

**BARRIERS TO PROVISION OF PSYCHIATRIC NURSING CARE: A CASE  
STUDY OF A TEACHING HOSPITAL, NIGERIA.**

**BY**

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A DISSERTATION SUBMITTED TO THE UNIVERSITY OF CAPE TOWN

*In fulfilment of the requirements for*

**MASTER OF SCIENCE IN NURSING**

**Faculty of Health Sciences**

**UNIVERSITY OF CAPE TOWN**

**SCHOOL OF HEALTH AND REHABILITATION SCIENCES**

**UNIVERSITY OF CAPE TOWN**

**UNDER THE SUPERVISION OF:**

**ASSOCIATE PROFESSOR SINEGUGU DUMA**

**DIVISION OF NURSING AND MIDWIFERY**

**AUGUST, 2014**

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## Declaration

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## Acknowledgements

I will like to thank God for the grace and mercy He permitted me to freely access throughout my study. Lord, I feel like singing every song of praise that I can remember now as an acknowledgement of the miracles I enjoyed before and during this study. Today is exactly fifteen months since I began this master's degree, may your name be praised and exalted.

My heartfelt thanks go to the participants. You made the data collection phase of this research an easy one for me, your willingness to share some personal issues means a lot to me. Thank you for the cooperation you gave me. God bless you all.

To my indefatigable supervisor, Associate Professor Sinegugu Duma I want to say thank you for choosing to supervise me even when my chosen field was not close to your areas of interest. Thank you for the tutelage and spontaneous response each time I submitted work to you.

I will like to salute the director, staff members and students of the Department of Health and Rehabilitation Sciences for the administrative assistance, educational mentoring/guidance and moral support you made available and accessible to me. Worthy of note are: A/Prof. Elelwani Ramugondo, A/Prof. Harsha Kathard, Dr. Helen Buchanan, Prof. Jelsma, Dr. Una Kyriacos, Usanda Qukula, Ruwayda Philander, Bonnie Croeser, Andy Emmanuel, Callista Kahonde, Ikechukwu Nwanze and Mamotlatsi Caroline Lefunyane. Your contribution towards the realisation of this dream is highly appreciated.

To my editor, Leverne Gething, thank you for investing your time and energy to polish my dissertation. Your expertise is worthy of note. Thank you for being prompt at such short notice.

My heartfelt thanks go to the Vice Chancellor, Professor Hayward Mafuyai Babale, Management and Staff of the University of Jos, for releasing me under the sponsorship of the TETfund grant of the Federal Government of Nigeria. Worthy of note is the Deputy Registrar Training-Mr Nimchak, Dean of the

Faculty of Medical Sciences Prof. Nuhu Dakum, the Head, Department of Nursing Science Dr (Mrs) S. A. Opalaye and the members of staff of the Department of Nursing. I hope to bring to bear the knowledge I acquired during my study.

I will like to register my profound thanks to the Chief Medical Director of the hospital I conducted the study Prof Edmund Banwat, management and members of staff. Thank you for the assistance I enjoyed during the conduct of the study.

To my dear friends, Averson Pius, Andy Emmanuel and Muknan Nshe, thank you for assisting with some errands as it pertains to the research. God bless you.

My thanks go to my parents – Mr Musa and Mrs Rahila Gimba, Mr Felix and Mrs Laraba Dakihis, my siblings – Isaac, Jonathan, Loretta, Eli, Katbang, Tapshak, Joy, Jemimah and Ezra, uncles and aunties (biological and in-laws) for the moral and spiritual support you gave me and my family in Nigeria. God bless you all.

To my spiritual family, the pastorate and members of Trinity Anglican Chapel, Jos, Nigeria and the pastorate and members of Latter House Parish of the Redeemed Christian Church of God, Cape Town, thank you for your hospitality, spiritual counsel and prayers. Worthy of note is Deacon Seun and Teju Ogundipe, Olumide Seun and Lanre Kunniji. God bless you all.

How can I forget my one and only family? My lovely wife, you became a father and mother to our son Jedidiah and your sister-in-law Jemimah. Your sacrifice is second to none; you are indeed my rare gem. “Kauna” thank you for assisting with some errands that pertained to the research process. God bless you irrevocably. Amen. I love you so much.

## **Abstract**

Barriers to the provision of psychiatric nursing care have been reported worldwide, although literature on these barriers in Nigeria is limited. The purpose of the study was to explore and describe the barriers to provision of psychiatric nursing care, using the case study methodology. A sample of 12 participants was recruited for the study, comprising four key informants and eight study participants. The data collection methods included grand tour interviews with the key informants, in-depth interviews with key informants and other study participants and participant observation of all 12 participants.

Content analysis was conducted. It yielded five themes related to barriers, namely: personal barriers to provision of psychiatric nursing care, relationship related barriers to provision of psychiatric nursing care, environmental barriers to provision of psychiatric nursing care, organisational barriers to provision of psychiatric nursing care and “public” related barriers to provision of psychiatric nursing care. The sixth theme: Motivators to provision of psychiatric nursing care despite barriers was discovered serendipitously. These findings are in line with previous findings of studies carried out in other settings.

The study findings raise the need for management to value the psychiatric nurses, refrain from the use of derogatory statements and passing comments and place high value on the educational and career progression of the psychiatric nurses and the design of a therapeutic environment.

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## Chapter one

### Overview of the study

#### 1.1 Introduction and background to the study

The provision of psychiatric nursing care to psychiatric patients is inevitably the responsibility of every psychiatric nurse and the right of every psychiatric patient who is admitted to a psychiatric hospital (Videbeck, 2006:8,150). Over the years the provision of psychiatric nursing care has suffered a lot of setbacks, with the patients at the receiving end of these. The World Health Organisation (WHO, 2001:85) reported that psychiatric nursing has been bedevilled with myriad of barriers. Similarly the WHO and the International Council of Nurses (ICN) (2007:3) revealed that in low- and middle-income countries the psychiatric nursing profession has received little or no attention from government and the public.

Several personal, relationship-related, environmental, organisational and 'public'-related barriers to provision of psychiatric nursing care have been reported in the literature reviewed across the globe. Some of the barriers to provision of psychiatric nursing care highlighted in literature included lack of sufficient skills/knowledge, lack of motivation and uncertainty of role, lack of appropriate and specific training and education, lack of use of the acquired skills due to time constraints and huge workload, and lack of knowledge of the role of psychiatric nurses within the psychiatric team and in the attainment of organisational goals (Wong, 2014:215; Brennan, Flood & Bowers, 2006:480; McAllister & Moyle, 2008:20; Mathers, 2012:49; Zarea et al, 2012:126; Ngako, Rensberg & Motogobe, 2014:5).

The impact of these barriers on psychiatric nurses has also been reported in the literature. Hercelinskyj, et al. (2014:24) revealed that role conflict and stress are by products of these barriers, and contribute greatly to the decision by psychiatric nurses to stay in practice. Similarly, Crawford, Brown and Majomi

(2008:1059) also report that barriers to provision of psychiatric nursing care result in a decrease in the number of psychiatric nurses in practice, with a decrease in their recruitment and retention, stress, burn-out, frustration and loss of professionalism. Supporting the impact of barriers on provision of psychiatric nursing care, Kutney-Lee et al. (2013:199) revealed that the working environment of psychiatric nurses has an influence on burn-out, they experience at work and their job outcome.

While barriers and their effect on the performance of the psychiatric nurses have been highlighted in literature around the globe, few barriers and effects on provision of care have been highlighted from literature accessed and reviewed from Nigeria. The dearth of data on barriers to provision of psychiatric nursing affects any attempt to proffer solutions to these barriers. This made conducting of this research into this area by the researcher a priority.

Worthy of note was the fact that an informal observation was made by the researcher and the students of the researchers' institution, indicating several barriers that had not been reported in any of the literature accessed and reviewed in Nigeria. Some of the barriers observed were lack of practice of acquired skills, like health education before administration of medication, gross inadequacy of facilities, lack of ward aesthetics, unprofessionalism and conflict among psychiatric team members. This informed the question which the researcher asked and answered in this research: 'What are the barriers to provision of psychiatric nursing care by psychiatric nurses in a teaching hospital in Jos, Plateau State, Nigeria?'

## **1.2 Rationale of the study**

The rationale for conducting this study was to understand those barriers which psychiatric nurses face while providing psychiatric nursing care to psychiatric patients, and to proffer recommendations that can eliminate or reduce the barriers to the barest minimum. The findings would inform the provision of standardised basic care. This in turn can be used to inform the creation of learning opportunities for student nurses to learn about the provision of

psychiatric nursing care while on clinical placement. Over the years the researcher, during supervision of students on clinical placement, observed that the psychiatric nurses provide care that is below the standard prescribed by the American Nurses Association (ANA), American Psychiatric Nurses Association (APNA) and International Society of Psychiatric Nurses (ISPN) in 2007. Case in point, during one of the clinical supervision visits, the researcher observed a psychiatric nurses serving medication without prior health education on the side effects, the nurse also did not supervise the intake of the medication by the patient.

This observation raised fundamental concerns, such as: health outcomes for the psychiatric patients who are admitted to this hospital and are under the care of these psychiatric nurses; and the missed learning opportunities for the student nurses who are exposed to this lack of provision of psychiatric nursing care to learn about psychiatric care and to be socialised into appropriate psychiatric nurse practitioner roles.

### **1.3 Problem statement**

Nigeria has both legal and educational provisions to enable psychiatric nursing care to be given to psychiatric patients by psychiatric nurses. The legal provisions include the Mental Health Policy, 1991, and the Lunatic Act, 1958 (WHO, 2006:6; 2011:1). These are complemented by both basic and post-basic nursing training programmes that are designed to equip psychiatric nurses to practice proficiently in psychiatric nursing care which are offered by different universities and colleges (Adejumo & Ehlers, 2001:218). Despite these provisions, a general and worrying observation by the researcher, who is a psychiatric nursing lecturer responsible for clinical placement and accompaniment of students for clinical teaching and learning in a university in Plateau State, was that psychiatric nursing care as prescribed by the ANA, APNA and ISPN in 2007 is not provided by psychiatric nurses in a teaching hospital in Plateau State. For instance, the psychiatric nurses administer medication without prior health education. This raised concerns with regard to

the health outcomes for the psychiatric patients admitted to this hospital and under the care of these psychiatric nurses. Another important concern for the researcher was the missed learning opportunities for the student nurses who are exposed to this lack of psychiatric nursing care nursing practice to learn about psychiatric nursing care and be socialised into appropriate psychiatric nurse practitioner roles.

Furthermore, factors that influence provision of psychiatric nursing care to psychiatric patients by psychiatric nurses despite the enabling legal and educational frameworks in Nigeria are poorly documented. Literature review highlighted only governmental and organisational barriers. There is no evidence that this phenomenon has been researched before in the northern part of the country. Therefore the identification and description of these barriers is important not only for research purposes, but also for improving the health outcomes of psychiatric patients and their families, enhancing the clinical learning opportunities for student nurses on the appropriate psychiatric nursing care, and to inform the development of an enabling environment for psychiatric nurses to render psychiatric nursing care without any barriers. The study was therefore imperative.

#### **1.4 Purpose of the study**

The purpose of the study was to explore and describe the barriers that hinder psychiatric nurses from providing psychiatric nursing care as prescribed by the ANA, APNA and ISPN in 2007 to psychiatric patients admitted to a teaching hospital in Plateau State, Nigeria.

#### **1.5 Objectives of the study**

The objectives of the study were to explore and identify the barriers to provision of psychiatric nursing care, and are as follows:

- To explore and identify organisational systems that constitute barriers to provision of psychiatric nursing care by psychiatric nurses to psychiatric patients admitted to a teaching hospital in Plateau State, Nigeria.

- To explore and identify incentives that constitute barriers to provision of psychiatric nursing care by psychiatric nurses to psychiatric patients who are admitted to a teaching hospital in Plateau State, Nigeria.
- To explore the barriers that constitute barriers to the use of psychiatric tools in the provision of psychiatric nursing care by psychiatric nurses to psychiatric patients admitted to a teaching hospital in Plateau State, Nigeria.
- To explore and identify physical environmental elements that constitute barriers to provision of psychiatric nursing care by psychiatric nurses to psychiatric patients admitted to a teaching hospital in Plateau State, Nigeria.

#### 1.6 Research question

What are the barriers to provision of psychiatric nursing care by psychiatric nurses to psychiatric patients admitted to a teaching hospital in Jos, Plateau State, Nigeria?

#### 1.7 Significance of the study

The findings of the study generated data that will inform the development of an enabling environment for psychiatric nurses to render psychiatric nursing care without any barriers, which will improve provision of psychiatric nursing care by the psychiatric nurses, which in turn will improve health outcomes for the psychiatric patients and their relatives. The findings also generated data that can allow for the provision of an enabling environment for enhanced clinical learning opportunities for student nurses on the appropriate psychiatric nursing care.

The findings of the study raised the need for development of policy statements and guidelines for psychiatric practice in the hospital and Nigeria, which will improve the provision of psychiatric nursing care by the psychiatric nurses.

The study also provided an opportunity for psychiatric nurses to speak and reflect on their current practices in the provision of psychiatric nursing care, which can allow for overhauling of their practice.

The findings of the study can be used to guide further study (ies) that will allow for development of a conceptual framework for provision of psychiatric nursing care in Nigeria.

## **1.8 Operational definitions of terms**

### **1.8.1 Psychiatric nursing care**

For the purpose of this study, psychiatric nursing care refers to all of the nursing management provided to psychiatric patients i.e. persons with diagnosed psychiatric illness or disorders (Mohr, 2013:15).

### **1.8.2 Psychiatric nurse**

The psychiatric nurse is a specialist who provides care and rehabilitative services to psychiatric patients (Mohr, 2013:15).

### **1.8.3 Barrier**

This refers to anything that has the capacity to obstruct or constitute a hindrance (O' Toole, 2013:183). In the context of this study a barrier implies an obstacle or challenge that affects or hinders provision of psychiatric nursing care to psychiatric patients.

## **1.9 Theoretical framework**

Yin (2009:3) advocated the use of theoretical framework to guide the conduct of case study research. The Wile's human performance technology model was used to guide the study (Wile, 1996:30). It is a representative example of recent models that are used in diagnosing human performance problems. The model assesses performance problems and reveals/explains the assessment to the persons assessed (Wile, 1996:34). The model also offers tangible solutions to varying performance/work/service provision problems (Wilmoth, Prigmore & Bray, 2002:19). This informs the need for communication of the findings and recommendations of the study to the hospital management and the psychiatric nurses after completion of the master's programme.



The Wile's model employs an innovative approach whereby two separate domains and paths of analysis are utilised to examine human performance, namely internal and external to the performer domains. The domains are further divided into seven constructs. (Wilmoth, Prigmore & Bray, 2002:19). The constructs of the model include organisational systems, incentives, cognitive support, tools, physical environment, skills/knowledge, and inherent abilities (internal or external) (Wile, 1996:32).

The organisational systems include policies, procedures, job designs, authority, and appropriate workload and how they affect the worker's performance. In this research organisational systems such as procedures, job descriptions, facilities and policies, were explored through grand tour question, interviews with key informants/study participants and participant observation to determine how they influence the psychiatric nurse's provision of psychiatric nursing care.

The incentives include financial or material compensation and staff appraisal. In this research the influence of incentives such as an award for excellence, salary and allowances, bonuses and staff appraisal on psychiatric nurse's provision of psychiatric nursing care was explored through interviews with key informants and study participants.

Cognitive support includes job aids and documentation. In the current research, the influences of job aids such as in-service training, supportive facilities and consumables which aid psychiatric nurses in the provision of psychiatric nursing care were explored via grand tour question and individual interviews with key informants.

Tools include any item other than cognitive support that the psychiatric nurse needs to perform her duty. In the current research, the researcher identified and explored the use and influence of therapeutic nurse-client communications and relationships, the environment, psychopharmacology and other tools to provision of psychiatric nursing care. This was done through individual interviews with key informants and study participants.

