients, their natural instinct should be to stop or minimize such behavior or to put in place some form of care plan to protect their patients. To separate smoking and non-smoking areas is not sufficient, as rooms are poorly ventilated, small and still close to the wards.

#### **4.4.2 Sexual behavior**

A more worrying issue concerns the possibility of sexual abuse of vulnerable patients, especially in cases where younger patients are grouped with older ones, as indicated by a participant in Group B *"In the ward that I was working, they were also concerned about this mixing of the inappropriate ages"* (Transcript B, lines 571–574).

According to Ruanne and Hayter (2008), nurses are faced with numerous challenges with regard to the sexual behaviour of those in their care. These authors believe that sexuality is an important part of physical and mental health. They warn, however, that while sexual practice is good for one's health, it must be equitable and it is essential that it is fulfilled with access to information and services to avoid the risk of unwanted pregnancies, illness or disease. They highlight, furthermore, that literature always describes a lack of recognition for sexuality or intimate

relationships amongst patients. Nursing staff sometimes tolerate some sexual behaviours like masturbation and sexual relationships between patients, but these are generally perceived as unacceptable behaviour.

Bartlett, Mantovain, Cratsley, Dillon, Claire and Nigal (2010) maintain the recognition of patients' sexual practices has been actively discouraged as a matter of policy resulting in the sexual behaviors of psychiatric in-patients being ignored. Turning a blind eye to the sexual activity of patients originated from a social climate in which sexual activity was regarded as taboo. Moreover, it was also assumed that people with major mental illnesses are asexual. What became apparent to the above authors, however, is that there was inconsistency across the institutions as to what was permitted or not. In some institutions, patients were given condoms with the approval of the responsible clinician, while in other institutions condoms were not allowed, showing that policies differ between individual service users.

#### **4.5. Promoting patient-centered care through activities**

All participants in the three focus groups agreed that activities and socializing are very important to enabling a therapeutic environment.

##### **4 .5.1 Psycho education**

Furthermore, participants in the focus groups believe that patient-centred care involves creating an environment in which patients are educated and informed on how to manage their illnesses and informed about the medication that they are taking. This is very important in providing a therapeutic environment.

In support of this finding, Brown, William and Griffin (2006) argue that being client-driven involves being both patient-centered and patient-empowering or, in other words, engaging clients to their optimal potential as partners in care. Therefore, it is important for patients to be informed of their care. McCabe (2002) further suggests that patient-centered care involves patient communication which is a basic component of nursing and facilitates the development of a positive nurse patient relationship which, along with other organizational factors, results in the delivery of quality nursing care. This, in turn, promotes a therapeutic environment.

#### **4.5.2 Socializing with visitors as well as with staff and students**

Participants felt that socialization was an important factor contributing to the well being of their patients.

#### **4.5.3 Group activities**

This is well expressed by a participant who explicitly stated that conducting different activities during the week is essential in enabling a therapeutic environment, *“In my ward ...I think therapeutic environment is much ensured because we do daily activities, we even have the timetable where we (do) -different activities in a week. And again our patients are allowed to be visited by their families... they are also allowed to socialize with the staff and as well as with us. And again their privacy is ensured because some sleep in single rooms and others share the rooms of their own choice”* (Transcript B, lines 394 –399).

Another factor was highlighted by a participant in Group B, who noted that the activities make the ward therapeutic because they help patients to be active instead of leaving them idle. This participant explained, *“According to my own opinion, I have seen that therapeutic environment is the main concern of these mental institutions I’ve already worked in. Actually I’ve worked in*



*both institutions and I've noticed that as students, we are given opportunities to perform some activities so as to make the ward therapeutic and that helps the patients to stay live".* (Transcript B, lines 417–421).

According to Uys and Middleton (2004) , patients should be able to choose what they would like to do as it enables them to participate in activities in which they find meaning. There should be a variety of activities available to enable patients to investigate various work related activities with a view to possible employment at a later stage. These activities also contribute to developing social and expressive skills. Patients, however, should not be taking part in activities to the advantage of the institution.

A participant corroborated the value of activities by stating that patients cannot become lazy or idle in an environment that is imbued with activities, *"Yes. I think that helps the patients not to sleep around because it's an open ward. Rather sleeping in the sun, that makes them do something"* (Transcript B, lines 449–450). Laziness and idleness creates a situation whereby patients spend most of their time sleeping; a practice that is not good for their general well-being.

The following excerpts point to the various ways that nurses can facilitate activities among patients:

#### **4.5.4 Art**

Participants in Group A shared similar views as participants in Group B in that they viewed activities such as drawing will keep the mind busy and, thus promote a therapeutic environment (Uys and Middleton ,2004 .

*“Like to make some drawings which give the meaning to the patient. We help them do things with their hands so as to learn art or sometimes they sing. An effort is made to have different activities every week. (Transcript B, lines 446–447).*

*“Therapeutic does mean some vital things. You can draw something for the patients. When spending time with the patients, there is a lot that can be created. The staff always complains to the management that there is nothing that can be done instead of being creative and the patients know what they want” (Transcript A, lines 88–92).*

#### **4.5.5 Discussion groups**

Discussion groups were identified as an activity that can be beneficial to the patient (Uys and Middleton, 2004). According to one of the participants, *“The activity can include signs and symptoms of relapse which the patient can read and understand so that he or she can be aware when he is got those signs and seek some medical attention. So I’ve really noticed that the staff in this institution is vigilant about patient centered care as far as the therapeutic environment is concerned” (Transcript B, lines 423–428).*

#### **4.5.6 Entertainment**

One of the participants in Group C identified entertainment as important to creating a therapeutic environment. According to this participant watching movies is good for patients because it takes their minds off their illnesses, *“In my ward they also go on Thursdays to watch movies. I think that is therapeutic because they put their minds off being in the ward and concentrate their lives on getting to know the other world” (Transcript C, lines 851–853).*

#### **4.5.7 Physical exercise**

According to Millers and Koop (1994) patient centered care includes the physical needs of the patient e.g. exercises. *“It could be exercises that can be done because while they are exercising, they are able to improve the blood circulation, they use it to stimulate their lungs, and at the same time it helps them reduce weight. It keeps them busy for may be about thirty minutes or so”* (Transcript A, lines 96–100).

#### **4.5.8 Excursions**

*“and one of the things that doesn’t promote the patients care is because most of the time, patients are confined to the rules, may be patients can be taken for outings in order to rehabilitate them, and see that it’s not the end of the world. The outing can play a great deal in their lives”* (Transcript A, lines 102–106).

#### **4.5.9 Lack of stimulating activities**

Despite acknowledging the value of activities in enhancing patient-centered care, some of the participants complained of the paucity of activities at their respective hospitals. Participants from all focus groups echoed concerns over the lack of stimulating activities that can assist patients to become rehabilitated. According to a participant from Group A, every day was much the same in the wards and the daily routine was not conducive for the quick rehabilitation of patients, *“And the other thing that worries me is the routine that the patients wake up in the morning they eat breakfast, sit, watch TV and have lunch. I wonder if that is how it is supposed to be, there are no activities that the patients are involved in, and I don’t see how that will lead to recovery or*

*rehabilitation of the patients. In one of the wards I was in, they don't even do their beds and they are not encouraged to make them, so really they do nothing. They just eat, sleep, and even one of the patients mentioned that we are just here to eat and go to bed. And because the patients are sleeping the whole day they want to go home. They don't see the reason for being institutionalized. So that is not so nice to the patients"* (Transcript A, lines 280–292).