The physical environment entails noise, light and physical layout. In this research, the researcher explored the presence and influence of psychiatric charts and posters, the layout and aesthetics of the psychiatric wards on the provision of psychiatric nursing care. The grand tour question and individual interview data collection sources were used to collect data from the key informants and study participants.

The skills/knowledge includes education, self-study programmes and on the job learning. In the research, the researcher explored the availability of scholarships for training by the management and, if available, the influence this has had on their provision of psychiatric nursing care. The researcher also explored the influence of further studies they embarked upon and attendance of seminars, scientific conferences and workshops on the provision of psychiatric nursing care.

Inherent abilities entail the physical ability to perform, intelligence, emotional ability to perform and internal motivation. In the current research, the researcher explored the influence of intuition and driving force (motivation) on provision of psychiatric nursing care. Find below Wile's Human Technology Performance Model.

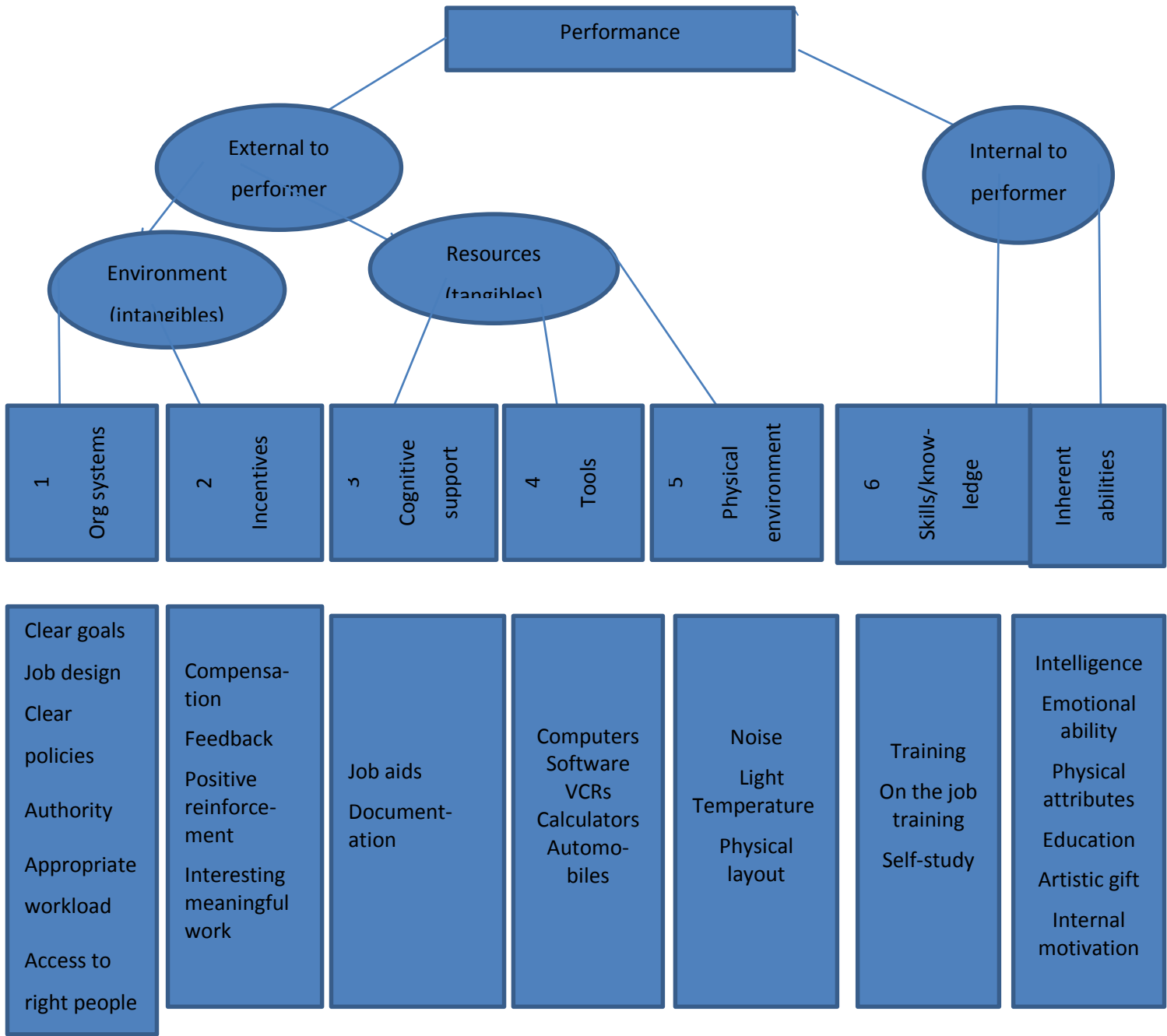


Figure 1.1: Wile's (1996) human performance technology model.

## 1.10 Outline of the dissertation

The research is structured as outlined below.

**Chapter 1** This chapter introduces the background and rationale for the study, problem statement, purpose of the study, objectives of the study, research question, significance of the study and operational definition of terms that are related to the study. It concludes with the conceptual framework that guided the study.

**Chapter 2** This chapter discusses the literature related to barriers to provision of psychiatric nursing care to psychiatric patients by psychiatric nurses.

**Chapter 3** This chapter presents the methodology of the study, which includes study design, study setting and population, sampling method, inclusion and exclusion criteria, sample size determination, recruitment of participants, pilot study and data collection. The ethical considerations conclude this chapter.

**Chapter 4** This chapter provides the details of data management and data analysis methods used in this study. It concludes with details of how trustworthiness was achieved.

**Chapter 5** This chapter presents the results and findings of the study.

**Chapter 6** This chapter includes the discussion of the findings, recommendations and limitations, and concludes the report of the study.

## 1.11 Conclusion

This chapter outlined the introduction and background of the study, rationale of the study, problem statement and purpose of the study, objectives of the study, research question and definition of basic terms. The conceptual framework used to guide the research was also outlined in relation to the hospital setting. The next chapter outlines the review of literature pertaining to provision of psychiatric care and barriers to provision of psychiatric care.

## Chapter two

### Literature review

#### 2.1 Introduction

This chapter outlines the literature included in the study, which includes the literature review that was conducted prior to development of the research proposal, data collection and during data analysis. The literature reviewed prior to data collection was used to develop the proposal for the study. It provided the researcher with baseline information to start the research process. This agrees with Burns and Grove (2011:189), who documented that literature review provides the researcher with knowledge on what is known and what is not yet known about a phenomenon. The literature review conducted prior to data collection also identified the dearth of literature on barriers to the provision of psychiatric nursing care in Nigeria. This is in line with the assertion of Burns and Grove (2011:189) who stated that literature review allows for identification of gaps in the knowledge base. The literature reviewed during data analysis was used to confirm the discovered themes and subthemes as findings and to allow for discussion of findings. It also enhanced the researcher's objectivity in the interpretation of data.

The following search engines were used to search for data: CINAHL, MEDLINE, Africa-wide information, Psych Info, Psych articles, Health source: Nursing/academic edition, eBook collection (EBSCOhost) and Google Scholar. Items from 2000 to date were used For the Google Scholar search. For the other databases, only items from 2012 to 2014 were used for searching literature from around the world. For the literature search from Nigeria, 2000 to date was used for all databases. The search terms used included: psychiatric nursing, mental health nursing, psychiatric, mental health, nursing, barriers, obstacles, constraints, hindrances, lived experience, psychiatric nurses and resilience.

The researcher also searched for related articles in databases in which a particular article was accessed. ScienceDirect made suggestions for related articles each time the researcher accessed an article from it, and these were also accessed. Grey literatures were also searched.

## **2.2 Overview of barriers to provision of psychiatric nursing care**

The literature reviewed highlighted a number of personal- or individual-related barriers, organisational- or hospital management-related barriers, physical environment-related barriers, societal barriers and relationship-related barriers to provision of psychiatric nursing care in hospital settings.

### ***2.2.1 Universal barriers to provision of mental health globally***

The WHO (2001:85) reported that the absence of or inadequate mental health policy and legislation, poor hospital conditions, poor infrastructure, insufficient resources, human rights violations, inadequate treatment and care/high cost of treatment constitute barriers to provision of psychiatric nursing care. Other barriers identified by the WHO (2001:85) included lack of skills and training and lack of specialist and general health workers with psychiatric knowledge and skills.

Another important issue raised by the WHO (2001:86) was that approximately half of the existing legislation on mental health was formulated in the past ten years, while close to one-fifth dates back over four decades. Case in point, the legislation on mental health in Nigeria dates back to 1991 (WHO, 2001:85; WHO, 2011:1).

The WHO (2001:86) report referred to some of these as universal barriers to the provision of psychiatric care. They include lack of psychiatric services, poor quality of treatment and services, and access/equity- related barriers. Other barriers identified by the WHO (2001:85) included lack of skills and training, and lack of specialist and general health workers with psychiatric knowledge and skills.

The implication of this is that psychiatric nurses in hospitals, including the research setting are faced with the challenge of working within an old legal framework that may not allow them to provide optimal psychiatric care to psychiatric patients.

### ***2.2.2 Barriers to provision of psychiatric nursing care in Nigeria, a low-middle-income economy***

Literature reviewed identified government- and organisational-related barriers to provision of psychiatric nursing care in Nigeria. Jack-Ide, Uys and Middleton (2012:701); Jack-Ide, Uys and Middleton (2013:126) reported the lack of political power and the absence of a nursing voice in the Ministry of Health, depriving the psychiatric nurses of the opportunity to be heard and/or receive attention at this level. Stigma within the hospital setting, lack of in-service training, system failure, and lack of access to treatment due to high costs were also identified as organisational-related barriers to provision of psychiatric nursing care in Nigeria (Jack-Ide, Uys & Middleton, 2013:127).

Similarly, Klecha, Barke and Gureje (2004:1118), in a report of the activities of a foundation in Nigeria, remarked that government- and organisational-related issues constitute barriers to provision of psychiatric nursing care to patients. They remarked that scarcity of resources such as equipment and manpower and placement of low priority on psychiatric services by management of hospitals and the government also constitute barriers to provision of psychiatric nursing care.

The WHO (2001:1) reported that the majority of primary health care nurses in Nigeria have not received any official in-service training on mental health within the last five years. The lack of current knowledge on psychiatric nursing care could affect the care provided by the psychiatric nurses in Nigeria. Furthermore, statistics have shown that there are just 0.19 nurses working in psychiatric hospitals in Nigeria per 100 000 members of the population (WHO, 2001:2). This indicates gross inadequacy of manpower, which has been reported in literature to constitute a barrier to provision of psychiatric nursing care.

Additional government- and organisational-related barriers to provision of psychiatric nursing care highlighted by the WHO and the Nigerian Ministry of Health (MoHN), report include the non-availability of essential drugs, lack of an office for mental health issues in the Federal Ministry of Health and poor budgetary allocation to psychiatric practice by government (WHO & MoHN, 2006:5).

It can be concluded that only governmental and organisational barriers to provision of psychiatric nursing care have been identified in Nigerian literature. This is probably due to the adoption of a narrow scope by the studies, or other reasons beyond speculation. For instance, the study conducted by Jack-Ide, Uys and Middleton (2013) used Townsend's mental health template to guide their discussion. This construct comprises only structural and resources constructs. The absence of literature on the other barriers reveals a gap in knowledge, which this study will contribute towards filling.

### ***2.2.3 Barriers to provision of psychiatric nursing care in other low- and middle- income economies***

Manpower-related barriers have been identified in low- and middle-income economies such as Iran, Botswana, Uganda and South Africa. For instance, in 2007 the WHO and ICN highlighted that the greatest barrier to provision of psychiatric nursing care in the low- and middle-income economies is severe shortage of manpower. They stated that there are fewer psychiatric nurses per capita in low-income economies and middle-income economies than in high-income economies. Lack of adequate opportunities for acquiring knowledge and skills in psychiatric nursing during regular nursing education and post-regular nursing education was reported to exacerbate the problem (WHO & ICN, 2007:29).

Other societal and organisational-related barriers to provision of psychiatric nursing care in low- and middle-income economies highlighted in literature include neglect of the psychiatric unit by hospital management, neglect by the public and the healthcare system, politics and rules of organisation (McDaid,



Knapp & Raja, 2008:81; Ngako, Van Rensberg & Motoboge, 2012:5; Zarea et al., 2012:701; 2013:126). Other authors reveal a number of organisational barriers to provision of psychiatric nursing care, including lack of, inadequate and poor distribution and appropriateness of resources like trained psychiatric nurses and ward facilities, and socio-cultural issues and lack of time to plan and provide care, which has been reported to be more critical in psychiatric nursing than other fields of nursing (Okasha 2002:34; Knapp, et al, 2006:159; Schierenbeck et al. 2013:113; Zarea et al., 2012:703; 2013:127). The organisational barriers to provision of psychiatric nursing care were the most reported barriers in low- and middle-income economies.

Relationship-related barriers to provision of psychiatric nursing care were also highlighted in the literature review from middle-income economies such as South Africa. These include patients' disrespectful and uncooperative attitudes towards psychiatric nurses, lack of mentoring/supervision by superiors, lack of emotional and psychological support from management and patients' relatives and unsupportive behaviours of psychiatrists, security personnel and patients' relatives. Psychiatric nurses were reported to be of the opinion that these barriers result in demotivation, emotional/physical distress and suppression (Tema, Poggenpoel & Myburgh, 2011:918; Ngako, Van Rensberg & Motoboge, 2012:5).

Several personal-related barriers to provision of psychiatric nursing care have been highlighted in literature from Iran and South Africa. For instance, Zarea et al. (2012:703) reported that lack of sufficient skills and knowledge, uncertainty of one's role; burn-out and safety issues constitute barriers. Ngako, Van Rensberg and Motoboge, (2012:5) revealed that security issues like fear of injury by patients, fear related to unpredictable behaviour of patients and demotivation constitute barriers to provision of psychiatric nursing care. Similarly, in a study conducted by Tema, Poggenpoel and Myburgh (2011:918) it was revealed that law and legal issues associated with potential harm to patients were viewed by psychiatric nurses as a barrier to provision of psychiatric care to psychiatric patients.

The literature review on barriers to provision of psychiatric nursing care in low- and middle-income economies revealed government and organisational barriers, relationship- related barriers and personal barriers. Environment-related barriers to provision of psychiatric nursing care are not reported in the literature accessed and reviewed from low- and middle-income countries. This study will contribute towards filling this gap.

#### ***2.2.4 Barriers to provision of psychiatric nursing care in high-income economies***

Literature review revealed environmental factors that constitute barriers to provision of psychiatric nursing care in high-income economies. In four different studies conducted in Turkey and Australia, lack of a family-centred environment, poor/unfavourable working conditions and a noisy and busy environment were reported to constitute barriers to provision of psychiatric nursing care (Eren, 2014:359; Innes et al, 2014:2006; McAllister & Moyle, 2008:20; Smith & Khanlou, 2013:5).

Other environment-related barriers to provision of psychiatric nursing care highlighted in the literature are limitations in the work setting and hazards in the physical environment (Brennan, Flood & Bowers, 2006:480; Innes, et al, 2014:2006; Weiland et al, 2011:680; Yadav & Fealy, 2012:119). Chevalier, Steinberg and Lindeke (2006:757) and Rose and Glass (2006:27) argued that an unsuitable physical environment exposes psychiatric nurses to physical, emotional and psychological harm which jeopardises psychiatric nursing care provision.

Several organisational-related barriers that affect provision of psychiatric care by psychiatric nurses have been highlighted in the literature. For instance, in three different studies conducted in Australia structural and policy issues in the workplace were reported to play a significant role in the burn-out which psychiatric nurses experience in the hospital setting (Fisher, 2014:266; Hercelinskyj et al, 2014:26). This barrier was reported to produce role conflict and stress, leading to role strain (Fisher, 2014; Hercelinskyj et al., 2012:26),

which obviously influences the psychiatric nurses' productivity, hence constituting a barrier to provision of care.

Hercelinskyj et al. (2014:27) further argued that conflict between what is expected of the psychiatric nurse within the health team and her role in meeting organisational set goals constitutes a barrier to provision of psychiatric nursing care by the psychiatric nurses. Hercelinskyj et al. (2014:26) also revealed that contradiction between policy and allocation of resources to psychiatric care by the management of hospital settings was perceived by psychiatric nurses as a barrier to provision of psychiatric care to their patients. This brings into the limelight the fact that non-delineation of the scope of practice, job description and policy statement for psychiatric nurses constitutes and will continue to constitute a barrier to provision of psychiatric care to psychiatric patients in hospital settings. This calls for an immediate response, which obviously is beyond the scope of this research.

Additional organisational barriers to provision of psychiatric nursing care identified from the literature reviewed include: lack of training opportunities, inadequate educational and funding opportunities for continued education, lack/gross inadequacy of resources (such as human resources, equipment and consumables), and absence of programmed sessions for the therapeutic relationship (Mathers, 2012:49; Patton, 2013:389; Happell, 2014:99; Brennan, Flood & Bowers, 2006:480; Innes et al., 2014:2006). Brennan, Flood and Bowers (2006:481) further revealed that facilities like interview rooms for conducting various therapies, lack of access to tools like Internet facilities, computers and printers for facilitation of evidenced-based practice among other activities constitute barriers to provision of psychiatric nursing care.

Other organisational barriers which psychiatric nurses face while providing psychiatric care to psychiatric patients in hospital settings as identified in literature were: long shifts, too much paperwork and administrative duties, involvement in a variety of duties within limited time, and huge workload

(Mesidor et al., 2011:285; Patton, 2013:389; Eren, 2014:365; Happell, 2014:99; Wong, 2014:215; Brennan, Flood & Bowers, 2006:475; Innes et al., 2014:2006).

The endless lists of organisational- related barriers to provision of psychiatric care in hospital settings include: leadership styles that are problematic, bureaucratic processes and complex management systems, and the predominant use of the medical model and relegation of the role of the psychiatric nurse to the background by management (Mesidor, et al., 2011:285; Fisher, 2014:264; Stein, 2014:115; Chevalier, Steinberg & Linda, 2006:757; McAllister & Moyle, 2008:20; Yadav & Fealy, 2012:119).

Other organisational barriers which psychiatric nurses face in hospital settings as highlighted in the literature include poor handling of human resources issues, lack of clarity of hierarchical structure, lack of or unfair incorporation of the integrated health model into provision of psychiatric care, limited scope of practice for psychiatric nurses, and failure of management to provide resources for planning and implementation of intervention programmes (Mesidor et al., 2011:285; Fisher, 2014:266; Stein, 2014:115; Chevalier, Steinberg & Lindeke, 2006:757; McAllister & Moyle, 2008:20; Yadav & Fealy, 2012:119).

Buchanan-Barker and Barker (2007:24) argue that the psychiatric nurses' role has witnessed a gradual shift from a specialisation that involves use of skilled interpersonal relationships to provide care to psychiatric patients to one dominated by excessive administration, patient observation and risk management, courtesy of the dominance of the medical model. Buchanan-Parker and Parker (2007:24) argues that the medical model obviously deprives the psychiatric nurse of a platform to engage the patient in a meaningful relationship that can lead to appreciation of bio psychosocial recovery processes, as enshrined in the integrated health model, thereby constituting a barrier to provision of total psychiatric nursing care by the psychiatric nurse. The literature reviewed from high-income economies also highlighted organisational barriers to provision of psychiatric nursing care as the most significant barriers.

Literature reviewed also highlighted several personal barriers to provision of psychiatric nursing care in high-income economies. For instance, Brennan, Flood and Bowers (2006:480) revealed that lack of knowledge of their role within the psychiatric team and in the attainment of organisational goals and lack of autonomy constitute barriers to provision of psychiatric nursing care. Other personal barriers to provision of psychiatric care are as follows: lack of appropriate and specific training and education, inability to use acquired skills due to time constraints and huge workload and allocation to inferior roles within the psychiatric team (Mathers, 2012:49; Wong, 2014:215; McAllister & Moyle, 2008:20). This obviously have an impact on optimal provision of psychiatric nursing care.

Other personal barriers to provision of psychiatric nursing care highlighted in literature in high-income economies include: indifferent attitudes of some psychiatric nurses towards provision of care, lack of interest in provision of psychiatric care among some psychiatric nurses, low morale and low self-esteem/confidence, and frustration from managers over perceived under-performance of their subordinates (Wong, 2014:215; Brennan, Flood & Bowers, 2006:480; Chevalier, Steinberg & Lindeke, 2006:757; Jelinek et al., 2011:18).

Hercelinkyj et al. (2014:26), in a study conducted in Australia; reported that psychiatric nurses express frustration due to a lack of role clarity and distinctiveness of their role within the health team. They also argue that a change in a hospital's policy on provision of care also allows for role changes of the psychiatric nurses, which results in role ambiguity/role conflict, which can lead to uncertainty about their professional identity. Similarly, Chevalier, Steinberg and Lindeke (2006:757) revealed that nurses felt forced to prioritise when caring for patients with high physical and medical needs and those with primarily mental health needs, in a limited time frame. The implication of these barriers is that the psychiatric patient is deprived of adequate psychiatric care by the psychiatric nurses.

Personal safety issues have also been highlighted in literature to constitute barriers to provision of psychiatric nursing care in high-income economies. In a study conducted by Chevalier, Steinberg and Lindeke (2006:758) many participants expressed concern based on the perception that people with psychiatric problems may be unpredictable and potentially dangerous. Jackson and Morrissette (2014:140) reported that the aggressive behaviour of psychiatric patients towards nurses constitutes a barrier to provision of care. They further pointed out that aggressive behaviour of patients makes room for taxing the nurses and reluctance to provide care due to concern for safety, especially among nurses with young families or who are pregnant.

Barriers to provision of psychiatric care that have their origin in society have been reported in the literature, and these include isolation from the public and lack of knowledge or misconceptions about what psychiatric nursing is by the public and other health personnel (Chevalier, Steinberg & Lindeke, 2006:757; Yadav & Fealy, 2012:119; Jackson & Morrissette, 2014:138). According to Chevalier, Steinberg and Lindeke (2006:760) the greatest barrier to provision of psychiatric care is lack of knowledge by the public of the existence of advanced practice roles of psychiatric nurses and lack of understanding of the role of psychiatric nurses by other health professionals.

Relationship-related barriers to provision of psychiatric care have been identified in the literature, and include lack or poor strengthening of the utilisation of acquired skills and competences by managers, lack of training and education support from psychiatric nursing managers, and unhealthy attitudes of nurse managers toward issues of autonomy and professionalism (Greenall, 2006:19; Mathers, 2014:49; Smith & Khanlou, 2013:8). Other relationship-related barriers which psychiatric nurses face while providing psychiatric care which are highlighted in the literature include difficulty in obtaining patients' vital information from relatives and overbearing attitudes (like opposition to treatment provision) of the patients' relatives (Wong, 2014:215; Innes et al. 2014:2006; Jackson & Morrissette, 2014:148).

Additional relationship-related barriers to provision of psychiatric care revealed in the literature include poor supportive peer relationships among psychiatric nurses, oppression from peers, uncooperative management who do not provide support and inadequate morale-boosting by management (Fisher, 2014:266; McAllister & Moyle, 2008:22). Others include lack/inadequate involvement in the decision-making process on patients' treatment within the psychiatric team, lack of teamwork within the psychiatric team, exhibition of superior attitudes by psychiatrists, indecision of psychiatrists on treatment options, poor attitudes of psychiatrists and the psychiatric team towards psychiatric nurses, and psychiatric health team's unwillingness to adopt current practices (Mathers, 2012:49; Eren, 2014:365; Fisher, 2014:266; Wong, 2014:215; Holm & Severinssen, 2012:518; Van Bogaert et al., 2012:11; Jackson & Morrisette, 2014:140).

Barriers to the provision of psychiatric nursing care in high-income countries seem to be very comprehensive, exhaustive and revealing. This may be due to the volume of published articles in circulation and/or the quality of the research process which the researchers adopted. This is in contrast to barriers to provision of psychiatric nursing care that were revealed from literature accessed and reviewed in low-income and middle-income countries including Nigeria. This may be due to the low number of publications on barriers to provision of psychiatric nursing care in circulation, lack of interest or resources in carrying out research, narrowness of the scope of research conducted by researchers in psychiatric nursing, or even poor documentation of findings of research. This therefore reinforces the need for psychiatric nurse researchers from middle-income countries and the African continent in particular to resolve issues bedevilling availability of literature on barriers to provision of psychiatric care.

### **2.3 Conclusion**

The literature reviewed gave an outline of the barriers associated with provision of psychiatric care by psychiatric nurses at different levels, including personal, relationship, environmental, organisational and public level. Another revelation

is that some barriers are universal which included shortage of manpower (the most significant), lack of or inadequate resources such as equipment, inadequate or limited policy, inadequate training and trained psychiatric nurses, poor welfare from management, unhealthy relationships among the psychiatric health team, and poor educational and training opportunities.



## Chapter three

### Methodology

#### 3.1 Introduction

This chapter discusses the study design, study setting, study population, sampling method, inclusion and exclusion criteria, sample size determination and recruitment of the participants, data collection process, pilot study and ethical considerations.

The purpose of the study was to explore and describe the barriers that hinder psychiatric nurses from providing psychiatric nursing care to psychiatric patients who are admitted to a teaching hospital in Plateau State, Nigeria.

#### 3.2 Study design

The case study methodology was used to explore and describe the barriers to provision of psychiatric nursing care to psychiatric patients who are admitted to a teaching hospital in Plateau State, Nigeria. A case study is defined as a detailed exploration of a “single unit of study” such as an organisation, a person or a subculture, which is “bounded” by time and location (Holloway & Wheeler, 2002). Similarly, Creswell (2013:97) stated that the case study methodology allows for generation of an in-depth understanding of an entity or exploring an event or phenomenon within the entity.

Providing a vivid description of the case study methodology, Yin (2009:3) stated that it allows for conducting research with individuals, groups, individuals within an organisation, organisations, social, political and any other entity for the sole purpose of generating an in-depth understanding of the real life events, situations and relationships peculiar to these entities. Yin (2009:17) further stated that the case study methodology is characterised by boundaries such as contemporary phenomenon, context, time and location. Multiple sources of data collection are employed to collect data, which are converged through triangulation. Yin (2009:17) also referred to case study research as an exploration of a “bounded system” or “case” for a period of time through

detailed, in-depth data collection involving multiple sources of information, each with its own sampling, data collection, and analysis strategies (Yin, 2009:18). According Yin (2009:18), the case study has the strength to examine in depth a “case” within its “real life context”.

In this research the single unit of study or contemporary phenomenon was the provision of psychiatric nursing care, the real-life context was psychiatric nursing practice, and the case was the teaching hospital. The psychiatric unit within the teaching hospital and the time frame of the in-depth data collection for the study formed the boundaries of the case studied. The multiple sources of evidence were grand tour interview, individual interviews and participant observation.

The features within the case that were examined in this research were the organisational systems, incentives, tools, inherent abilities, cognitive support, knowledge/skills and physical environment that hinder the provision of psychiatric care, and the case was the teaching hospital.

The case study methodology was selected as the best method for this study because the research problem existed within the confines of a bounded setting, which was the selected teaching hospital that is used as a clinical placement setting for undergraduate nursing students of the local university department of nursing. This methodology is the most appropriate for organisational studies, as stated by Yin (2009:17). The case study design does not focus on the participants but on the case under study and the in-depth understanding of the phenomenon within the case itself (Yin, 2009:18). This methodology allowed the researcher to get an in-depth understanding of the barriers that influence provision of psychiatric nursing care by the psychiatric nurses.

### **3.3 Study setting**

The study was conducted in one teaching hospital in Plateau State, Nigeria. This teaching hospital is used as a clinical teaching and learning facility for student nurses from one of the local universities where the researcher is employed as a

lecturer. The hospital is a tertiary institution that is responsible for providing tertiary health services and training of nurses and other health professionals.

The teaching hospital is located in the central part of Jos town in Jos North Local Government Area of Plateau State. Plateau State is located in the middle belt region of Nigeria. Below is a map of Nigeria showing Plateau State where the hospital is located.

Figure 3.1. Map of Nigeria showing Plateau State.



Source: First Bank of Nigeria, 2009.

The hospital was established by the then administration of Shehu Shagari. It is made up of 28 departments, units and community health centres and has a total of 600 beds.

The psychiatric unit has one male and one female ward. The female ward has 26 beds while the male ward has 25 beds, making a total of 51 beds in the unit. Each ward has 11 nurses, and there is 1 nurse in charge. Both wards are under the leadership of a coordinator. The psychiatric unit therefore has 25 nurses in total. Of these, 20 are trained psychiatric nurses while 5 are general nurses. These teams cover morning, afternoon and night duty (Mikan, P. – personal communication, April 4, 2014; Jos University Teaching Hospital, 2005). Data were collected in both wards.

### **3.4 Study population**

Study population refers to the total number of elements from which the sample is selected (Babbie & Mouton, 2011:173). The study population was all of the 20 trained psychiatric nurses, including the unit coordinator and the two nurses who are in charge of the psychiatric wards in the teaching hospital. This is because they all had both the knowledge and skills for providing psychiatric nursing care provision and could provide information required to answer the research question.

### **3.5 Sampling method**

Sampling is the process through which a group of people, an event, place, institution or any other element is selected to allow for the conduct of research (Grove, Burns & Gray, 2013:708). A convenience sampling technique was used to select the research setting as case. Convenience sampling is a non-probability sampling technique used by researcher to select participants as he comes in contact with the sample (Neuman, 2012:391).

Currently there are two hospitals used for psychiatric clinical placement of undergraduate student nurses from the university. The hospital selected for the study was selected because of the hospital's proximity to the researcher's workplace and residence, which allowed for easy access in terms of distance and hence maximisation of time and other resources like finances.

Purposive sampling was used to select only those psychiatric nurses who had the information the researcher was looking for to answer the research question and met the inclusion criteria. This is because they would provide information that is based on their experience in the psychiatric unit. Purposive sampling is a technique in which the researcher uses predetermined criteria to select participants who have the knowledge or experience that is needed for the research purpose (Neuman, 2012:399).

### **3.6 Inclusion criteria**

Inclusion criteria are the list of requirements outlined by a researcher which an individual must meet to be eligible to participate in a research study (Grove, Burns & Gray, 2013:696). The inclusion criteria for this study were as follows:

- Nurses who have received training in either basic or post-basic psychiatric nursing at either the nursing school or university.
- Post basic trained psychiatric nurses who have practiced in the selected psychiatric units for a period of at least one year. This period allowed them to obtain adequate experience in relation to most barriers that hinder them from providing psychiatric nursing care in the hospital.
- Post basic trained psychiatric nurses who have had opportunity to supervise the nursing students, because the barriers they face would have had an influence on the training of the students.
- Post basic trained psychiatric nurses who are willing to participate in the study.

### **3.7 Exclusion criteria**

Exclusion criteria refer to the characteristics that the researcher outlines that would prevent someone from being eligible to participate in a research study (Grove, Burns & Gray, 2013:694).

The exclusion criterion for this study was:

- Those post basic trained psychiatric nurses who were on vacation or study leave, because they could not be observed during the study.

### 3.8 Sample size determination

Sample size is the number of participants who have consented to be recruited for a study (Grove, Burns & Gray, 2013:708). Holloway and Wheeler (2002:128) stated that most often the sample size used in qualitative research falls between 4 and 40 participants, although certain qualitative research projects contain as many as 200 participants. Similarly Grove, Burns and Gray (2013:268) stated that depending on the study design a sample size between 12 and 25 can be adequate for conducting a qualitative study. The most important things to note when determining the sample size in qualitative research are the research question, time frame and resources available for conducting the research, quantity of data to be collected, scope of the study, amount of useful information to be obtained from the participant, number of interviews per participant and the study design to be used (Morse, 2000:3; Patton, 2002:272).