This was confirmed by another participant who described how most patients spend most of their time watching TV, eating and sleeping, which is not very healthy for them. The participant pointed out the lack of stimulation by commenting that patients *"like formulating things like the football team because most of the patients like football but there is nothing that is happening inside the institution to make them whole"* (Transcript C, lines 830–832). This issue was echoed by another participant from Group C who said, *"Like that point of the limited activities, I agree nothing is stimulating them"* (Transcript C, lines 825–826).

#### **4.6. Attitudes of nurses towards patients**

Another central theme that emerged from the focus group discussions had to do with the attitudes of nurses towards patients when interacting with them. The view expressed by a participant in group A indicated that it is important for all staff members to communicate to patients by reducing themselves to the level of the patients, *"one thing that one might suggests, is the staff members coming to the level of the patients. When the patient comes to the nurse, be able to communicate with and help out the patient and thus make the patient feeling more at home"* (Transcript A, lines 123–127).

According Uys and Middleton (2004), an emotional climate can be created by the negative attitudes of the staff. Negative attitudes lead to anti therapeutic behaviour such as rigidity, teasing, withdrawal and the formation of cliques.

#### **4.6.1. Communication style/techniques**

Accordin Uys and Middleton (2004) , the staff should show active friendliness by taking the initiative in interactions and showing interest in each patient. The patient, in turn , respond positively to the staff. The interaction should be casualness and informal to establish a comfortable pattern. There should be open communication channels between the staff and patients, staff and staff, and patients and patients. Each person is be considered to be an important source of information and therapy, and therefore, be fully informed and involved. There should be no secrets. The staff must be able to accept frank communication and acknowledge their faults.

#### **4 .6.2 Building a therapeutic trust relationship**

The excerpt in 4.6 above, points out that when nurses interact with patients on the same level, it fosters a relationship in which there is trust, and in which patients feel comfortable in disclosing their problems to staff or their caregivers. It follows that this, in turn, enables nurses to help the patients with their problems. This view is supported by Joffe, Macocchia, Weeks, and Cleary (2003) who argue that patients in hospital value trust, respect and autonomy. These authors emphasize that trust, respect and autonomy should be given attention in ethical models of healthcare. Therefore, by fostering a relationship of trust and being considerate about patients' needs, patients will realize that healthcare providers respect them. According to Millers and

Koop (1994), patient-centered care includes the physical, emotional, social and spiritual needs of the patients.

#### **4 .6.3.Respecting patients’ privacy**

According to one of the participants, creating an atmosphere in which nurses show interest in the patients can promote patient-centered care. According to this participant, it is easier to engage with the patients when a relationship of trust is built through maintaining their privacy, “*we ... (want to) learn more about them so that’s why it’s easier in maintaining the privacy*” (Transcript A, lines 180–181). This is also supported by Joffe, Macocchia, Weeks, and Cleary (2003) who state that patients in hospitals value trust, respect and autonomy. Privacy is an ethical concern that should be taken seriously in hospitals. When a relationship of trust is created and when patients trust that staff members are taking their needs into consideration, patients will realize that health care providers respect them. Respect and dignity are central to a trustworthy relationship (Millers and Koop, 1994).

A way that privacy is realised, according to one of the participants, is by ensuring that each patient have their own locks, “*And let me add to that point, I notice that therapeutic is more promoted here because each and every person having her own lock and they are using their own keys to open it. That means that each and every person is treated individually*” (Transcript B, lines 410–412). To mitigate cases of misplaced locks, “*each and every person has his own keys and then they are having loops that they can hang it over to their necks*” (Transcript B, lines 414–415).

#### 4.6.4 Staff superiority

Participants stressed that most staff members take their positions of authority to the extreme in that they exercise their superiority. The following excerpt captures this lucidly, “*But we remain in that, I don’t know if I can call it superiority or what, she will say I am the staff member and you take my orders and my orders are these without seeing that the patient, is comfortable, what is it that makes him not comfortable, may be the patient is sick or there is a problem that he is carrying. And we can be able to help out the patient*” (Transcript A, lines 128–132). Therefore, patients end up not feeling comfortable in communicating or sharing their feelings with them. As a result, this leads to an untherapeutic environment, thereby defeating the whole purpose of patient-centered care. The atmosphere that nurses create in the wards by exercising unnecessary power on patients often leads to situations in which patients are frightened to share their feelings. The participant pointed out that nurses should “*really come down to the level of the patients*” (Transcript A, line 132). The insight being expressed here is also supported by Koivisto et al (2004) as cited in O’ Donovan (2007), who claim that the atmosphere in the ward may impede patient-centered care; a turbulent insecure ward environment can leave clients feeling frightened.

The participants also pointed out that communication is the key to making patients comfortable with the staff. This view is shared by McCabe (2002) who argues that patient-centered care involves patient communication which is a basic component of nursing and facilitates the development of a positive nurse-patient relationship. This, along with other organizational factors results in the delivery of quality nursing care. Interestingly, in a study in Finland, Twinn (1995) observed that clients are found to be more relaxed when they are with student nurses because they are more supportive than permanent staff.

#### **4 .6.5 Welcoming atmosphere**

One of the participants in Group A stated that some staff members do not make patients feel at home. She went further to explain why there seems to be a closer connection between student nurses and patients, *“when we are introduced in the ward they introduce us as patients these are the new students from so and so college, they’re coming to do their work for the next so many weeks. So immediately in their minds when they are told these are the students they know that we are inferior to the staff so we are the closest level to them and that makes it easier for them to talk rather than going to the big guys on top”* (Transcript A, lines 162–167).

#### **4 .6.6 Language barrier**

A hindrance to effective communication between patients and nurses is the language barrier. One of the participants pointed out that a lack of effective communication as a result of language barriers interfered with patient-centered care, *“And in my unit, from the old grannies that side, there life is a burden. Most of them they are Afrikaners and so we can’t communicate with them nicely because they don’t understand English, I don’t understand Afrikaans. Therefore they just sit there and I would sit on the other side”* (Transcript A, lines 293–296). Participants showed that it was immensely difficult for them to provide effective services because most of the patients spoke Afrikaans and the nurses are not well versed in this language. Not fully understanding what was required of them made it difficult to provide quality health care to these patients. The participants acknowledged that this is a limitation on their part, as nurses, in providing the basic services required. As a result the of language barriers, patients become alienated and no relationship of trust develops between them and their care givers.



According to Trnobranski (1994), a nurse-patient relationship which fosters the involvement of the patient in negotiation and decision making regarding his or her care is very important. This author argues that patients need to be aware of what is being discussed with them. Latvala, Janhonen and Moring (2000) argue that psychiatric nurses need to listen carefully to their patients to understand their needs concerning their daily life. This can only be achieved through communication in a language that is understood by both parties.

Although much of the literature pertaining to nursing in South Africa emphasizes that competent nurses should be sensitive to cultural differences, very little attention, however, is being given to multilingualism and the need for nurses to be able to speak more than one language (Ndimande, Hlongwa, Balfour, Mkhize and Engelbrecht, 2008). These researchers maintain that it is important for nurses to know different languages because being able to communicate in the same language as their patients influences the working relationships of the team.

#### **4 .6.7 Individualized care**

Participants identified that patients should be perceived as individuals who need individualized care. They felt that giving individualized care was important in creating a therapeutic environment. As one of the participants claimed, “*We nurse them as an individual*” Another participant explained that they provide individualised care to every patient instead of treating them as a group, “*it’s individualized so we try and meet each person for their needs, we don’t take them as a group and nurse them as a group*” (Transcript C, lines 914–915). This is in line with the arguments put across by other researchers who argue that by knowing the patients as

individuals, students gain insight into their circumstances, needs and desires and, thus, provide better nursing care (Seed, 1994; Fagerberg and Kihlgren, 2001).