The sample size for the study was 12 participants, who included 4 key informants and 8 study participants who were recruited from both psychiatric wards (4 from each ward). The sample size was not predetermined, but was reached through data saturation. Data saturation is reported by Guest, Bunce and Johnson (2006:59) as “the point in which no new information or theme is observed in a data”.

The sample size of 12 participants was considered adequate because it generated adequate data to answer the research question ‘What are the barriers to provision of psychiatric nursing care by psychiatric nurses to psychiatric patients admitted to a teaching hospital in Jos, Plateau State, Nigeria? The sample size also fell within the 4 to 40 participants recommended for qualitative data (Holloway & Wheeler, 2002:128; Grove, Burns & Gray, 2013:268).

### **3.9 Recruitment of participants**

The recruitment of participants started in February 2014. The researcher arranged and met with the coordinator of the psychiatric unit and head of the psychiatric department of the teaching hospital separately to discuss the purpose of the research, request permission to conduct research in the psychiatric unit and to recruit them for participation as key informants in the study. They were given the information sheet (see Appendix VI) to read. They were asked to indicate their willingness to participate in the study, and both gave their consent to participate in the research and also gave the researcher permission to commence data collection in the unit.

A meeting was then scheduled with the two nurses in charge of the two wards and the psychiatric nurses at different times of the day to discuss the purpose of the research and to request their participation. Criteria for participation were ascertained from all potential participants individually by requesting their qualifications and years of practice in the unit. The information sheet and consent forms were given to those who met the inclusion criteria to read and signify willingness to participate in the study (see Appendices V, VI and VII). Those who met the inclusion criteria and consented to participate in the research signed and returned the consent forms (see Appendix V).

The date, time and venue that suited each participant for the interview were determined individually with each participant.

### **3.10 Pilot study**

The pilot study refers to a mini version of a full-scale study, and the specific pre-testing of a particular research instrument. It increases the likelihood of the success of the research because it gives advance warning about where the main research could fail (van Teijlingen & Hundley, 2002:33). Grove, Burns and Gray (2013:703) similarly referred to pilot study as mini study usually carried out before a proposed study in order to allow for the development or to refinement of

the research methodology. The pilot study was conducted in the second week of February with two participants.

The pilot study was conducted in order to: determine whether the proposed interview guide and observation checklist could collect data that would answer the research question in order to refine the interview guide and observation checklist, if needed; identify potential problems in following the research procedure; identify local politics or problems that may affect the research process; and provide a platform for the researcher to build on his skills as a novice qualitative researcher, as suggested by van Teijlingen & Hundley (2002:34).

The transcribed data from the pilot study were shared with the researcher's supervisor to determine if the data collected were adequate and to assess the researcher's skills in collecting qualitative data. The research supervisor identified the need for the researcher to improve his interview by adding relevant probing questions to enhance data collection skills. This was done and once both were happy the main study data collection commenced.

Data collected from the pilot study were analysed and it showed that the interview guide and observation checklist generated data that were relevant to the research objectives. This was also confirmed by the researcher's supervisor. The interview guide and the observation checklist were therefore not reviewed, but certain questions in the interview guide that were found to produce similar data were merged. The questions that were merged were questions 4, 5 and 8 respectively:

- Despite everything else that you have already told me, what would you say keeps you motivated to give psychiatric nursing care?
- Despite what you have told me already, what would you say demotivates you from providing psychiatric nursing care to your patients?
- How have your skills and knowledge on psychiatric nursing informed your provision of psychiatric nursing care to your patients? In your personal



capacity, what motivates you to give psychiatric nursing care? What demotivates you from providing psychiatric nursing care to your patients?

The question that emerged from the merger was question 8:

- How have your skills and knowledge on psychiatric nursing informed your provision of psychiatric nursing care to your patients?

The analyses of the pilot study data were used in the main study because the pilot study participants were homogenous and the process of data collection and analysis was the same as in the main study. Using data collected from the pilot study is supported in qualitative research. For instance, Duma (2006:105) reports that data from the pilot study can be included in the main study without any alteration of the data, provided similar data collection and analysis methods are used.

### **3.11 Data collection**

Data collection and preliminary data analysis began in the second week of March and ended in the last week of April 2014. The interview with the key informants took place in their offices, which is where all of the key informants chose to have the interview, and these were conducive for the interviews.

The interviews with the study participants took place at the nurses' station of the ward, which is where the participants chose to have the interview, and the venue was conducive for the interviews.

The main data collection techniques for the study were grand tour question or interview, semi-structured individual interview and covert participant observation as proposed by Yin (2009:18).

#### **3.11.1 Grand tour question/interview**

The grand tour question allows for obtaining data about a physical setting, the activities within a given space while helping the researcher meet the research objectives (Fetterman, 2010:43). The grand tour interviews were conducted in the second week of February 2014. The objective covered by this method was to explore and describe the physical factors like ward layout and noise that

hinder psychiatric nurses from providing basic psychiatric nursing care to psychiatric patients admitted to a teaching hospital in Plateau State, Nigeria.

The first grand tour interview was conducted with the coordinator of the unit. This was followed by grand tour interviews with each of the two nurses in charge of the two wards who are responsible for managerial functions of the psychiatric unit and psychiatric wards respectively of the teaching hospital.

A semi-structured interview guide (see question 6, Appendix II) was used to conduct an informal and conversational interview, in order to encourage the participants to express their views on the effects of the physical environment on the provision of psychiatric nursing care in the psychiatric unit of the teaching hospital.

The responses of participants were taken down as field notes immediately after the interview to ensure that the participants were not distracted during the interview process and thus had no difficulty in responding to the questions. This is suggested by Grove, Burns & Gray (2013:272).

### ***3.11.2 Individual interviews with study participants and key informants***

The interviews with all the study participants were conducted between February and March 2014. An interview is the process through which a researcher converses with a participant with the sole aim of obtaining a desired data in the form of words (Grove, Burns & Gray, 2013:271). A semi-structured interview guide (see Appendices II and III) that was designed by the researcher in relation to the identified research objectives was used to collect data. The semi-structured interview creates equality between the researcher and participant and allows the researcher to obtain real data from participants (Yin, 2009:102). Participants shared adequate and desired information on barriers to provision of psychiatric nursing care with the researcher willingly.

The objectives that were covered during the individual interviews were:

- to explore and identify organisational systems, including the policies, procedures and job description;

- to explore and identify incentives like salaries, allowances and bonuses, awards of excellence and performance appraisal,
- to explore and identify skills and knowledge and inherent abilities like inner motivation and intuition that hinder psychiatric nurses from providing psychiatric nursing care to psychiatric patients admitted to a teaching hospital in Plateau State, Nigeria.

The individual interviews with each of the study participants and key informants were conducted in the nurses' station of the psychiatric wards and offices of the managers respectively. This is supported by Grove, Burns & Gray (2013:271). Each participant was asked for permission to audiotape the interview. The nursing station and offices of the managers were found to be relatively quiet for the interviews. Each interview took approximately one hour. Field notes were taken to record the observations made during the interviews. Polit and Beck (2012:728) defined field notes as "notes taken by researchers to record of observations made in the field and the interpretation of those observations".

### ***3.11.3 Covert participant observation***

The covert participant observations were conducted between the fourth week of February and the end of April 2014. Covert participant observation refers to a process that enables a researcher to collect data via observing participants while participating in their activities (Polit & Beck, 2012:237).

The objective for conducting the covert participant observation was to explore the psychiatric nurses' use and influence of psychiatric tools like therapeutic communication and relationships, milieu management and psychopharmacology in provision of psychiatric nursing care to psychiatric patients admitted to a teaching hospital in Plateau State, Nigeria.

Permission was obtained from the coordinator of the ward and the psychiatric nurses on duty before commencement of participant observation. The researcher participated as a participant observer in each of the psychiatric wards for about 4 weeks in each ward. The researcher participated in the

provision of psychiatric care daily for 6 hours within a shift, and this happened four times a week. During this period observation of psychiatric nursing care, such as therapeutic relationship, milieu management and psychopharmacological care of the patients, was done using the checklist as a guide. Other activities of the participants that were observed were administration of electroconvulsive therapy (ECT), handing over and taking over. The researcher observed the psychiatric nurses as they performed these responsibilities and interacted with their patients. A total of 12 psychiatric nurses were observed on different shifts and dates. A detailed description of the covert participant observation was recorded as field notes.

A checklist that was designed by the researcher by following the three steps identified by Creswell (2009:181) was used for the observation. This included:

- Identifying the main category of the characteristic to be observed
- The various characteristics in the various categories and
- What the researcher is expected to note reflectively and descriptively from the categories, written out in a table with columns and rows.

The checklist (see Appendix IV) addressed the observation of therapeutic nurse-client, therapeutic nurse-nurse manager and therapeutic nurse-other health professionals' communications and relationships, milieu management and psychopharmacology activities.

### **3.12 Ethical considerations**

The requirements of the Helsinki Declaration (World Medical Association, 2013) were applied throughout the study. This included submission of the research proposal to the University of Cape Town, Faculty of Health Sciences Human Ethics Research Committee for ethical clearance of the research. Ethical clearance was obtained with ethics reference number HREC REF: 089/2014 (see Appendix VIII).

A letter was written to the Research Ethics Committee of the Hospital for ethical clearance to carry out research in their facility. This was obtained with ethics reference number JUTH/DCS/ADM/127/XIX/5966 (see Appendix IX). As soon as the ethical clearance was granted, the researcher met with the coordinator of the psychiatric unit and head of the psychiatric department of the teaching hospital separately to discuss the purpose of the research, request permission to conduct research in the unit and then recruit them for participation as key informants. Afterwards the researcher sought permission from the coordinator of the psychiatric unit to recruit other psychiatric nurses and the two nurses in charge of the ward.

The ethical principles that were observed throughout the study are outlined below.

### **3.12.1 Autonomy**

Autonomy is the principle of respecting the decision-making capacities of the participants (Holloway & Wheeler, 2002:52). This was observed in the study as follows:

- Each participant was given the information sheet and informed consent was obtained for voluntary participation in the study (see Appendices V, VI and VII).
- Each participant was given the opportunity to ask questions or seek clarification after reading the information sheet.
- Each participant was informed of the right to withdraw from the study at any time and to share only information that they are comfortable to share.
- Each participant was asked to choose the time and venue for the interview session.
- Each participant was asked for permission to use an audio-recorder and to take field notes from observations.

Participants were given the information sheet (see Appendices VI and VII) to go and read at home in a relaxed atmosphere to make an informed decision to participate in the study. Some consented to participate in the research a day or

two after reading the information sheet, while others read the information for up to a week before consenting to participate in the research, after which they all filled in and signed a consent form before commencement of the interview.

### ***3.12.2 Confidentiality***

Confidentiality can be defined as providing protection to study participants by ensuring that information that can be traced to the participant are managed in such a way that it cannot be linked to the participant by the public (Grove, Burns & Gray, 2013:690).

This was observed in the study as follows:

- Each participant's information was stored under pseudonyms.
- Each participant's data were transferred to the researcher's personal computer, which was pass worded, in order to limit access to the data to only him.
- Each participant's interview was listened to with the aid of headphones to prevent it from being heard by a third party.
- Each participant's consent form was kept under lock and key until after the write-up of the research.
- Each participant's information was reported in such a way that it could not be traced to him or her.

### ***3.12.3 Beneficence and non-maleficence***

Beneficence and non-maleficence implies weighing the good that will be derived from the research against the potential harm, and the benefits must outweigh the risks for the individual (Holloway & Wheeler, 2002:52).

This was observed in the study as follows:

- Each participant was informed that there were no direct benefits to them by participating in the study. They were informed that the indirect benefits of the study included generating data that could be used to review policy statements and guidelines for psychiatric practice in the hospital to

improve the provision of psychiatric nursing care and guide the training of nursing students in relation to tackling identified barriers.

- Each participant was assured that that interview questions were phrased with minimal potential for psychological harm to occur.
- Each participant was informed of the right to withhold any information that they were not comfortable with sharing and that they were not obligated to provide information that they were not comfortable in sharing. Each participant was given a debriefing by the researcher after every interview to aid airing of tensions and to recover from any apprehension that resulted from the interview and observation.
- Each participant was given assurance that the information they shared with the researcher will not be used to harm their job or career in future.

#### **3.12.4 Justice**

Justice implies applying strategies and procedures in a fair and just manner when carrying out research (Holloway & Wheeler, 2002:52).

This was observed in the study as follows:

- Selection of participants was based on inclusion and exclusion criteria which were explained during the recruitment meeting.
- The participants were treated in the same way regardless of age, culture, rank and beliefs.
- The concerns of participants and agreements made with them prior to commencement of the interview were treated with utmost respect.
- The participants' culture and belief system was respected. Participants were not interviewed further over issues that they did not want divulged. One of the participants was not willing to share information on therapeutic relationship; hence the researcher did not probe further.

### *3.12.5 Risks and benefits*

Risks refer to the potential of an outcome occurring following an exposure to something (Porta, 2008:218) while benefit refers to advantage that is gained after exposure to an intervention (Porta, 2008:16).

The following were foreseen as risks of participating in the study and were addressed accordingly:

- Participants' apprehension during covert participant observations due to fear of the unknown. The participants were assured that the data collected were for research purposes only and would not be used to penalise them for the observed behaviours during observations.
- Participants' regrets due to reflection on past unpleasant experiences of barriers to provision of psychiatric care. The researcher listened to the participants as they shared their regrets without any interruption. The researcher also expressed empathy with participants by sharing in their pain. The researcher praised and encouraged them to hold on to areas of strength. The researcher also commended their resilience in choosing to work amidst the said barriers. The researcher debriefed the participants by recapping the main issues discussed, placing emphases on their braveness and strengths.
- Participants' feelings of job insecurity in relation to divulging of sensitive information about hospital policies and regulations to the researcher as an "outsider". The participants were assured of confidentiality and anonymity of their data before the commencement of interviews and observations respectively. Participants were asked to give the researcher their pseudonyms, but they declined and asked the researcher to use any means of hiding their identity. The researcher used the word "participant" as the pseudonym and the participants consented to this.

There were no direct benefits to the participants. They were informed that the indirect benefits of the study included generating data that could be used to



review policy statements and guidelines for psychiatric practice in the hospital to improve the provision of psychiatric nursing care in the hospital and to guide the training of nursing students in relation to tackling identified barriers.

### **3.14 Conclusion**

The chapter discussed all aspects of the research process, from the pilot study to the main study. Limitations of the study were also discussed. Finally, all aspects of the ethical considerations were discussed. This is provided as part of an audit trail, which provides an obvious representation of the pathway a researcher followed during collection and management of data, i.e. a detailed account of the decisions that were made in the field so as to allow for anyone to be able to follow the process (Marshall & Rossman, 2011:230)

## Chapter four

### Data analysis

#### 4.1 Introduction

This chapter discusses the processes of data management and analysis that the researcher employed to analyse and interpret the data generated from the participants. It also contains an outline of the means by which the researcher ensured trustworthiness throughout the study.

#### 4.2 Data management

According to Holloway and Wheeler (2002:238) data management is the process through which structure and order are brought to manage the “not easily managed” data. This helped the researcher in the eventual retrieval and final analysis of data.

The individual semi-structured interviews and grand tour interviews were transcribed verbatim within 24 hours after the interview so as to capture the details of the information provided by the participants and to allow for easier, faster and detailed verbatim transcription. The transcript of each participant's interview was stored as a file with a pseudonym and all of the transcripts of the individual interviews were stored in a folder named ‘transcripts of individual interview’, while the transcript of the grand tour interviews was stored in file named ‘transcripts of grand tour interview’ in the researchers' personal computer and external hard drives (external hard drive and flash drive as back-ups) for storage purposes and easy retrieval during analysis. The above is in consonance with principles of storing data as identified by Creswell (2013:182). The demographic information (excluding names) of the participants and the date of the interview were included in the transcript of each participant.

Field notes obtained during covert observation were stored as a folder named ‘CO’, for easy retrieval in the researchers' personal computer and external hard drives (external hard drive and flash drive as back-ups).

### 4.3 Data analysis

Holloway and Wheeler (2002:236) refer to data analysis as the process of organising, reducing and transforming data by exploring meanings of research participants and researchers searching the data for concepts and categories. Similarly, Bernard and Ryan (2010:5) defined data analysis as the process through which patterns are sought for in data and ideas that help to explain why the patterns exist in the first place. According to Polit and Beck (2012:563) the main goal of data analysis is to organise data, put it into a structure and bring out meaning from it.

Content analysis, using the interpretative content analysis was employed to analyse the data and the data were analysed manually (see steps followed below). Polit and Beck (2012:564) refer to content analysis as the process of “analysing the content of a narrative data to identify prominent themes and patterns among the themes”. Similarly Grove, Burns and Gray (2013:281) referred to content analysis as the process of categorising words into text. It involves “breaking down data into smaller units, coding and naming these units according to the content they represent, and grouping the coded units into themes base on shared concepts” (Polit & Beck, 2012:564). Triangulation of data from the grand tour interviews, individual interviews and participant observations was done during data analysis.

The five steps for carrying out interpretative content analysis outlined by Blanche, Durrheim and Painter (2006) were used. These include: familiarisation and immersion, coding, induction of themes, elaboration and interpretation, and checking. A within-case and across-case approach was also used to analyse the data which implies analysing data from the individual cases first and then proceeding to analyse the data for commonalities across the cases (Duma, 2006:125; Creswell, 2013:101).

- **Familiarisation and immersion:** The process of reading through research texts or data many times over to gain immersion into the text or data (Blanche, Durrheim & Painter, 2006:322).

- **Coding:** The process of marking different sections of the data that have meaning in relation to the research question (Blanche, Durrheim & Painter, 2006:324).
- **Inducing themes:** Labelling categories from the text or data to generate themes (Blanche, Durrheim & Painter, 2006:323).
- **Elaboration:** The process of exploring the themes more closely to capture the finer nuances of meaning not captured by the original, possibly quite crude, coding system (Blanche, Durrheim & Painter, 2006:326).
- **Interpretation and checking:** Could be defined as the process of putting together the interpretation of data, which involves writing an account of the phenomenon that was studied, most probably but not necessarily using the themes as headings (Blanche, Durrheim & Painter, 2006:326).

#### ***4.3.1 Familiarisation and immersion***

The researcher read through the transcribed interviews (grand tour and individual interview transcripts) and observation field notes many times over to gain in-depth familiarity with the collected data. Notes on identified meanings were made reflectively where appropriate in the margins of the sheet containing the data.

#### ***4.3.2 Coding***

This was done twice by the researcher. The first coding was done by the researcher as follows: phrases and sentences that were relevant to the research were underlined one after the other in the all the transcripts, starting from the first to the last transcript. Numbering of the individual codes was done for purposes of storage and retrieval for case-to-case and across-case analysis. The second coding was done by the researcher and the supervisor and two other colleagues of the researcher as part of debriefing. This was done as follows: phrases and sentences that were relevant to the research were

underlined using colours. Similar codes were synthesised. An example is illustrated in Table 1.

**Table 4.1: Codes**

<b>Transcript</b>	<b>Data from transcript</b>	<b>Code</b>
Participant 1	... Even though we are not supposed to admit patients with their relative, we do it here because of understaffing ...	Understaffing (4)
Participant 2	... Sometimes you see, the barriers may be the uncooperative attitudes of patients' relatives themselves ...	Uncooperative attitudes of patients' relatives (8)
Participant 3	... there is no maximum security ...	No maximum security (5)
Participant 4	... This place is not a conducive place for psychiatric care ...	Not a conducive place (5)

#### ***4.3.3 Inducing themes***

The bottom one-quarter of each page was used for inducing subthemes from the codes generated. The codes in the individual transcripts, which were numbered, were grouped to generate categories based on their similarity in meaning. The categories were then grouped to form subthemes, based on similarity. The subthemes from each transcript were numbered on separate sheets and then grouped across the 12 transcripts, based on similarities, to generate six themes. Some notes on identified meanings were made in the left, right, top and bottom margins of the transcripts. The whole process was submitted to the supervisor for review. See Table 2 for how one theme was generated.

**Table 4. 2: Theme and subthemes**

Theme	Subthemes	Categories
Personal barriers	Internal personal barriers	<ul style="list-style-type: none"> <li>• Lack of motivation</li> <li>• Lack of intuition</li> <li>• Personal stress from home</li> <li>• Lack of practice of professional skills</li> <li>• Exhibition of nonchalant attitudes</li> <li>• Display of unprofessionalism</li> </ul>
	External personal barriers	<ul style="list-style-type: none"> <li>• Huge/excessive workload</li> <li>• Lack of appreciation and recognition from hospital management</li> <li>• Personal safety</li> <li>• Poor remuneration</li> <li>• Irregular training and attendance of update courses</li> <li>• Movement of patients, relatives and visitors in and out of the ward</li> </ul>

**4.3.4 Elaboration**

The researcher described and explored the meanings of the individual themes in order to construct an exhaustive, in-depth understanding of the barriers to provision of psychiatric nursing care in the case study and the meanings attached to psychiatric nursing care as a phenomenon within the case study. The field notes of the covert participant observations were used to bring out meaning based on participants’ nonverbal communication and to capture other salient meanings of barriers that were not captured in the interviews, to allow for in-depth understanding of the barriers.

#### **4.3.5 Interpretation and checking**

The researcher described and explored meanings of the barriers and the motivators to provision of psychiatric nursing care to construct an inferred meaning of the phenomenon being studied within the context of the setting of the case study. This was reviewed by the researcher's supervisor. There was agreement between the researcher and his supervisor. The themes included personal barriers to the provision of psychiatric nursing care, relationship-related barriers to the provision of psychiatric nursing care, environmental barriers to the provision of psychiatric nursing care, organisational barriers to the provision of psychiatric nursing care, governmental and societal barriers to the provision of psychiatric care, and motivators to provision of psychiatric nursing care amidst barriers

Member checking was conducted by taking the findings back to the participants for them to check and verify whether the researcher's interpretations were a reflection of the participants' views and to ask for corrections if any were necessary. No corrections were made by participants, and a final write-up was completed. The member checking was conducted with all of the participants. Member checking refers to checking and verification of the data or interpretations by participants (Holloway & Wheeler, 2002:287).

#### **4.4 Scientific rigour/trustworthiness of the research**

Grove, Burns and Gray (2013:708) referred to scientific rigour as the act of conducting scientific research in accordance to outlined principles excellently, strictly and in detail. Similarly, Holloway and Wheeler (2002:288) defined rigour/trustworthiness as the means by which researchers show their ability to conduct research according to laid out processes that is verifiable. To ensure the rigour of this research the researcher adopted the four basic frameworks for ensuring rigour which have been in existence for many years. They are transferability, credibility, confirmability and dependability (Shenton, 2004:73).

#### **4.4.1 Credibility**

This refers to the extent to which interpretation of data collected from participants is a true reflection of the participants' views and not the researchers' assumptions (Whittemore, Chase & Mandle, 2001:530). To achieve credibility, the following was done:

- Data from multiple sources were collected and analysed and compared to generate in-depth and extensive understanding of the barriers. This is known as triangulation (Holloway & Wheeler, 2002:288). The data that were collected from all of the methods were compared to check consistency of findings, and the different perspectives of the various methods were reviewed to give a big picture of the phenomenon which the researcher was seeking to understand.
- Prolonged engagement was ensured as the researcher spent almost three months in the field during participant observation for data collection, and compared analysed data from interviews with observations made, to ensure that data collected were a true reflection of the participants' views.
- The trial audit was provided to the research supervisor, who is an expert in qualitative research, to review. Audit trial refers to a detailed description of the decision-making processes of the researcher to demonstrate the logic and development of the research path (Holloway & Wheeler, 2002:284).
- Member checking was done by going back to participants with the findings to check and verify the interpretation of the researcher (Holloway & Wheeler, 2002:287).

#### **4.4.2 Confirmability**

This implies that the findings of the research are supposed to be the result of the experiences and ideas of the informants and documents reviewed, rather than the characteristics and preferences of the researcher (Shenton, 2004:73). To ensure confirmability, the following was done:



- Bracketing was done to prevent the researcher's predetermined assumptions from influencing his interpretation of the data during analysis. Bracketing refers to the process of putting aside all assumptions of a researcher before going into the field (Holloway & Wheeler, 2002:285).
- The raw data and coded data were shared with the supervisor for peer debriefing and review.
- An audit trail was kept to contain the interaction between the researcher and the respondents during interview sessions, and the description of activities and structures and procedures used in reviewing the documents to show the sequence of how data were collected.
- Description of the process of constructing the themes and interpretation of results to provide an idea of the process of data analysis.
- Construction of the themes and interpretation of data under the supervision of the research supervisor.
- Findings of the research were kept in the researcher's computer and password-protected should there be a need for re-analysis.
- Documentation was kept on the time frame for collection of data and analysis, the techniques that were used for each data collection source, as well as the number of participants in the research.

#### *4.4.3 Dependability*

This implies the extent to which similar findings will be generated should the research be repeated with the same or similar participants, in the same context and with the same methods (Shenton, 2004:73). To ensure dependability the following was done:

- Conducting of a pilot study to check clarity of interview questions.
- Member checking to rule out the possibility of biases that can influence interpretation of data.
- Application of all of the steps documented by Blanche, Durrheim and Painter (2006) to authenticate the process of data analysis.

- Documentation of the demographic characteristics of the participants.

#### **4.4.4 Transferability**

This refers to the extent to which the findings of a research study can be applied to other situations and other populations (Shenton, 2004:69). To ensure transferability the following was done:

- Provision was made for thick description of the barriers to provision of psychiatric nursing care in relation to the context of the teaching hospital as a case.
- Provision of detailed description of the sample and setting of the study to allow for generalisation to other similar populations or settings by the reader.
- To provide clarity on the sequence of data collection, organisation and analysis to allow for comparisons with other settings and populations, a description of demographics of the participants was given, as well as the setting of the case, the way the questions were asked, the promptings used, and how the data were processed in terms of organisation and analysis as part of the research report.

#### **4.5 Conclusion**

This chapter discussed the processes of data management and analysis that the researcher employed to explore and identify the six themes and 14 subthemes as the findings of the study. The findings are further discussed in Chapter five.

## Chapter five

### Findings

#### 5.1 Introduction

This chapter presents the findings of the study. It also includes the description of the sample. The findings are discussed according to themes and subthemes. The extracts from the participants' raw data are used to illustrate the discovery of themes and subthemes.

The research question 'What are the barriers to provision of psychiatric nursing care by psychiatric nurses at a teaching hospital in Jos, Plateau State, Nigeria'?, was answered.

#### 5.2 Description of the sample

The sample consisted of 12 participants, which included 4 key informants and 8 study participants. The 4 key informants were the managers of the psychiatric unit who were identified as key informants because of their managerial role in the psychiatric unit/ward. They were all males, and comprised 3 psychiatric nurses and 1 psychiatrist.

The males in the sample and the key informants is typical of gender differences in the psychiatric nursing profession, which is a nursing specialty mostly preferred by male nurses. This is supported by Adejumo and Ehlers (2001:218) who reported that majority of the psychiatric nursing educators were males in a study conducted among psychiatric nurses. Similarly Kumpula and Ekstrand (2009:543) reported that psychiatry is primarily populated by male care providers.

The 8 study participants were the psychiatric nurses who worked in the psychiatric unit which was used as a research setting. They consisted of 2 males and 6 female nurses. The selection of more female psychiatric nurses

was done purposely by the researcher to allow for adequate gender representation.

The age of the participants ranged between 36 and 56 years. Their work experience in psychiatric service provision ranged between 8 and 31 years. All the participants (except the psychiatrist) had psychiatric nursing qualifications and all were licensed psychiatric practitioners.

### 5.3 Findings

Six themes were generated from content analysis of the triangulated data from all data sources, including grand tour interviews, individual interviews with key informants and other study participants and participant observations.

The first five themes are directly related to the research question about the barriers to provision of psychiatric nursing care; the sixth theme was serendipitously discovered from the data. The sixth theme is related to what motivates the psychiatric nurses to continue to provide psychiatric care despite all the challenging barriers to provision of psychiatric nursing care.

These themes were as follows:

1. Personal barriers to the provision of psychiatric nursing care
2. Relationship-related barriers to the provision of psychiatric nursing care
3. Environmental barriers to the provision of psychiatric nursing care
4. Organisational barriers to the provision of psychiatric nursing care
5. Governmental and societal barriers to the provision of psychiatric care
6. Motivators to the provision of psychiatric nursing care amidst barriers

The themes have related subthemes. Although the researcher organised and named the themes differently, they are all aligned to Wile's (1996) human technology performance model which was used as the theoretical framework that guided the study and its objectives. The alignment is highlighted in the discussion of each theme and its related subthemes.

### **5.3.1 Personal barriers to provision of psychiatric nursing care**

This theme emerged from data that related to the individual's intrinsic capabilities that were perceived to hinder the individual from providing psychiatric nursing care. This theme is similar to the inherent ability and skill/knowledge constructs of Wile's human technology performance model that guided the study. This theme had two subthemes, internal personal barriers and external personal barriers to the provision of psychiatric nursing care.

#### **5.3.1.1. Internal personal barriers to provision of psychiatric nursing care**

The internal personal barriers to provision of psychiatric nursing care included the lack of motivation, personal stress from home and work, lack of practice of professional skills, lack of innovation, exhibition of nonchalant attitudes and unprofessionalism and poor attitude towards education.

One of the participants explained the lack of motivation as a barrier to the provision of psychiatric nursing care as follows:

*"As a psychiatric nurse, you need motivation ... but when there is no motivation you feel reluctant in carrying out your quality nursing care"*

Another participant highlighted lack of motivation as a barrier to the provision of psychiatric nursing care as follows:

*"... There is no motivation when your work is not recognised, you are demotivated and it bounces back on the patient"*

The following extract from one of the participants captures the lack of motivation as follows:

*"You know, like this health education before serving medication, some of us don't do it, because the motivating factor is not there anymore...."*

Personal stress from home as a barrier to provision of psychiatric nursing care was highlighted by one participant as follows:

*“You find that, maybe a nurse has some problem at home, by the time she comes here, she will transfer her aggression on her patients thereby affecting her care”*

Another participant revealed personal stress from work as a barrier to provision of psychiatric nursing care:

*“You see by the time our problem at work is even more than that of the patient, we are not likely to achieve anything, because our care will be affected”*

Lack of practice of fundamental skills by the psychiatric nurses was observed during the participant observations. The following excerpt from the observation field notes captures this barrier:

A male nurse was observed serving medication. Before serving the medication the psychiatric nurse failed to give health education. The patient was also not supervised by the psychiatric nurse while taking the medication to determine whether he really took medication or not.

Another observation on the field notes highlighted lack of practice of professional skill, as follows:

A male nurse was observed dressing a patient’s wound. The nurse did not call the patient by his name before the procedure and did not engage the patient in therapeutic relationship throughout the period of the procedure.