#### **4 .6.8 Respect and dignity**

Another attitude that was identified by the participants was that patients should be treated as human beings who have certain rights. The participants pointed out that patient-centered care focuses on respecting the rights of the patients, and that respect and dignity should be given to patients at all times. Recounting her experience of working at the hospital, one of the participants noted, *“What I can say? here is, looking at this ward and the other wards I have worked in, I think the rights of mental health care users are not violated”* (Transcript B, lines 480–482). According to this speaker, the rights of patients have not been violated in the hospitals she has been allocated to.

#### **4 .6.9 Patient rights**

When prompted to highlight some of the patient’s rights , one of the participants noted, *“Like the right of being treated with dignity. That’s what we do to mental health care users and a right to safe environment. They are locked in and we watch them now and again to ensure that they don’t injure one another or prevent any harm in the environment”* (Transcript B, lines 487–489). Patients should also have the right to make choices. This entails that they can choose to go home if they want to. Koivisto, Janhonen, Vaisanen (2004, as cited in O’Donovan, (2007), are in agreement with this practice. They state that individuals with psychosis want the space to decide about their own matters and not be coerced. These researchers further state that when individuals are restrained without being told why, or offered an alternative without explanation, it leaves

them feeling humiliated and fearful (Koivisto, Janhonen, Vaisanen 2004, as cited in O'Donovan, 2007).

Patients also have the right to privacy and it is up to the nurses to ensure that they do not walk around naked, *“And another right is that of privacy because we don't allow patients to walk naked to in and out of the bathroom.. At least he must have towel to cover his private part or breast”* (Transcript B, 501–504).

Patients are made aware of their rights by means of posters on the walls, which are written in various languages to make it easy for them to read and understand, *“And to add, patients' rights in most of the wards they are put on the wall in different languages so that all the patients must read and understand their rights”* (Transcript B, lines 493–495).

All patients, according to one of the participants, are taught about their rights by the nurses. The following excerpt captures this lucidly, *“There is a right that is specific for that month. The patients are taught and recorded in the book. All the patients then are expected to know their rights”* (Transcript B, lines 497–500).

Participants noted that there are instances where the rights of the patients are not respected. According to them, the violation of patients' rights can impede the creation of a therapeutic environment.

#### **4.6.10 Violation of patients' rights**

Some of the participants told of patients being beaten as punishment for wrongdoing and that such acts were routinely performed by members of permanent staff, *“I want to add on the right of the patients. The patient are psychotic sometimes they do wrong things but I don't think it is*

*right to hit the patient but you find that in other wards is the routine to beat patients*” (Transcript B, lines 557–561). This participant added that the student nurses were unable to intervene because of their position, *“As a student you don’t have anything to say about that”* (Transcript B, line 563).

This apparent disempowerment that student nurses experience has been stressed by Barker (2000), who states that though nurses wanted to provide patient-centered care their hands were tied due the structure, nature and function of the admission units. Similarly, Johns (1999) points out that nurses are not free to fulfill moral obligations to the patient without considering organizational and professional implications.

Punishment of patients was also highlighted by participants in Group B. They had observed that in certain instances the nurses did not exercise the punishment themselves, but authorized one of the patients to beat another. *“To add on that the staff don’t even beat the patients themselves, they order the other patients to beat those they feel are naughty”* (Transcript B, lines 566-567).

#### **4.7 Lack of resources**

The lack of resources was highlighted as an issue that prevents nurses from fulfilling their moral obligations to patients. According the participants, there is an acute shortage of requisite resources to carry out their tasks. The participants put the blame primarily on management for not making enough funds available to ensure the smooth running of the department, *“If the people at the top management can provide funds, enough resources, and have enough well paid staff, then there won’t be a problem with therapeutic environment being brought to the required standard”* (Transcript A, lines 43–46). This finding is supported by Hau (2004), who states that

the lack of resources is one of the factors that impact on the relationship between nurses and management. While nurses are striving to improve the quality of service, the goal of management is on how to cut costs.

#### **4.8.Understaffing**

On the same note, the issue of understaffing in the wards was raised. Nursing staff are being overworked in terms of their ration of patients in the ward and are dissatisfied with their jobs, which may well explain the negative attitudes of staff towards patients. This is consistent with Brown, William and Griffin (2006), who argue that there are system level barriers that impede service delivery in the hospitals, including governmental financial constraints. Chiovitti (2008) adds that there are also barriers being experienced at organizational level which obstruct nurses' efforts to incorporate client centered and client empowering care and these include centralized allocation and control of service delivery.

#### **4.9.Organizational conflict**

Thus, the conflicting relationship between nurses and management around resources continues with nurses trying to get as much as they can for the patients and managers trying to save as much as they can for the service (Hau, 2004). This conflict prevents them from working together to achieve the same goal of providing patient-centered care. According to Brown, William & Griffin (2006), managers who continue to exercise centralized allocation and control of scarce service resources send a mixed message to nurses, undermining their ability to confidently enact a client-centered partnership.

#### **4.10 Patient involvement in decision making**

It is important to emphasize that allowing patients the liberty to participate in decision making is in line with Trnobranski (1994), who argues that a relationship should be fostered between nurses and patients in that patients should be involved in decision making regarding their care. According to Titchen (2001), mutuality between patients and nurses creates trust between them and facilitates the patients' treatments. This insight is also supported by Latvala, Janhonen and Moring (2000), who suggest that psychiatric nurses need to listen carefully to the patient to understand their needs concerning their daily lives, a practice that is performed through participatory dialogue. It is also reaffirmed by the eleven Batho Pele Principles which hold that patients have the right to be given value-for-money services (Government Gazette No 18340, 1997). .

Despite participants emphasizing the need to involve patients in the decision making process pertaining to their care, participants highlighted instances where the views of patients were completely ignored. Participants in group B expressed a concern that patients in the psychiatric wards are not often involved in the decision-making process concerning the treatment that they receive. One of the participants said that doctors were not taking time to listen to the patients in terms of their medication and were making decisions regarding medication without consulting the patients, *"I can say patients are not involved in decision making because one of the patient was complaining that the doctor just changed a medication without notifying her and she was not happy about the new medication"* (Transcript B, lines 541–546). As a result, this dampened the relationship between nurses and patients in such a way that patients would refuse to take medication. Rather than the care being centered on patients, doctors become the center of the

treatment. This, according to Byrne and Long (1976), as cited in Thistlethwaite and Jordan, 1999), is an obstacle to patient-centered care.

A situation such as this not only negatively affects the wellbeing of patients, but also interferes with the aim of creating a therapeutic environment for them. This is captured by the following excerpt, *“To add on that, it creates problems between patients and staff because in the morning when medication is given the patients will refuse to take the medication because she’ll say this is not my medication, I know my medication. Why is it changed without me being informed”* (Transcript B, lines 457–549). According to Brown, William and Griffin (2006) , being client driven involves being both client-centered or focused on clients, and client empowering or engaging clients to their optimal potential as partners in care. McCabe (2002) argues that patient centered-care involves patient communication which is a basic component of nursing and facilitates the development of a positive nurse patient relationship, which along with other organizational factors results in the delivery of quality nursing care.

Clearly, each person has intrinsic worth and has the right to participate in decisions that ultimately affects his or her own life. Allowing patients to participate in such important issues is central to treating them with respect and upholding their dignity. According to Trnobranski (1994), nursing literature widely promotes the importance of a nurse-patient relationship which fosters the involvement of the patient in negotiation and decision making regarding his or her care. Literature supports the view that patients should be involved in decision making instead of being taken for granted simply because they are being treated in psychiatric ward. Denying patients the opportunity to participate in decisions that affect them and refusing to provide the appropriate structures to ensure this ultimately go against the basic goal of putting the patient at the centre of health care, which is what patient-centered care is all about. The extract above

expresses how neglecting to involve patients can interfere with patient-centered care. According to Robertson (2010), patient or family-centered care places an emphasis on collaborating with patients of all ages and their families, at all levels of care and in all health care settings. Families are essential members of care and the care giving team. Family members can be called upon to make decisions on behalf of the patients when they are not capable of making decisions themselves.

#### **4.11. The place of family in patient-centered care**

Another central theme pointed out by participants in the focus groups is how involving the family can enhance patient-centered care. It was also pointed out that nurses should promote a therapeutic environment by ensuring that the patients socialize with their families. This entails creating opportunities whereby family members are encouraged to come and engage in various social various activities during the week, *“And again our patients are allowed to be visited by their families and staff is also allowed to socialize with them and as well as with us”* (Transcript B, line 396-399). Maintaining contact with their families, either physically or telephonically, not only reassures patients that they are cared for and loved, but also helps alleviate the feelings of loneliness and isolation brought about by the separation from their families, *“The families are always advised to visit the patients because some of the patients have been here for so long. The patients sometimes show the signs of depression because they are missing home”* (Transcript B, lines 647-651).

One of the participants also pointed out that in view of the fact that some of the patients have done considerable harm in the family prior to being admitted in the hospital, involving the family in their care and rehabilitation is also a healing process for the family, *“ Some patients are admitted because they have caused violence at home, and the family is still very angry with them because they don’t understand the person’s action like this is because of mental illness and*



*they will be scared to accept the patient back home. So they probably like back off and they leave it totally for the doctors and nurses take care of the take care of their patient. The family will only phone and check up on the patient but will rarely come and visit the patient”* (Transcript B, lines 957-966). By involving the family, they will come to see and appreciate the condition of the patient, which often leads to an acceptance of the patient’s condition - a central part of the healing process. It also helps in eliminating the feeling of unworthiness felt by most patients. This feeling of unworthiness, according to Olofsson and Jacobsson (2001), is a hindrance to patient-centered care.

One of the participants pointed out that in light of the harm that the patient might have caused in the family, patient-centered care entails counselling the family to help them accept the patient back home when the time comes for them to be released back to the family. The following excerpt captures this remarkably well, *“If he goes back now is he going to be comfortable? Is the family willing to accept him back for those few days or will still have those grudges? The report is written if they can send him back or not”* (Transcript A, lines 266-278). This strategy seeks to avoid a situation whereby patients who have experienced significant improvement are not sent back to a hostile environment that might have negative impact on their wellbeing and is, thus, significant in patient-centered care.

#### **4.12. Participants’ observations on current practices**

##### **4.12.1 Staff attitudes**

Although participants acknowledged that a caring environment is a prerequisite of patient-centered care, they noted that such an environment was not being created because of the attitudes of permanent staff. Their behaviors as well as facial expressions were not conducive to creating

an environment of care, *“Yes, the permanent staff they have those facial expressions, you know, their gestures, they show that “don’t come near me”. So they find us caring than the permanent staff, in turn we learn more from them”* (Transcript A, lines 178–180). This attitude of permanent staff towards patients alienates them from the patients because even in their mental states, patients can easily recognize that they are not wanted by the permanent staff.

This is echoed by Morin, Patterson, Kurts and Brzowski, (1999); Granskar, Edberg and Frilund, (2001); and Patterson and Morin, (2002) who have found that prejudice and negative attitudes have an influence on student-patient relationships. Other researchers argue that by focusing on knowing each individual as an individual, student nurses can gain insight into patients’ circumstances, needs and desires and, thus, provide quality nursing care (Seed, 1994; Fagerberg and Kihlgren, 2001; White 2003). Students who are aware of patients’ feelings help to create a therapeutic relationship (Johns, 1994). Patients seem to benefit from these therapeutic interactions with students (Richard, 1993; Twin, 1995).

#### **4.12.2 Poor work attitude**

Participants pointed out that a poor attitude to work hindered the provision of patient-centered care. An example of this poor work ethic can be seen in certain behaviours such as inconsistency in the allocation of medications. A participant from Group B expressed how this could be an obstacle to patient-centred care, *“I can say about the treatment; they don’t get it at the same time. Somebody comes early in the morning maybe at seven she will give the treatment and then maybe tomorrow somebody else will give it at nine. Sometimes they are given without food”* (Transcript B, lines 517–520). She explained that such inconsistencies are not beneficial to the

patients and can interfere with an effective therapeutic environment, especially when patients are given medication without food.

This is in direct contrast to the views of Barker (2003), who maintains that within psychiatric nursing, patient-centered care involves putting people at the centre of nursing care. These issues raised by participants regarding health care in the psychiatric wards indicate an approach that is far from being patient-centred. All the respondents were in agreement that nurses sometimes give patients their medication as and when they see fit.

#### **4 .12.3 Unsupportiveness**

Another attitude that participants pointed out as being a hindrance to patient-centered care is that of unsupportive staff. Participants were deeply concerned that when permanent staff are unsupportive, it may interfere with patients' wellbeing. A participant from Group A raised concerns of how patients did not trust permanent staff with their problems because of the uncaring and unsupportive environment they created, *"to add on that, it is true what is mentioned by the colleague. Because we are the students, patients prefer to talk to us than the permanent staff, because they don't get what they want. We find that we can get many problems from the patients as students because they often come to talk to us for their problems. Will find that she has not communicated her problem to any one because the sisters there don't have time to listen to the patients"* (Transcript A, lines 134–141). Similar concerns have also been raised by various scholars pertaining to the service that patients receive from psychiatric hospitals. Latvala, Janhonen and Moring (2000) highlight the need for all psychiatric nurses to listen carefully to the patients in terms of their day to day needs. This, they suggest, will create a mutual relationship of trust in that patients will have confidence in nurses to share intimate details of their personal

problems. According to the above authors, mutual dialogue needs to take place between nurses and patients. Studies conducted by Thorne & Robinson (1988), Jewell (1994) and Ricketts (1996) have all found that one of the issues that interferes with patient-centered care is that nurses often based the patients' decisions on their own values, not considering that their values are not the same as those of the patients. This results in conflicting relationships between patients and staff. A participant from Group A commented that when nurses display attitudes of superiority towards patients, patients stop confiding in them.