Lack of innovation was revealed by participants during individual interviews as a barrier to the provision of psychiatric nursing care, one of the participants describing it as follows:

*“They lack innovation because they are preoccupied with only what they read in book and not to initiate for themselves, that places limitations on the care they provide to psychiatric patients”*

The following extract from another participant highlighted this barrier of ‘lack of innovation’ as follows:

*“There are certain trainings that are not taught in the class, you have to initiate them yourself. Some of the nurses don’t initiate better ways of providing care; they only know how to do normal routine”*

Data from individual interviews and participant observations revealed a nonchalant attitude and unprofessionalism as barriers to provision of psychiatric nursing care, as the following extract from a participant attests:

*“You will see a nurse leave the whole ward with nobody and she will just lock the place not minding what happens to the patients and during that period the patient is deprived of his right to care”*

The data from participant observations revealed several incidents of nonchalant and unprofessional attitudes. For instance, the psychiatric nurses were observed shouting at the patients when they brought complaints to the nurse or asked for help. In one instance a patient came to report to a nurse that he was bleeding from his nose and the nurse shouted at the patient, reiterating the fact that the patient was told to rest and stop malingering.

Poor attitude towards educational advancement was highlighted as a barrier to provision of psychiatric nursing care as follows:

*“We don’t go for further studies. We just stay in one place and continue with our outdated practice, which prevents us from providing up to date care”*

Another participant explained poor attitude towards education as a barrier to provision of psychiatric care as follows:

*“If the nursing profession can rise to the recognition that knowledge is power and is what places you ahead or on par with other professions, then we should be able to utilise the potential of the people we have in nursing to provide evidence- based care. Nurses generally are anti-education and that affects our currency of knowledge and the care we provide.”*

### 5.3.1.2 External personal barriers to provision of psychiatric nursing care

This subtheme was derived from data that related to extrinsic factors that affected individual nurses' capabilities for providing psychiatric nursing care. These included: huge/excessive workload, lack of appreciation and recognition from hospital management, poor remuneration, personal safety, irregular training, attendance of update courses and movement of visitors and relatives in and out of the ward.

The field notes from the participant observations and responses of participants to individual questions revealed "huge workload" to be a barrier to provision of psychiatric nursing care. One participant highlighted this as follows:

*"You will be the only one to make beds, attend ward rounds, serve medications, do the ward report and a lot of other things and if there are discharges or admissions, you do it alone, because of staff shortage, so you end up unable to do everything to the best of your ability"*

Another participant explained huge workload as a barrier to provision of psychiatric nursing care as follows:

*"We go extra miles. Instead of confining patients to one place, sometimes you have to follow them when they walk about, abandoning your responsibilities and other patients in the ward. When you come back to the ward; you do vital signs, ECT, serve medication, give psychotherapy and health education. All this is too much for one nurse on duty"*

An extract from another participant described huge workload as follows:

*"We have the capacity of 26 patients and in some shifts you will be the only one on duty. This patient needs your attention. That patient needs your attention at the end of the day; when you go home you become wasted for the remaining part of the day, because you don't want to keep your patient without that care, so you stretch out yourself and you still cannot give quality care"*



Huge workload as a barrier to provision of psychiatric nursing care was also observed by the researcher during participant observation. In one instance a patient was wheeled in for admission, but the two psychiatric nurses on duty did not admit the patient because the nurse in charge was busy writing a report while the other nurse was conducting the ward round. It took a while before the nurse in charge could finish the report and attend to the patient and his relatives. The lack of recognition of hard work as a barrier to provision of psychiatric nursing care was revealed by one of the participants as follows:

*“..... When your hard work is not recognised, you are demotivated and it bounces back on the patient, because when you come to the hospital you know your work is not appreciated, paid for, you are not recognised. You are not supposed to stress yourself; hence you provide care anyhow sometimes”*

Another participant indicated as follows:

*“... When you don't recognise our contribution you make us feel bad and so you calm our nerve, our zeal is killed; after all, even if I do, nobody will appreciate me”*

An extract from another participant highlighted lack of recognition and appreciation as a barrier to provision of psychiatric nursing care as follows:

*“If I am doing well, encourage me, even if it means by writing a commendation letter, you have done well, we appreciate what you are doing, keep it up. That will ginger [motivate] me to do more. Lack of this motivation affects our care-giving”*

Participants mentioned poor remuneration as a barrier to provision of psychiatric nursing care while responding to interview questions. One highlighted it as follows:

*“How much is your salary? Not much at all, no kobo for special allowance for a psychiatric nurse; it demotivates us and kills our zeal to provide quality care”*

Another participant stated as follows:

*“Salary is a hindrance, because you know the truth of the matter is that psychiatric nursing is the most risky aspect of nursing; anything could have happened, OK, the patient can injure you, strangulate or kill you”*

Personal safety emerged as a barrier to provision of psychiatric care from data collected through individual interviews and participant observations. For instance, the non-allocation of security personnel to the wards to maintain law and order makes it difficult for the psychiatric nurses to calm aggressive patients. As one participant put it:

*“Facing a psychiatric patient is as good as facing the terrorists, these people have lost their senses just as mad men, so they can do anything, and there are many instances where the psychiatric patient kills the nurse or harms them or injures them. So most times you have to be careful when providing care”*

Another participant highlighted personal safety as a barrier to provision of psychiatric nursing care as follows:

*“... Some of the patients can be aggressive, they can attack you, your life is in danger. Like if you see a patient in crisis now, the doctor will sit down and write a prescription. Sometimes even before you call the doctor, the patient comes directly in contact with you, so you are the most vulnerable person that comes in contact with the patient, and that has an effect on the care you provide in some instances”*

Responses of participants to the interview questions highlighted irregular training and attendance of seminars and workshops as barriers to provision of psychiatric nursing care. As one participant expressed it:

*“The last course I attended in therapeutics was in 2006 and so many changes have evolved between that time and now and that ... affects provision of up-to-date care to patients”*

An excerpt from another participant stated as follows:

*“I think I went for seminar only once and since then I have never been gone for any. This affects the provision of up-to-date care”*

Movement of relatives and visitors in and out of the wards was highlighted as a barrier to provision of psychiatric nursing care in the data collected from individual interviews. This was also observed by the researcher during participant observations. As one participant put it:

*“A good number of the patients we admit here are the Hausas and they have the tradition of trooping to the hospital to see their sick ones .... they will not allow us to perform our duties”.*

High volume of visitors as a barrier to provision of psychiatric nursing care was observed during the participant observation data collection phase, which exposed the researcher to first-hand experience of one of the barriers identified by the participants. Throughout the period of participant observation a high number of visitors were noticed. The relatives trooped in and out of the unit without any regulation, and there were no prescribed visiting hours. This provided the researcher with experience of this barrier to provision of psychiatric nursing care. For instance, on a few occasions the researcher observed that certain procedures such as injections were carried out in the nurses' station or the nurses' changing room.

### ***5.3.2 Relationship-related barriers to provision of psychiatric nursing care***

This theme emerged from data that showed how the influence of the relationship among the psychiatric nurses, between the psychiatric nurse and the patient, the psychiatric nurse and the patients' relatives, the psychiatric nurses and other members of the psychiatric team, and between the psychiatric nurse and the management of the hospital hinder provision of psychiatric nursing care.

The theme had four related subthemes, including nurse-nurse-related barriers to provision of psychiatric nursing care, nurse-patient/patients-related barriers to provision of psychiatric nursing care, nurse-other health team member-related

barriers to provision of psychiatric nursing care, and nurse-management-related barriers to provision of psychiatric nursing care.

#### 5.3.2.1 Nurse-nurse-related barriers to provision of psychiatric nursing care

The nurse-nurse-related barriers to the provision of psychiatric nursing care revealed in this study included lack of support from colleagues and superiors and the “pull her down syndrome”.

One participant explained lack of support from colleagues and superiors as a barrier to provision of psychiatric nursing care as follows:

*“At times ... you put in your best to help a patient and maybe one of those unlucky things happens; instead of your colleagues and your superiors saying you have tried, they will rather turn and say why you went an extra mile .... so you begin to blame yourself, is it wrong to go an extra mile, so next time when such things come I will stop at the periphery, I will not go deeper”*

Another participant described “pull her down syndrome” as a barrier to provision of psychiatric nursing as follows:

*“Well another challenge that I can talk on is on nursing generally. You know we have this problem of ... PhD [pull her down] .... Nurses that are already up don't want you that are coming up to go up .... Like now, the issue of going for this BNSc (Bachelor of Nursing Science degree) .... The department can say, 'Let us train those who are interested in the conventional university', but they don't do that, and even when you apply they will fight you.... they want us to work but there are no means to allow us to work the way you really want .... This is really challenging and it affects care provision.”*

### 5.3.2.2 Nurse-patient/patients' relatives-related barriers to provision of psychiatric nursing care

The subtheme nurse-patient/patients relatives-related barriers to provision of psychiatric nursing care emerged from the influence of attitudes and behaviours between the nurse, patients or patients' relatives on provision of psychiatric nursing care. These included: bullying of nurses by patients, uncooperative attitudes of patients and patients' relatives, and inadequacy of information provision by relatives during admission procedures.

The following extract from one participant highlights the "bullying of nurses by patients" as a barrier to provision of psychiatric nursing care:

*"Sometimes there may be bullying; despite the care you give, they can say rubbish and this is usually frustrating, it makes us feel like not caring for them anymore"*

Another participant described non-compliance with treatment by patients as a barrier to provision of psychiatric nursing care as follows:

*"Another thing that discourages me is that when you are doing your best for a patient to get better and after a period of time they don't comply with their drugs, they don't come back, you know .... this person just went ahead and flaunted everything, it discourages me"*

The uncooperative attitudes of patients' relatives were highlighted as a barrier to provision of psychiatric nursing care by one participant:

*"By the time you get to the ward, you are telling them this is what you want them to do that will facilitate the speedy recovery of the patients; they are doing opposite of it. This demotivates one to give care"*

An excerpt from one of the participants revealed provision of inadequate patient information by relatives as a barrier to provision of psychiatric nursing care:

*"Sometimes when the patients' relatives bring in patients they don't give us enough information about the patients, which can affect our care. For*

*instance, if the patient has had head injury, there are some drugs that cannot be given to the patient”.*

#### 5.3.2.3 Nurse-other members of the psychiatric team-related barriers to provision of psychiatric nursing care

This subtheme emerged from data that show the influence of a negative relationship between the nurse and other members of the psychiatric team on provision of psychiatric nursing care. This included communication problems within the psychiatric team, lack of collaborative treatment within the psychiatric health team and conflict among psychiatric team members.

One of the participants described communication problems within the psychiatric team and conflict among psychiatric team members as follows:

*“There seems to be a communication barrier between the health team, the pharmacy, nursing, psychology, medical departments; there seems to be a barrier in communication. Because of the barrier in communication in the team, a sort of conflict, that is another thing I see as another factor. Communication problem among the team, because everybody will like to usurp certain power or authority or responsibility ... and is like, if you do this you are encroaching, so I think these are issues that really hinder us from delivering our services effectively”*

Another participant narrated lack of collaborative treatment and conflict among the psychiatric team as a barrier to provision of psychiatric nursing care:

*“When a drug is prescribed for a patient and is not available in the pharmacy... the idle thing is for the pharmacist to indicate either out of stock or not available .... but sometimes the response we get from the pharmacy department will be they don't write OS or NA on prescription sheet, so how do you know that these drugs are not available? Now sometimes if they indicate OS or NA, you may not see the doctor to transfer the prescription to the outpatient prescription sheet for the relatives to go and buy, and if the nurses write it on plain paper it will not*

*be honoured there at the pharmacy store. So you see, the whole thing bounces back on the patient and you the nurse that is in constant contact with the patient, it becomes a hindrance to your provision of care”*

Another participant highlighted communication problems and conflict among psychiatric team members as a barrier to provision of psychiatric nursing care as follows:

*“... all these conflict/problems among health workers bounces back on the patient and this is a very small thing that can be solved. OK, what is the policy of the organisation, simple, you know your limits, boundary, you don't encroach into the other professions' roles and the patient will not be waiting for who will attend to him or who will do this at a particular time”*

#### 5.3.2.4 Psychiatric nurses-management relationship barriers to provision of psychiatric nursing care

This subtheme emerged from data that showed the negative influence of the relationship between nurse and management. These included deprivation of opportunity and sponsorship to attend update courses, poor response to training requests and procurement of facilities, use of derogatory statements and passing comments, and demeaning attitudes towards the psychiatric nurses. These behaviours from management were reported to affect relationships with the psychiatric nurses, resulting in demoralisation of the psychiatric nurses and hindering them in provision of psychiatric nursing care.

One participant highlighted deprivation of opportunities and sponsorship to attend update courses as a barrier to provision of psychiatric nursing care as follows:

*“I think I went for a seminar only once and that is on VCT. Since then I have never been allowed to go for a seminar, even if I want to. By the time they say self-sponsor, maybe 50 000 or 100 000 and all those things, then the financial aspect will discourage you. This usually demoralises one and it affects the care we give”*

Another participant highlighted deprivation of opportunities to attend update courses as a barrier to provision of psychiatric nursing care:

*“The management is frustrating us ... when you appeal to them to provide you with opportunity to attend the course, they don’t give you that. If we apply for seminar they hardly will approve. If let’s say five applied, they will approve maybe one or sometimes they will say no money. Then we do not know the latest in the provision of psychiatric care anymore”*

One participant revealed lack of sponsorship for update courses as a barrier to provision of psychiatric nursing care as follows:

*“Trainings like workshops, seminars, short courses were not sponsored, because government don’t have enough money says management, this affects the currency of our practising skills and knowledge, which affects the care we provide to our patient”*

Another participant highlighted deprivation of opportunities to attend update courses as a barrier to the provision of psychiatric nursing care as follows:

*“If I am deprived to go for update courses invariably it is my patients that will suffer, but where you have new things that are coming in through update courses, it attracts changes and facilitates faster and better recovery of your patients”*

One participant highlighted a demeaning attitude and use of derogatory statements towards psychiatric nurses as a barrier to provision of psychiatric nursing care as follows:

*“Naturally with the experience I have in this hospital, the management tends to look down on psychiatric nurses, because the CMDs [management staff] ... they used to refer to us as mahaukatas [meaning ‘mad people’], which affects us psychologically. This in turn affects how we render care to our patients”.*

Another highlighted the use of derogatory statements and passing comments as a barrier to provision of psychiatric nursing care:



*“He [the Assistant Director of Nursing] makes utterances like is it not psychiatric patients you are taking care of? What is so special about it ... because of that, when you say manpower needs improvement, he will say is it not psychiatric patients? Is it not for you to sedate them and forget it? I don’t know, maybe the management does not like psychiatric nursing ... and this affects us and sometimes the care we give”*

An extract from one participant highlighted poor response of management to requests for training as a barrier to provision of psychiatric care as follows:

*“If we apply for a seminar they hardly will approve; if say five apply, they will approve maybe, one or sometimes they will say there is no money. This attitude demotivates us from doing our responsibility properly”*

Another participant’s quote captures the poor response to a request for facilities as a barrier to provision of psychiatric nursing care:

*“The management is frustrating us ... when you appeal to them to provide these facilities, they don’t; when you go to other departments, they have everything to work with”*

Stripping off of roles was observed during the covert observations. In some instances the psychiatric nurses were observed sending the patients home without prescriptions, simply because the doctor did not respond to a call by the nurses or declined to come at the request of the nurses, and they don’t have prescriptive authority. This is usually the case, especially when the patients come during the afternoon shifts; the patients usually went home without medication, which allows for relapse.

### **5.3.3 Environmental barriers to provision of psychiatric nursing care**

This theme emerged from data that showed how the physical structure can be seen as a barrier to provision of psychiatric nursing care. This theme is similar to the physical environment construct of the conceptual framework that guided the study. The theme had two subthemes, namely physical layout and location of

the unit as a barrier to provision of psychiatric nursing care, and aesthetics of the unit as a barrier to provision of psychiatric nursing care.

#### 5.3.3.1 Physical layout and location of the unit as barriers to provision of psychiatric nursing care

This theme emerged from the data from participant observations and individual interviews. It included inadequate facilities and lack of ideal ward setting with location of the ward in the heart of town, presence of occupational hazards and broken-down structures.