#### **4.12.4 Lack of innovation and creativity**

According to a participant from Group A, student nurses were left with the burden of creating an environment that is therapeutic to the patients, *"I will say that leaders of the therapeutic environment are not so creative, they are not even innovative. Most of the time it is the student nurses that come up with the new ideas, change the environment, making it appealing for the for the patients."* (Transcript A, lines 27–31). In addition to the lack of innovation and creativity, it was pointed out that permanent staff members are often very unsupportive in that they do not take time to educate student nurses on what is required of them to create a therapeutic environment, *"it is true because the staff don't take initiative on ...therapeutic environment. Sometimes you ask for something, he or she just says I don't know. That shows that they don't care"* (Transcript A, lines 32–35). The following excerpt from another participant corroborates this claim, *"the staff is not providing the therapeutic environment that is expected or desired but the truth is: the services that are rendered do not give enough facts to be able to render the services and that jeopardize the therapeutic environment for the patient"* (Transcript A, lines 36–43). Additionally, participant five (Group A) stated that student nurses were not being given enough facts to provide value-for-money service as prescribed in the Batho Pele Principles

(Government Gazette No. 18340, 1997) . Similar difficulties experienced by students have been identified by other studies. Thistlethwaite and Jordan (1999) who found that students were rarely introduced to the idea of patient-centered consultation, either through training or observation, during their hospital training and that they were only exposed to the concept when allocated to community clinics where patient-centered care was promoted. Twinn (1995), when conducting a study at a university hospital in Finland where students were receiving practical training, observed that clients were more relaxed when they were with student nurses because they are more supportive than permanent staff. Participants observed that permanent staff members often lack the enthusiasm or zeal to create an environment that is engaging by providing various activities to stimulate patients towards a quick recovery. Various studies have been conducted to discover the reasons behind such negative behavior of permanent staff. According to Olofsson and Jacobson (2001), staff may display negative attitudes towards patients because they believe that since patients were involuntary they do not have to provide them with answers to anything. In their study, Hem and Heggen (2004) pointed that the lack of resources often frustrates psychiatric nurses when they want to carry out their tasks and because they are burdened by complex problems which prevents them from devoting time to individual patients. According to Olofsson & Jacobsson (2001), patients have described feeling unworthy of care, of being completely changed by medication, of not being allowed to express their emotions as normal people and of being viewed as inferior. The findings of this study have raised some interesting concerns why patients might be feeling this way.

#### **4.13 Summary**

Patient-centered care is a collaborative effort involving a patient, the patient's family and the relevant health professionals which is aimed at achieving the common goal of the patient's

recovery. It is placing the patient at the centre of the health care system and developing good services that resolve around them and being responsive to their needs and preferences. This study used Peplau's framework as a guide and focused on interpersonal processes and therapeutic relationships, communication patterns, integration and the roles of the nurse. Three focus group interviews were conducted and the results indicated that all three groups had very similar perceptions regarding patient-centered care. The common themes about patient-centered care were identified and analysed.

The participants, however, highlighted various instances where current practices do not meet their expectations of patient-centred care. According to the findings in this study, permanent staff are not creating an environment that is conducive to patient-centred care. Peplau (1997) identified four sequential phases in interpersonal relationships and is it during the second phase that most problems became apparent. The second phase is when nurse are supposed to help the individual recognise and understand his or her problem. According to the findings, however, this only happens to a certain extent and it appears that only some of the nurses are doing what is expected of them. The superior attitudes of some staff members leave patients feeling alienated. Patient's rights are violated and cases of neglect and violence were also reported. Participants said that patients often identified student nurses as being more sympathetic and turned to them for help and support. The language barrier was also highlighted as a factor impeding effective communication between patients and nurses.

## **Chapter 5**

### **Discussion of findings, recommendations, strengths and limitations**

#### **5.1 Introduction**

This chapter discusses the findings of the study and also includes the recommendations, the strengths and limitations of the study and the summary. Analysis of the data of the three focus groups revealed various common themes which will be presented and discussed.

#### **5.2 Perception of patient-centered care**

Participants explored the patient-centered care provided. They observed that when the doctors come for rounds, although they would sit with the patient for a while, they only discussed treatment with the nurses and never involved the patient or the family. Participants felt that patients need to become more involved in the decisions concerning their treatment. They also felt that a nurse patient relationship needs to be developed to reach a common understanding of the goals of treatment. The participants stressed the importance of being at the same level as the patients, as they had noticed that some members of staff practice extreme authority and superiority. These practices made patients feel uncomfortable so they do not communicate or share their feelings. This is supported by Koivisto (2004), who claims that the atmosphere in the ward may impede patient-centered care and that a turbulent insecure ward environment can leave clients feeling frightened. McCabe (2002) suggests that patient-centered care should involve communication which is a basic component of nursing and facilitates the development of positive nurse patient relationship. When the staff and the students get to know the patients, they gain insight into their circumstances, needs and desires, thus providing better nursing care. The

patients should be assisted from a state of dependency to one of independency. The participants also stressed the importance of patient education, saying that health providers have the opportunity to educate patients about their illnesses. This is supported by Brown, McWilliams and Griffin (2006) when they state that patients should be engaged as optimal potential partners in care. Participants felt that it was important for nurses to understand the meaning of patient-centered care, so they can be aware of what is expected from health providers.

### **5.3 Factors hindering patient-centered care.**

Participants raised some important points that may be the greatest hindrances to patient-centered care. They complained about the inconsistent practices of permanent staff members. In some cases, although the staff are aware of what they are supposed to do, they are not consistent. The administration of medicine was given as an example. Patients were not being involved in decision making and their rights were being violated. Patients were being beaten by the staff or other patients. This may all be due to staff being burdened by complex problems, which is supported by Hem and Heggen (2004) who maintain that sometimes the management is an obstacle in the care of patients. Johns (1999) is in agreement saying that nurses are not free to fulfill moral obligations to the patients without considering organizational and professional implications. The lack of resources is found to be the biggest problem and there is also a paucity of stimulating activities. In summary, the participants raised interesting concerns that are acting as hindrances to patient centered care.

### **5.4 Factors promoting patient-centered care**

The participants concluded that patient centered care can be promoted if the environment is made as conducive as possible and that trustworthiness should be at the centre of the care. This is



supported by Joffe, Macocchia, Weeks and Cleary (2003) when they state that patients in hospital value trust, respect and autonomy. Millers and Koop (2004) state that respect and dignity are the key to a trustworthy relationship.

## **5.5 Strengths**

The strengths of undertaking qualitative study are that it is flexible and that there is greater interaction with the researcher. One of the strengths of this study is that new information was obtained.

## **5.6 Limitations**

The biggest limitation of the study was that it was conducted in only two institutions in the province of KwaZulu-Natal. To gain a more comprehensive picture of patient-centered care provided in South Africa, a national study should be undertaken. In addition, there were more female than male participants. Future research should have the equal numbers of both sexes so as to compare their perceptions.

## **5.7 Recommendations**

### **5.7.1 Nursing Practice**

- There should be adequate time for nurses to identify patients' needs and to educate them on issues related to their illnesses so that they can make informed decisions. Nurses should provide adequate support to the patients and communicate effectively with them, this includes motivating patients and their relatives to be involved and participate in their own treatment and care. It is also recommended that there be constant monitoring and

evaluation of the health care services, especially regarding patients' satisfaction. Patients and their relatives should be encouraged to participate in decision making.

- Barriers to effective communication between staff and patients should be removed by making sure that interpreters are available to doctors at all times, this include emphasizing health education giving to patients and the practice of empathy. The service providers who are able to speak other languages should be flexible enough to help others to communicate with the patients. The culture of patients should be considered. There should be positive interpersonal relations.
- Providing sufficient staff and material resources should receive attention from the authorities. The nursing staff needs management support in the form of debriefing sessions especially in mental health nursing setting as insufficient resources and caring for mental health care users may also contribute to moral distress so that they will be able implement appropriate patient-centered care.

### **5.7.2 Nursing Education**

- The approach of patient-centered care should be included in the training nursing curriculum.
- Improving communication skills of nurses by having language programmes.
- Improving in-service training programmes to include such topics as how to interact with mental health care users and dealing with the stigma attached to mental illness. These measures will go a long way on improving patient-centered care.

### **5.7.3 Nursing Policy Makers**

- It is recommended that policy makers and hospital administrators should allow the psychiatric nurses and members of patients' families to be involved in the formulation of policies.