The whole structure of the unit was observed to be unfavourable for provision of psychiatric care and harmful to the psychiatric nurses and patients alike. For instance, the septic tank was broken and some of its contents exposed, there was broken glass from the louvres, and naked wires which are dangerous to the patients.

As one participant highlighted:

*“At times we don’t have equipment, enough equipment to care for the patients. Like if you have these violent patients, unlike where I was trained; you have this seclusion room, you have restraint rooms, but here ‘tho’ [mannerisms], unless we improvise. This affects our care”*

Another participant revealed lack of ideal ward setting as a barrier to provision of psychiatric nursing care as follows:

*“We don’t have the drug section, we just have conventional wards where all the patients are jam-packed. Like for the addicts, you carry out detoxification and allow them to go home, while if it is a real therapeutic set-up, patients will be allowed to stay for three to six months before they are allowed to go. This is not good for provision of care”*

An extract from one of the participants explained lack of ideal ward setting as a barrier to provision of psychiatric nursing care:

*“Like the environment is not conducive for quality care, especially to be given to a psychiatric patient, because like where I work is just a unit, and the kind of patients we come across on a daily basis especially – when you look at the number of patients, we have a percentage of them mostly drug patients. When you are taking care of drug patients, you need an exclusive area, but if you have an exclusive area to prevent them from going out at will, then you find out that your aim of admitting them is not achieved. That is one of the challenges here”*

An extract from one participant highlighted location of the hospital in the heart of the town as a barrier to provision of psychiatric nursing care:

*“Generally the location of the place is not good for psychiatry. The hospital is in the midst of the town, which is not good for psychiatric patients and provision of psychiatric nursing care. The situation of the psychiatric hospital is supposed to be distant from the town, the patient needs quietness”*

An extract from another participant supported this:

*“The hospital is just close to the market and everybody that goes to the market to buy something comes in, whether the person is close to the patient or not. If they find themselves around the hospital they just want to come in, because it is easily accessible. So we are having hindrances to providing care”*

The general state of the physical layout and location of the unit was observed to be a major barrier to provision of psychiatric nursing care. This was further confirmed by the field notes of observations whenever the participants were talking about the physical structure. For instance, when asked if the hospital management was aware of the state of the facility, one participant’s response was “don’t mind them, they always say we will see what we can do about it and that is the end, and you never hear them talking about it again.”

The participants revealed occupational hazards as barriers to provision of psychiatric nursing while responding to the interview questions. Participant observation provided the researcher with the first-hand opportunity to observe occupational hazards in the ward.

An extract from one of the participants highlighted occupational hazards as a barrier to provision of psychiatric nursing care as follows:

*“In the job there are hazards [occupational hazards], I can look at it as a job of hazards, the patient you can never predict since they are unpredictable, you might think this patient is calm and suddenly the patient might want to attack you, maybe due to hallucinations or anything can be happening; he is just unpredictable”*

Another participant expressed occupational hazards as a barrier to provision of psychiatric nursing care as follows:

*“There was a time one patient attacked two nurses on duty; he threw both of them to the ground because he was very aggressive, so most times we are careful when providing care to aggressive patients, which affects your concentration on the care you are providing”*

An extract from one participant highlighted dilapidated/broken-down structures as a barrier to provision of psychiatric nursing care as follows:

*“Sometimes you find naked wires around; even the glass is broken and dangerous to the patient and the nurses ... this influences our care”*

Another described dilapidated/broken-down structures as a barrier to provision of psychiatric nursing care as follows:

*“The environment is not conducive for psychiatric nursing and it demotivates me and also affects care provision. All these windows are broken, the glass, which are not good for psychiatric patients, no mosquito nets. They are so exposed, they come here with psychiatric illness, they go back home with malaria and typhoid fever”*

Another participant commented as follows:

*“If you just look at the environment, you know the doors, windows, the everything, they are not fit enough for psychiatric patients, you see glass, which makes the environment unconducive and unsafe for the psychiatric nurse and patient. This definitely affects care”*

#### 5.3.3.2 Aesthetics of the unit as barriers to provision of psychiatric nursing care

This subtheme relates to poor supply of light and lack of a therapeutic environment. Most of these issues were reported to be barriers to provision of psychiatric nursing care and to have a negative influence on the psychiatric patients' recovery process and period of recovery.

One of the participants explained poor supply of light supply as a barrier to provision of psychiatric nursing care as follows:

*“We have poor light supply in the unit, sometimes you come in the night, this part of the ward will have no light. You will be struggling to, you want to give IV and you will be looking for rechargeable .... when there is no NEPA [electricity] light there is no provision for generator. Even when there is a generator they will tell you there is no diesel, and even when they are on the generator they will tell you it's for one hour only. This makes it difficult to give care to patients in the night”*

An extract from one of the participants described poor supply of light as a barrier to the provision of psychiatric nursing care as follows:

*“The issue of light has been poor. When you tell management, they will tell you they cannot manage two hospitals at the same time, even when you tell the generator man to turn on the generator, the diesel doesn't last for two hours. You just have to be with your torch, sometimes we ask the patients relatives to bring their torch, so that we can have good light. So at times you will see yourself working in the dark, and it affects our work”*

One participant revealed lack of therapeutic environment as a barrier to provision of psychiatric nursing care:

*“If you are not in a good environment for managing psychiatric patients, it is not encouraging. You need at least the environment to be therapeutic enough. Like somebody that has mania now, we don’t have a regulator for dim light, which affects our care”*

Extract from one of the participants described absence of a therapeutic/conducive environment as a barrier to provision of psychiatric nursing care as follows:

*“The environment is not good for the patient, because we are in the temporary site, so we have to manage what we have by creating an enabling environment. You know most of the patients, there is no way you can remove distractions, because of the way the ward is. It is a hindrance because for a manic patient going by the way the place is rowdy and will excite the patient, but for the depressed patient it is ok, because you want that patient to come out of her shell. So these are the obstacles we are facing”*

A participant revealed lack of therapeutic environment as a barrier to the provision of psychiatric nursing care as follows:

*“There is nothing like home-likeness here; in psychiatry there should be a home- like setting; when you parole with the patient, the patient does not directly go to his home. At least there should be a setting where the patient can be monitored, at least for one or two weeks, and when he is doing well you can discharge him. All these things are lacking, so it is really a hindrance”*

#### **5.3.4 Organisational barriers to provision of psychiatric nursing care**

This theme emerged from data that related to human resources, policies, and other tools that are supposed to enable the psychiatric nurses to give psychiatric nursing care. This theme is similar to the organisational systems construct of the conceptual framework that guided the study. This theme had two subthemes,

namely absence of tools for provision of psychiatric nursing care and managerial barriers to provision of psychiatric nursing care.

#### 5.3.4.1 Absence of tools as barriers to provision of psychiatric nursing care

Three main tools emerged under this subtheme – human resources, facilities, and policies and guidelines three – that relate to barriers to provision of psychiatric nursing care.

Human resource-related barriers to provision of psychiatric nursing care included gross shortage of manpower, inadequate psychiatric-trained manpower, and stigmatisation from other health personnel, staff of the hospital and management staff.

Participants also reported that patients abscond because of the gross shortage of manpower, and sometimes they have to abandon their responsibilities in pursuit of the malingering patients.

One participant highlighted the problem of staff shortage as a barrier to provision of psychiatric nursing care as follows:

*“One staff member can run a shift; as you can see, we are just two on duty, you come on night duty alone and you have drug addicts to care for, you have alcoholics that will crave substances at night. You need sufficient hands to cater for these patients”*

One participant described the barrier of manpower shortage as follows:

*“You cannot give quality care when you have 25 patients to one nurse; what kind of care will you give? At the end of the day you the caregiver will get choked up, tired and confused. You don’t know which part to play, you are so confused that you end up attending to some patients and not attending to others”*

Another participant revealed manpower shortage as a barrier to the provision of psychiatric nursing care as follows:

*“In the night duty you can have only one nurse on duty, and imagine if there is an aggressive patient. How will you tear yourself into two? So the care.... is actually affected”*

*“With enough manpower, you see, you will go in for job allocation, one nurse can take care of 3 or 4 patients, sit down with them, and talk with them, know their problems; but when you have only one person possibly on duty to cater for say 20 patients, you try as much as possible to do what you can do and not what is expected of you”*

Participant observations further highlighted the problem of manpower shortage as a barrier to provision of psychiatric nursing care. This was observed at different times. For instance, on one occasion the researcher witnessed the psychiatric nurses abandon all the care that they were providing, lock the nurses' station and go after a patient that had absconded. In another instance the two nurses on duty took antipsychotics with them and invited some patients' relatives to accompany them to calm and arrest an aggressive patient who had absconded from the ward. On another occasion the nurses on duty were observed administering ECT with patients' relatives participating in the provision of ECT. After one of the ECT sessions the relatives were left in the improvised ECT room to monitor the patient as he recovered from the therapy. The psychiatric nurses had to do this because they needed to go back to the ward in order to attend to other patients.

Inadequately trained psychiatric nurses and specialists as a barrier to provision of psychiatric nursing care was revealed by participants during individual interviews, and also observed by the researcher during participant observations.

One participant highlighted inadequately trained psychiatric nurses as a barrier to the provision of psychiatric nursing care as follows:

*“In our ward presently, not all the nurses are trained psychiatric nurses, which are results of reduced number of trained nurses around. So we have general nurses in the ward; that constitutes a major barrier to giving what is needed to the patient”*



An extract from one participant revealed lack of specialists as a barrier to provision of psychiatric nursing care:

*“We don’t have nurses who have specialised in an area of specialisation geared towards treating and managing other forms of cases ... we don’t have such at all, and this prevents the provision of specialised nursing care to patients”*

The inadequacy of trained psychiatric nurses as a barrier to provision of psychiatric nursing care was observed first-hand by the researcher during the participant observations. During one of the shifts one of the psychiatric nurses was confronted with a patient that needed cognitive behavioural therapy, but the nurse only gave the patient medication.

One participant highlighted discrimination from management as a barrier to provision of psychiatric nursing care:

*“You know psychiatric nursing, let me just say, is neglected. What I am seeing here, you discover that we are not given proper attention as in other departments. The psychiatric staff, the psychiatric patient, going by what you are seeing here, they allow us here and this affects us and the care we give to our patients”*

The following extracts from two participants’ revealed stigmatisation and discrimination as barriers to provision of psychiatric nursing care:

*“The management look at us as mad men and women. Whenever you go for a congress meeting, most times people [other nurses] will not want to sit with you. This usually affects your morale and sometimes it even affects the care you give your patients”*

*“Nurses, doctors, and the public have stigmatised psychiatric nursing. I remember when I came back from the course in psychiatric in 2006, the ADNS [assistant director of nursing services] even said, so psychiatric nurses now know how to organise courses, you know that time they will*

say 'mahaukata ne a nan' [*it is mad people that are here*], you can imagine”

A couple of facilities-related barriers to provision of psychiatric nursing care emerged from data collected through the grand tour question, individual interviews and participant observations. These included: lack of basic supportive facilities like weighing scales and urine strips, lack of or gross inadequacy of consumables like drugs, needles and syringes, lack of indoor and outdoor games like sporting facilities and other games, and lack of a functional occupational therapy unit.

Extracts from three participants revealed lack of basic supportive facilities as a barrier to provision of psychiatric nursing care as follows:

*“Now like a simple weighing machine, we don't have. Patients will come, you will admit them, but you can't measure their weight. We don't have urine strips to carry out basic urinalysis in the ward and we don't have sterilised equipment to attend to our patients. We don't have bed sheets, the ones we have are tattered, so these are things that could actually hinder our provision of care effectively”*

*“For the past six months we had been admitting patients without doing urinalysis, which is one of the baseline investigations during admission. We cannot weight our patients due to a faulty weighing scale, and how much is a weighing scale that you cannot provide? How much are urine strips that you cannot provide to check for patients' urine on admission?”*

*“Some of the basic challenges are lack of equipment to carry out what we have been trained to do. Our problem is that sometimes you don't have equipment to carry our legitimate functions. For example, when you admit the patient, you are supposed to weigh the patient, carry out tests like urine test, but for a very long time now we don't have the reagents from management”*

A lack of indoor and outdoor games and other supportive facilities like sporting facilities, games and audio-visual gadgets in the wards were highlighted as barriers to provision of psychiatric nursing care in the data collected through the grand tour interviews, individual interviews and participant observations.

Two participants highlighted the lack of indoor and outdoor games and supportive facilities as a barrier to provision of psychiatric nursing care as follows:

*“Ordinarily the facility for indoor and outdoor games like volleyball, table tennis and a host of other games will reduce boredom, and should be made available for patients who find it difficult to rest. This usually affects the care we provide and recovery time for patients. If they don’t want to sleep they can go and watch TV or video and what have you ..... but all the facilities are not there, this will definitely affect the patients’ care”*

*“Absence of monitors ... the offices are not available for a few of them to actually work, the OT [Occupational Therapy] we don’t have available accommodation for them. The patient we admit here is dependent on availability of bed, recreational facilities are largely not available, and the OT department is not functioning yet”*

Lack of or inadequate supply of consumables such as medication and needles and syringes were revealed in the data collected through individual interviews and participant observation.

Two participants highlighted inadequate supply of consumables as a barrier to provision of psychiatric nursing care as follows:

*“The issue of drugs, it is not all the time that the hospital have drugs and there are times you will see all sort of discouragement when patients come and pay admission fee and then you are writing for them drugs to buy outside, it is not encouraging ... these basic drugs they need to have in the hospital. It really affects our care”*

*“When the hospital doesn’t have drugs, it usually discourages us, when patients come on admission you start giving them prescriptions to go outside, meanwhile their money is tied down”*

The participant observations exposed the researcher to barriers to provision of psychiatric care related to the absence of or inadequate facilities. Throughout the period of participant observation the researcher noticed that urinalysis, mental examination, weighing and the like were not carried out on any patient. The researcher also noted that occupational therapy sessions were done verbally due lack of a functional occupational therapy unit. On several occasions the researcher observed that the patients’ relatives were asked to go and buy drugs outside of the hospital after the hospital would have billed the patients for medication.

Hospital policy and regulations that influence provision of psychiatric nursing care were highlighted in data collected through interviews. These included: limitations placed by hospital policy and regulations, absence of a policy statement on psychiatric nursing, absence of scope of practice for psychiatric nurses in the hospital, and lack of delineation and clarity of roles within the psychiatric health team.