### **5.7.4 Nursing Research**

- It is recommended that ongoing research be conducted on patient-centered care provided in other hospitals, and in all the other nine provinces.
- A patient satisfaction survey could be conducted to identify whether their needs are met.
- Research should be undertaken on health providers' knowledge and understanding of patient-centered care.

## **5.8 Summary**

The findings suggest that inconsistent practices are the biggest hindrance to patient-centered care. Patients and relatives are not encouraged to become involved in the process of care and lack of information given to patients by health providers contributes to patients' inability to make decisions and choices for themselves. Their rights are violated and the lack of resources interferes with the goal of promoting patient-centered care. Some of the current practices are in accordance with the principals of patient-centered care, which is good. The researcher noticed that different hospitals have different practices, which is why it is recommended that there should be constant monitoring and evaluation of the health care services.

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## **Appendix A**

### **Information sheet**

I, LuntukaziMatanzima invite you to take part in a research study .The purpose of the study is to explore and describe how you perceive patient centered care in your allocated units. The study will be undertaken with strict confidentiality .Names will not be used for the study and your contributions will not affect your work or studies in anyway .You will be required to participate in a discussion with the researcher which last for 30-45 minutes in the hall in the psychiatric unit and the discussion will be tape recorded in order to capture all the information as is, and only the researcher and the external coder and the supervisors will have access to this recorded information. In case you have any questions about the study the researcher or my supervisor can be consulted. The findings will only be used for this study and no other purposes. Please your honest, best opinions will be appreciated. You are free to withdraw from the research study any time you want to without any discrimination. You also have the right to have access to the report or published findings. You do not have to suffer any injury or harm during the research process.

Supervisor: Charlotte Engelbrecht

UKZN-Tel-0312602513

Email HYPERLINK "mailto:–engelbrehtc@ukzn.ac.za" –engelbrehtc@ukzn.ac.za

Thank you

LuntukaziMatanzima

Tel-033-3927564Email-209521226@ukzn.ac.za

## **Appendix B**

### **The Consent Form**

I.....confirm that I was fully informed of the research project .I am aware that my privacy will be safe guarded. That all the information I share with the researcher will be confidential. I also have the right to have access to the report or published findings. I know that I do not have to suffer any injury of harm during the research process. The participation is voluntary and I do not have to suffer an injury of harm during the research process. The participation is voluntary and I have the right to withdraw at any time.

Participation's signature.....

Date.....

Researcher's signature.....

Date.....

Ethics committee contact no.031-2602613

Email – HYPERLINK "<mailto:ximbap@ukzn.ac.za>" ximbap@ukzn.ac.za

## **Appendix C**

### **Interview Structure**

TOPIC: EXPLORING THE PERCEPTIONS OF STUDENT NURSES ON PATIENT CENTERED CARE PROVIDED IN PSYCHIATRIC INSTITUTIONS IN PIETERMARITZBURG, KWAZULU –NATAL PROVINCE.

**PLEASE INDICATE WITH A CROSS(X) IN THE APPLICABLE BOX.**

#### **1. Gender**

Male                  Female

#### **2. Race**

Black                  Indian                  Colored                  White

#### **3. Age. 22 – 40 years**

#### **4. Job title**

#### **5. Ward allocated in**

### **Questionnaire Guide**

#### **1. How do you perceive patient centered care in the following areas?**

- Therapeutic Environment
- In service training
- Observation of patient centered care
- Factors that blocks or hindrance to patient centered care
- Factors that might promote patient centered care



## Appendix D

10 November 2010

Ms I Matanzima  
School of Nursing  
HOWARD COLLEGE

Dear Mr Matanzima

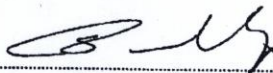
**PROTOCOL:** Exploring the perceptions of student nurses on patient centered care in  
psychiatric Institutions in Pietermaritzburg, KwaZulu-Natal  
**ETHICAL APPROVAL NUMBER:** HSS/1274/2010 M: Faculty of Health Sciences

In response to your application dated 27 October 2010, Student Number: 209521226 the  
Humanities & Social Sciences Ethics Committee has considered the abovementioned  
application and the protocol has been given **FULL APPROVAL**.

**PLEASE NOTE:** Research data should be securely stored in the school/department for a  
period of 5 years.

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

Yours faithfully



Professor Steve Collings (Chair)  
**HUMANITIES & SOCIAL SCIENCES RESEARCH ETHICS COMMITTEE**

SC/sn

cc: Ms C Engelbrecht (Supervisor)  
cc: Mr. S Reddy



15 Paramount Park  
6 Firtree Avenue  
Cleland  
3201  
22 November 2010

The Principal  
Edendale Campus  
29 Havelock road  
Pietermaritzburg  
3200

Dear Mrs Majola

**RE: REQUEST FOR PERMISSION TO CONDUCT A RESEARCH PROJECT**

I am a mental health lecturer at Edendale campus. I am doing my Masters degree at UKZN School of Nursing.  
I am requesting permission to collect data from the fourth year student nurses at Edendale Campus.

Please find the attached copy of the research proposal and ethical clearance letter from UKZN.

**RESEARCH TITLE: EXPLORING THE STUDENT NURSES PERCEPTION ON PATIENT CENTERED CARE IN PSYCHIATRIC INSTITUTIONS IN PIETERMARITZBURG, KWAZULU NATAL PROVINCE.**

Thank you,  
Luntukazi Matanzima  
.....*L. Matanzima*.....  
Student No. 209521226  
Contact No. 0837630795  
Email address: [209521226@ukzn.ac.za](mailto:209521226@ukzn.ac.za)

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Email address: [engelbrechte@ukzn.ac.za](mailto:engelbrechte@ukzn.ac.za)

Ethics Committee: [ximbap@ukzn.ac.za](mailto:ximbap@ukzn.ac.za)

## Appendix F

15 Paramount Park  
6 Firtree Avenue  
Cleland  
3201  
23 November 2010

The Principal  
KwaZulu –Natal College of Nursing  
211 Pietermaritz Street  
3200

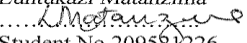
Dear Dr L.L.Nkonzo Mthembu

**RE: REQUEST FOR PERMISSION TO CONDUCT A RESEARCH PROJECT**

I am a mental health lecture at Edendale campus. I am doing my Masters degree at UKZN School of Nursing.  
I am requesting permission to collect data from the fourth year student nurses at Edendale Campus.

Please find the attached copy of the research proposal and ethical clearance letter from UKZN.

**RESEARCH TITLE:** EXPLORING THE STUDENT NURSES PERCEPTION ON PATIENT CENTERED CARE IN PSYCHIATRIC INSTITUTIONS IN PIETERMARITZBURG, KWAZULU NATAL PROVINCE.

Thank you,  
Luntukazi Matanzima  
.....  
Student No. 209521226  
Contact No. 0837630795  
Email address: [209521226@ukzn.ac.za](mailto:209521226@ukzn.ac.za)

Research supervisor: Ms Charlotte Engelbrecht  
School of Nursing  
University of KwaZulu- Natal  
4041  
Contact No. 031-2602513  
Email address: [engelbrecht@ukzn.ac.za](mailto:engelbrecht@ukzn.ac.za)

Ethics Committee: [ximbap@ukzn.ac.za](mailto:ximbap@ukzn.ac.za)



## Appendix G

15 Paramount Park  
6 Firtree Avenue  
Cleland  
3201  
23 November 2010

The Research Officer  
Natalia Building  
Pietermaritzburg  
3200

Dear Mr X.Xaba

**RE: REQUEST FOR PERMISSION TO CONDUCT A RESEARCH PROJECT**

I am a mental health lecturer at Edendale campus. I am doing my Masters degree at UKZN School of Nursing.

I am requesting permission to collect data from the fourth year student nurses at Edendale Campus.

Please find the attached copy of the research proposal and ethical clearance letter from UKZN.

**RESEARCH TITLE:** EXPLORING THE STUDENT NURSES PERCEPTION ON PATIENT CENTERED CARE IN PSYCHIATRIC INSTITUTIONS IN PIETERMARITZBURG, KWAZULU NATAL PROVINCE.

Thank you,  
Luntukazi Matanzima  
...  
Student No. 209521226  
Contact No. 0837630795  
Email address: [209521226@ukzn.ac.za](mailto:209521226@ukzn.ac.za)

Research supervisor: Ms Charlotte Engelbrecht  
School of Nursing  
University of Nursing  
4041  
Contact No. 031-2602513  
Email address: [engelbrecht@ukz.ac.za](mailto:engelbrecht@ukz.ac.za)  
Ethics Committee: [ximbap@ukzn.ac.za](mailto:ximbap@ukzn.ac.za)



**HEALTH**  
KwaZulu-Natal

**EDENDALE NURSING CAMPUS**

Private Bag 9099, Pietermaritzburg: 3200  
29 Havelock Road, Pietermaritzburg  
Telephone : 033 392 7566  
Fax: 033 345 9477  
[www.kznhealth.gov.za](http://www.kznhealth.gov.za)

22 November 2010

Ms. L. Matanzima (209521226)  
15 Paramount Park  
6 Firtree avenue  
Cleland

Dear Ms Matanzima

**REQUEST TO CONDUCT RESEARCH AT EDENDALE NURSING CAMPUS**

*Protocol: "Exploring the student nurse's perception on patient centered care in psychiatric institution in Pietermaritzburg, KwaZulu-Natal Province"*

Your letter dated 22.11.10 refers.

We are pleased to inform you that the permission is granted provided:

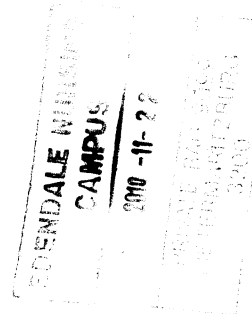
- Confidentiality is maintained at all times
- Your research does not interfere with smooth running of the Campus
- Proper consent is obtained from the participants

Thank you

Yours sincerely

Dr N.V. Mkhize  
(Chairperson Research committee)

Mrs N.C. Majola  
(Campus principal)



uMnyango Wezempilo . Departement van Gesondheid

*Fighting Disease, Fighting Poverty, Giving Hope*

## Appendix I



**KWAZULU- NATAL COLLEGE OF NURSING**  
P/Bag X9089, Pietermaritzburg, 3200  
Tel.: (033) 264 7800, Fax: (033) 394 7238  
e-mail: lulama.mthembu@kznhealth.gov.za  
www.kznhealth.gov.za

Enquiries: Mrs. S. Maharaj  
Telephone: 033 – 264 7806  
Date: 03 December 2010

Principal Investigator:  
Ms Luntukazi Matanzima  
School of Nursing  
University of KwaZulu-Natal

Dear Madam

RE: PERMISSION TO CONDUCT RESEARCH AT EDENDALE CAMPUS

I have pleasure in informing you that permission has been granted to you by the Principal of the KwaZulu-Natal College of Nursing to conduct research on:

***“Exploring the student nurses perception on Patient Centered Care in Psychiatric Institutions in Pietermaritzburg, KwaZulu Natal Province”***

Please note the following:

- 1) Please ensure that you adhere to all policies, procedures, protocols and guidelines of the Department of Health with regards to this research.
- 2) This Research will only commence once this office has received confirmation from the Provincial Health Research Committee in the KZN Department of Health.
- 3) Please ensure this office is informed before you commence your research.
- 4) The KwaZulu-Natal College (Edendale ) will not provide any resources for this research.
- 5) You will be expected to provide feedback on your findings to the Principal of the KwaZulu-Natal College of Nursing.

Thanking You.  
Sincerely

Dr. LL. Nkonzo-Mtembu  
Principal:KwaZulu-Natal College of Nursing

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uMnyango Wezempilo. Departement van Gesondheid  
Fighting Diseases, Fighting Poverty, Giving Hope.

## Appendix J



Health Research & Knowledge Management sub-component  
10 – 103 Natalia Building, 330 Langalibalele Street  
Private Bag x9051  
Pietermaritzburg  
3200  
Tel.: 033 – 3953189  
Fax.: 033 – 394 3782  
Email.: [hrkm@kznhealth.gov.za](mailto:hrkm@kznhealth.gov.za)  
[www.kznhealth.gov.za](http://www.kznhealth.gov.za)

Reference : HRKM19410  
Enquiries : Mr X Xaba  
Telephone : 033 – 395 2805

29 November 2010

Dear Ms L. Matanzima

**Subject: Approval of a Research Proposal**

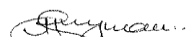
1. The research proposal titled 'Exploring the student nurses perception on patient centred care in psychiatric institutions in Pietermaritzburg, KZN' was reviewed by the KwaZulu-Natal Department of Health.

The proposal is hereby **approved** for research to be undertaken at Edendale Nursing College Campus.

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

For any additional information please contact X. Xaba on 033-395 2805.

Yours Sincerely

  
Mrs. E. Shyman

Interim Chairperson, Health Research Committee

KwaZulu-Natal Department of Health

Date: 03/12/2010

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uMnyango Wezempilo . Departement van Gesondheid

*Fighting Disease, Fighting Poverty, Giving Hope*

## **Appendix K**

### **Example of transcriptions of interviews of focus groups**

#### **Focus group A**

1. Good morning everyone
2. Good morning
3. about to start our recessional. So my first question is how you perceive
4. patient centered care in the following areas? We've got the therapeutic environment,
5. we've got the service training; we've got the observation of patience centered care,
6. we've got the factors that block or hinder patience centered care. But let us apply
7. it to promote patience centered care. So we will firstly be dealing with the therapeutic
8. environment: how do we perceive patience centered care in your allocated units
9. concerning the... therapeutic environment?
10. Ok, thank you.
11. I don't think it is actually taken very seriously although it is understood
12. that it is helping most of the patients even when we are creating
13. atherapeutic environment we only do something just to get marks.
14. So, we do something that will not even help the patient in the
15. long run.
16. ok, thanks so much. As you have heard perspect number one, how do you feel
17. about that point?
18. well, when you look around if it is not because of



19. the quality assurance process that is coming to check on the  
20. hospital, patients don't get what they want .the members of staff  
21. are doing the right thing only in order to get marks for quality assurance.  
22. patients are suffer once the quality assurance days are over.  
23. Thank you. So the patients are not involved in their therapeutic environment,  
24. what the patients are interested in  
25. we just do it because we are also doing our assessments whereas at the same time  
26. promoting therapeutic environment. Ok, thank you. Let's hear the next person.  
27. I will say that the leaders, of the therapeutic environment, are not creative  
28. nor innovative. Most of the time it is the students who are creative and  
29. they notice that whenever there are new students, they come up with ideas  
30. they are changing the environment, making appealing for the  
31. patients. But the staff doesn't do anything.  
32. it is true because the staff don't take initiative in therapeutic  
33. environment. Sometimes let's say you want to know something,  
34. he or she just says I don't know. That shows that they don't care  
35. ok.  
36. they can keep on saying that the stuff is  
37. not providing the  
38. therapeutic environment that we expected or desired but the truth is: the  
39. services are not rendered .  
40. Like if you just need a simple the only  
41. cloth you will find in the kitchen is a rag and the soap you find is even diluted so

42. that it can last for longer day. And that jeopardize the therapeutic environment for  
43. the patient. So if the people at management can provide the funds,  
44. material and have enough well paid staff to meet  
45. the ward demands and then there won't be any problem with therapeutic  
46. Environment being brought to standard  
47. ok, thank you.  
48. well, with the point that have, mentioned now, I don't think that it  
49. right  
50. The ward staff contribute to the shortage of materials because they sometimes  
51. take these home, whereas they know that is  
52. helping the patient. So with that I don't think it has to do with the funds.  
53. to be creative in the ward  
54. staff nurses, the registered nurses, the enrolled nursing assistants can  
55. gather together and discuss things  
56. in order to help the ward. Because when you see pictures now you come  
57. like after three months and you still see the same pictures or the same  
58. things that are depicted on the wall. but it's not working  
59. for the patients because they need to see like different things they love  
60. ok, thank you  
61. Even the patients are not involved in therapeutic environment,  
62. because if you ask them about it  
63. they don't know what is meant by therapeutic environment  
64. and they just see those things there, they don't understand

65. and I think the objectives of therapeutic environment should be there  
66. because even with the staff they really don't understand the meaning of  
67. environment, what it means for the patient, because even though patients are  
68. institutionalized, they need to be rehabilitated, so it's very important  
69. that therapeutic environment is considered and be revised in order to get a clear  
70. understanding. Ok, thank you.

71. No, I just wanted to say that some of the staff isn't properly trained  
72. to understand the condition, or they just know highlights, so for  
73. they are just coming to work, do the routine, and then sitting with the  
74. patients and not doing anything. They don't see the importance of stimulating or  
75. doing therapeutic environment for the patients.

76. Ok, thank you. From the unit that you are allocated in, are there any activities that  
77. are done for the patient in order to promote therapeutic environment?

78. No

79. No activities?

80. None

81. Ok, from the point that I have just mentioned is there any point that you would like  
82. to discuss?

83. the managements must give out the funds.

## Appendix L

Theme	Meaning Units
Safety and Security	<p>1. Safety and security emerged as integral to a therapeutic environment of the patients.</p> <p>According to participants the installation of security devices such as cameras was essential to ensuring that patients are cared for in a therapeutic environment. A secure environment ensures the stability of patients in Transcript B, lines 367–379</p> <p>2. Constant supervision by the nurses through security cameras is ensured (Transcript C, lines 816–818)</p> <p>3. Labeling of rooms emerged as a security feature in that patients will easily locate where they intend to go and those who are mentally unstable will not jeopardize the safety of others (Transcript B, lines 380–384, Transcript B, lines 386–389).</p> <p>4. the labeling of personal items like toothbrushes was highlighted as important to the safety of patients especially health wise (Transcript B, lines 453–455, Transcript C, lines 801 – 804)</p> <p>5. Diseases are easily transferable through carelessness of sharing (Transcript B, lines 457–458).</p> <p>6. Through the changing of linen nurses are able to improve the health of the patients (Transcript B, lines 466–469).</p> <p>7. Putting mats in bathrooms is important since it deters patients from encountering slippery floors which might be dangerous to their health (Transcript B, lines 462–464).</p> <p>8. Mixing of patients of different age groups in the same ward considered unsafe due to potential sexual abuse (Transcript B, lines 569–574).</p> <p>9. Combining new and old patients was considered un-therapeutic because of intimidations (Transcript B, lines 576–577, Transcript B, line 578).</p>

	10. Mixing smokers with non smokers was regarded to be unsafe (Transcript C, 855–858).
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Theme	Meanings Units
Promoting patient centered care through activities.	<ol style="list-style-type: none"> <li>1. Activities, socializing are very important to enabling a therapeutic environment (Transcript B, lines 394 –399, Transcript B, lines 417–421).</li> <li>2. Drawings promote a therapeutic environment (Transcript B, lines 423–428, Transcript B, lines 446–447).</li> <li>3. Activities are regarded as valuable in that they reduce idleness and improve the circulation of blood of patients(Transcript B, lines 449–450,Transcript A, lines 88–92, Transcript A, lines 96–100).</li> <li>4. Watching movies regarded as entertaining (Transcript C, lines 851–853).</li> <li>5. Paucityof stimulating activities regarded as a deterrent to a stimulating environment (Transcript A, lines 280–292).</li> </ol>

Theme	Meaning Units
Attitudes towards patients	<ol style="list-style-type: none"> <li>1. Attitudes of nurses towards patients and how these are manifested in nurses' engagement with patients was highlighted as significant for patients to feel at home (Transcript A, lines 123–127).</li> <li>2. Student nurses believed that a relationship of trust is built through maintaining their privacy (Transcript A, lines 180–181).</li> <li>3. Permanent staff were accused of taking a superiority position to the extreme (Transcript A, lines 128–132, Transcript A, line 132).</li> <li>4. Patients more relaxed with student nurses (Transcript A, lines 162–167).</li> <li>5. Lack of effective communication as a result of language barriers expresses as interfering with patient-centered care Transcript A, lines 293–296).</li> <li>6. Individualized care was highlighted as an important part of a therapeutic</li> </ol>

	<p>environment (Transcript B, lines 410–412, Transcript B, lines 414–415, Transcript C, lines 914–915).</p> <ol style="list-style-type: none"> <li>7. Respecting of patients regarded as enhancing a therapeutic environment (Transcript B, lines 480–482).</li> <li>8. Communicating to patients their rights by pasting them on the wall in different languages for easier reading and understanding regarded as therapeutic (Transcript B, lines 493–495).</li> <li>9. The violation of patients' rights can impede the creation of a therapeutic environment Transcript B, lines 557–561).</li> <li>10. Punishment of patients is stressed by student nurses that in certain instances it is not the nurses themselves that exercise punishment but they authorize patients to beat other patients(Transcript B, lines 566-567).</li> <li>11. Lack of resources was highlighted as an issue that prevents nurses from fulfilling their moral obligations to patients (Transcript A, lines 43–46).</li> <li>12. Patient-centered care involves creating an environment in which patients are educated and informed on how to manage their illness and informed about the medication that they are taking (Transcript C, lines 780–784).</li> <li>13. Student nurses highlighted that doctors were not taking time to listen to the plight of patients in terms of the medication they were taking. In fact the doctors were over-stepping their boundaries by making decision for patients without consultation (Transcript B, lines 541–546).</li> <li>14. Nurse behaviors as well as facial expressions are said not to permit the possibility of creating an environment of care (Transcript A, lines 178–180).</li> <li>15. Attitudes are also manifested in behaviors such as inconsistency in the allocation of medications of patients (Transcript B, lines 517–520).</li> </ol>
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Theme	Meaning Units
The Place of Family in Patient-Centered Care	<ol style="list-style-type: none"> <li>1. It was also pointed out that nurses should ensure a therapeutic environment by ensuring that the patients socialize with their families (Transcript B, line 396-399).</li> <li>2. Maintenance of contacts with family either physically or telephonically, patients are assured that they are cared for and loved by their family. It helps alleviate the feeling of loneliness and isolation brought about by the separation from the family (Transcript B, lines 647-651, (Transcript B, lines 957-966).</li> <li>3. Patient-centered care entails going to the family to access their willingness and readiness to accept the patient before they are released back to the family (Transcript A, lines 266-278).</li> </ol>