Two of the participants described limitations placed by hospital policy as barriers to provision of psychiatric care as follows:

*“You know this thing about boundary as to what to do and not do is frustrating. For instance, basic care like the ECT, where I was trained it was given by the nurses, here a doctor has to be there, to be the one to order it, do it. I can do it, but I am not allowed, so it is a hindrance to providing care. The policy is affecting my work as a psychiatric nurse, because there are certain things I wish to do for my patient, which I am trained to do but I can’t, because of this hindrance”*

*“Like I have been telling you, the problem with the hospital policy has not allowed me to exercise my knowledge, it has not, because I know as a trained psychiatric nurse I am supposed to organise psychiatric sessions*

*for my patients, OK, which is not in place. I am supposed to organise individual or group psychotherapy, which the hospital policy has not really explained to us”*

Hospital regulations were revealed by participants during individual interviews as barriers to provision of psychiatric nursing care. Quotes from four of the participants highlighted limitations placed by hospital regulations as a barrier to provision of psychiatric care as follows:

*“We are confined to just some few basic responsibilities like giving a lecture to our fellow colleagues when they come on clinical posting ... You know what to do to your patients but you have to wait for the doctor [psychiatrists and intern doctors]. This affects our care provision”*

*“You know this issue of doctor/nurse, there are some things you want to carry out on your patients, they will say its doctor’s procedure, so we have to wait for them even when your patient is at risk. This prevents us from practicing what we have been taught”*

*“Sometimes when a patient comes that you ordinarily know what to do, to calm down the patient pending when he is reviewed by a psychiatrist on call, the policy says you have to wait till he comes and sometimes even if it is a general practitioner comes for psychiatric posting, when you know better what to do – you still have to wait for him. It is actually painful, you know what to do to your patients but you have to wait for the doctor. This policy is not allowing us to give our patients the best care”*

*“Like the administration of ECT that you know, after you prepare the patient for ECT, you have to go and look for a doctor to come and press the button for the ECT, after which you do the cleansing and observe him till he is fully recovered. But this is something you taught them. These are some of the things you know. It is painful and it frustrates us and it affects our care”*

One participant highlighted lack of scope of practice for psychiatric nurses as a barrier to provision of psychiatric nursing care:

*“It is unarguable that there is a problem in the health sector that has to do with the scope of practice .... Well I think the nursing profession has not been exercising its scope of practice.... Sometimes we don’t seem to know our defined roles, OK. Sometimes we are just guided by the hospital’s policy and that affects the quality of care we give”*

Two participants described lack of a hospital policy statement on psychiatric nursing practice as a barrier to provision of psychiatric nursing care:

*“Without policy you move without direction, if there is policy you move with direction, with certain things you want to achieve at the end of the day, but when it is not there you move randomly, you cannot quantify, you cannot measure what you are doing, and this affects the care we give. If there are policies you move towards the direction of the policy and it will help us and it will help the management”*

*“There is no copy of the scope of practice regarding what to do and what not to do, OK, except you know you do things based on experience, what you see your seniors doing and what they don’t do, and this affects our care ... Since I came to this organisation I have never seen a document that contains the hospital policy as regards psychiatric nursing care to the patient, so we use our discretion most of the time, which doesn’t have a standard”*

One participant revealed lack of delineation and clarity of roles within the psychiatric health team as a barrier to provision of psychiatric nursing care, as follows:

*“Sometime, the policy, because it is not a written document, does not have a defined responsibility for the nurse ... Sometimes you will be told to take a blood sample, sometimes you will be told it is not your responsibility, sometimes like giving IV injection to the patient, you will be*

*told it is your duty, sometimes they will tell you it is the doctors' duty, so these are things that are not defined and it affects our care"*

#### 5.3.4.2 Managerial-related barriers to provision of psychiatric nursing care

This subtheme emerged from several behaviours of management staff that were perceived as barriers to provision of psychiatric nursing care, which include lack of sponsorship for specialty training, poor value system and lack of interest in psychiatric nurses' training, stripping off of some roles of the psychiatric nurses, neglect of the psychiatric unit, and exhibition of favouritism and bias.

An extract from one of the participants highlighted lack of sponsorship for specialty training as a barrier to provision of psychiatric nursing care:

*"No nurse has ever been sponsored to go for forensic, child or community psychiatric nursing ... since I graduated psychiatric ... I have not been able to specialise in any area of psychiatric, but I am expected to provide care to these patients, how?"*

The following extract from two of the participants revealed management's 'poor value system' on psychiatric nurses' training as a barrier to provision of psychiatric nursing care:

*"The management's willingness to send the nurse out for training and all that is not there ... the management said no budget line for training and research ... the fewer nurses we have around, giving room for people to go for study, will further deplete what is available (management's position); without this training how can we provide efficient and up-to-date care"*

*"There are little seminars/workshops even around or outside the state that if they are going they should look at psychiatric nurses, but they look at it that we don't even need it, and this affects our zeal in caring for our patients"*

Stripping off of some responsibilities as barrier to provision of psychiatric nursing care emerged from data collected through individual interviews with participants.

Three of the participants highlighted this as follows:

*“Some years ago we use to consult patients, administer ECT, prescribe medications, admit and discharge patients, but management stopped us from doing them. You know, we know how to do some of these procedures better than them; actually we were the ones that train most of the doctors we have today, even the consultants to carry out some of these procedures. This is really demoralising”*

*“Initially we were the ones taking care of treatment with ECT, we taught them how it is done ... when they became knowledgeable they deprived us, you see some of these things are frustrating and it discourages you ... you know how can you teach somebody how to do something and later on it turns out to be that he must be there before you do something? I find it difficult to understand and it really affects the care we give our patients.”*

*“When I took appointment here .... We had just 2 consultants, 2 residents .... we the trained psychiatric nurses do see some patients, you can review, prescribe and the patients go back home ... as time went on, the doctors were multiplying ... and a directive came that all psychiatric nurses should hands off those ones, so we stop. This is really humiliating and it really affects our zeal to provide care*

Two participants described exhibition of favouritism and bias as a barrier to the provision of psychiatric nursing care as follows:

*“No psychiatric nurse has ever gone abroad to study, but several doctors have gone and are still going .... And I ask myself why the management deprive me from going for an update course each time I apply? This is partiality and injustice. It discourages one most of the time and it affects my provision of care”*



*“You see the problem with the profession where the leadership favours one and the other is not favoured is always a problem. In this profession that we find ourselves, you discovered that anything that has to do with the doctor is usually given greater attention than all the other health professions, like nursing, pharmacy, medical laboratory science, etc., unless a doctor is part of it you don’t get sponsorship. This is really demoralising and sometimes unconsciously it influences your care”*

One of the participants highlighted neglect of the psychiatric nurses as a barrier to provision of psychiatric care as follows:

*“We have been neglected even, what they are supposed to provide for us as members of [the hospital], they don’t even remember we are still here. This is really frustrating and it usually affects my morale when providing care”*

### **5.3.5 Public -related barriers to provision of psychiatric nursing care**

This theme emerged from data that revealed government activities and societal values and belief systems that influence the provision of psychiatric nursing care. This theme is similar to the construct ‘incentive’ of the conceptual framework that guided the study. This theme had two subthemes, governmental barriers and societal barriers to provision of psychiatric nursing care.

#### **5.3.5.1 Governmental barriers to provision of psychiatric nursing care**

Governmental barriers to provision of psychiatric nursing care that were explored and identified include: absence of scope of practice and policy statement for psychiatric nursing practice in Nigeria, neglect of the psychiatric sector by the government, poor salary structure and hazard allowance as compared to hazards associated with practice, and non-implementation of the hazard allowance for persons working in hazardous institutions (which includes psychiatric nurses).

Two of the participants highlighted neglect of psychiatry as a barrier to provision of psychiatric nursing care as follows:

*“So that negligence, given to the psychiatric patients, that lack of care, concern by the Nigerian Government, is the effect of what the profession is suffering, this affects care given to the patients”*

*“Government and management have shifted its attention completely from this psychiatric unit, because most times there are no lights, water to even flush the toilet, no bed sheets, you have to manage all this to see that the patient is comfortable and the patient suffers and the nurse ... I can tell you with all humility that psychiatric nurses are one of the best nurses you can see anywhere, they do their jobs selflessly ... but yet the government is not giving it any recognition. This affects our morale and sometimes we are demoralised to give our best”*

Two of the participants highlighted poor salary and lack of an allowance as a barrier to provision of psychiatric nursing care:

*“There is no special allowance attached to a psychiatric nurse, by virtue of his work or training, which is a hindrance, because not so many people want to specialise in psychiatric nursing ... psychiatric nurses should have special allowance, if you consider other specialties in nursing, they are less risky, and yet they are enjoying call duty allowance, etc. Recently a dialysis unit has been introduced, they are enjoying special allowances. Are we saying psychiatric nursing is not important? The government must wake up to her responsibility”*

*“How much is the government paying you? Not much at all, no kobo or special allowance for a psychiatric nurse. It demotivates and it affects your optimal performance.”*

One participant explained non-implementation of the special allowance for persons working in hazardous institutions or specialisations as a barrier to the provision of psychiatric nursing care:

*“Recently there was a document which I was privileged to see, released by APNON [Association Of Psychiatric Nurses of Nigeria], that during the*

*regime of late president Yar'adua, there was a document signed, that psychiatric nursing is a highly hazardous job just like people who work in chemical industries, the hazard is placed alongside those people and so they should be given special allowance, because of the nature of the job, and up till date this thing has not been actualised”*

Two of the participants highlighted lack of a scope of practice and policy statement as barriers to provision of psychiatric nursing care as follows:

*“There is no written policy (for psychiatric nursing practice), so whatever you are doing, you don't really have confidence, which can affect the quality of care you provide because you are supposed to know what you are supposed to do and what not to do”*

*“Without policy you move without direction, if there is policy you move with direction, with certain things you want to achieve at the end of the day, but when it is not there you move randomly and this definitely affects the standard of the care we provide to our patients”*

#### 5.3.5.2 Societal barriers to provision of psychiatric nursing care

An extract from one of the participants also highlighted stigmatisation as a barrier to provision of psychiatric nursing care:

*“It is one of the most stigmatised specialisations, both the patients and the caregivers are stigmatised ... There is a saying that those who work in the field have mental illness, this really affects us and sometimes it influences the care we provide”*

One of the participants highlighted discrimination as a barrier to provision of psychiatric nursing care:

*“If a psychiatric patient is as important as other patients, then we should consider his care as paramount; unfortunately our society does not give priority or concern to psychiatric patients you see on the streets”*

### 5.3.6 Motivators to provision of psychiatric nursing care

This theme was serendipitously discovered from the data. It emerged from data that revealed the inherent belief systems that motivate the psychiatric nurses to provide psychiatric nursing care to psychiatric patients amidst the barriers they experience. This theme had two subthemes which included the love for God/fear of God and good knowledge base, and love for the patient and psychiatric nursing and inner drive.

#### 5.3.6.1 Motivators related to intrinsic belief system and abilities

These motivators emerged from data that highlighted the belief system and inherent capabilities that enable the psychiatric nurses to remain in the psychiatric unit despite the barriers to provision of psychiatric nursing care. These included love for God, fear of God and a sound knowledge base.

Extracts from two of the participants highlighted the love of God and fear of God as motivators to provision of psychiatric nursing care as follows:

*“The love for God and the knowledge that at the end I will be accountable for every work you do, if you have that at the back of your mind, is just like the story of the talents, if you use it good for Him, He said occupy till I come, at the end you will give an account. It enables you to do what you are supposed to do with ease”*

*“You know psychiatric nursing is a calling, though some are here for the money, but I am here to serve humanity, because our lord Jesus Christ said I have come to serve not to be served, this encourages me to provide psychiatric nursing care despite everything else”*

An extract from another participant highlighted sound knowledge/skills as motivators to provision of psychiatric nursing as follows:

*“I can authoritatively say I have all the skills and knowledge to care for my patients, because right from my basic training I picked an interest in psychiatry; as a matter of fact I decided to specialise in psychiatry since*

*my intermediary, because I had a very good training. This is one of the things keeping me here”*

#### 5.3.6.2 Motivators related to intrinsic belief system and abilities influenced by the environment of the psychiatric nurses

These motivators emerged from data that highlighted the belief system and inherent capabilities influenced by the environment of the psychiatric nurses that enable the psychiatric nurses to remain in the psychiatric unit despite the barriers to provision of psychiatric nursing care. These included love for the patient and psychiatric nursing and inner drive as motivators to provision of psychiatric nursing care.

Two of the participants described love for the psychiatric nursing/psychiatric patients and inner drive as a motivator to provision of psychiatric care as follows:

*“For you to go to psychiatric you must have that in-built passion before you go to study psychiatric, like I earlier said, even when those things are not coming that passion, that feeling, the conscience in you will make you to overlook those things and go ahead to give out your quality nursing care to your patients despite lack of all those things.”*

*“I discovered that there is an aspect of nursing that I can be passionate about and I had a drive for, it was psychiatric nursing, which was one aspect I loved even when I was a student. So eventually after my graduation, I decided to go for psychiatric nursing, I love psychiatric nursing, I love psychiatric patients. This is what keeps me going despite the barriers to the provision of psychiatric nursing care”*

An extract from one of the participants also highlighted interest in psychiatric nursing and love for psychiatric patients as a motivator to provision of psychiatric nursing care:

*“I joined the psychiatric unit not because of the money, because before I went, I knew there was no special allowance. I was challenged that why should I go for something like that, I said I am interested in it and that has*

*been my motivation factor. I don't look at the money in anyway, I go by my heart, my heart goes for those patients. If everybody will run away from psychiatry, who will help them?"*

Another extract from one of participants supporting love for psychiatric nursing and psychiatric patients as a motivating factor to provision of psychiatric nursing care is the following:

*"What enables me to provide care for my patients is the general love I have for psychiatry as a whole, and you should also consider the fact that psychiatric patients are like any other person, they are members of the society, they have responsibilities, they have families, they should be given the care they deserve. So the love I have for people, especially those having psychiatric illness, is my driving force, it is what keeps me in the profession and what makes me to do what I am doing for my patients"*

The following quote from one of the interview sessions highlighted one of the things the psychiatric nurses do to ensure that they provide psychiatric nursing care to patients amidst the barriers to provision of psychiatric nursing care:

*"It might interest you to know that sometimes we remove our money to put some of these facilities in place, like these bulbs, most of the time they are from our pocket. You can see we are supposed to have a fridge here but it is spoilt, we have spent up to 20,000 to repair it, still it is not working"*

#### **5.4 Conclusion**

This chapter outlined a description of the sample of the study and the findings. Six themes and several subthemes emerged from the data that were collected through the grand tour interviews, individual interviews and participant observations. Five themes were barriers to provision of psychiatric nursing care while one was motivators to provision of psychiatric nursing care. The five themes were identified deductively using Wile's (1996) human technology

performance model and inductively based on the objectives of the study. The sixth theme was serendipitously discovered from the data.

The findings of the study revealed several barriers to the provision of psychiatric nursing care. These barriers are both internal to the psychiatric nurses and external to the psychiatric nurses. The most significant barrier as reported by the participants and observed by the researcher was organisational barriers to provision of psychiatric nursing care.

The study also revealed a couple of motivators to the provision of psychiatric nursing care, which were also of internal and external origin. The most significant motivator was love for the profession and for psychiatric patients.

## Chapter six

### Discussion of findings, recommendations, limitations and conclusion

#### 6.1 Introduction

This chapter discusses the findings of the study and the limitation of the study. The recommendations and the conclusion are also presented. The purpose of this case study was to explore and identify the barriers to provision of psychiatric nursing to psychiatric patients by psychiatric nurses in a teaching hospital in Jos, Plateau State, Nigeria. Six themes were discovered as the findings of the study in response to the research question 'What are the barriers to provision of psychiatric nursing care by psychiatric nurses in a teaching hospital in Jos, Plateau State, Nigeria.

#### 6.2 Personal barriers to provision of psychiatric nursing care

The findings revealed that there are two types of personal barriers to provision of psychiatric nursing care, i.e. internal personal barriers and external personal barriers. The participants remarked that the external barriers to the provision of psychiatric nursing care affect their morale and hence service provision. This is similar to the assertion of Wile (1996), which states that constructs that are internal to the performer are influenced by constructs external to the performer.

The internal personal barriers to the provision of psychiatric nursing care include lack of motivation, personal stress from home and work, lack of practice of professional skills, lack of intuition, poor attitude towards education, and exhibition of nonchalant attitudes and unprofessionalism. These findings are similar to those identified in the international literature (Mathers, 2012:49; Wong, 2014:215; Brennan, Flood & Bowers, 2006:480; McAllister & Moyle, 2008:2024; Ngako Van Rensberg & Motoboge, 2012:5). This could imply that solutions to these barriers cut across countries of the world.



Other similar findings which support the current findings of internal personal barriers to provision of psychiatric nursing care are those reported by Ngako Van Rensberg & Motoboge (2012:5) and Zarea et al. (2012:701). These include the indifferent attitudes of some psychiatric nurses towards provision of care, lack of interest in the provision of psychiatric care among some psychiatric nurses, low morale and low self-esteem.

External personal barriers to the provision of psychiatric nursing care revealed in the current study included: huge workload, lack of appreciation and recognition from hospital management, poor remuneration, personal safety, irregular training and attendance of update courses. The finding on personal safety as an external barrier to the provision of psychiatric nursing care was the most supported by literature from Africa and around the world, and includes safety and security issues like fear of injury from a patient, fear related to unpredictable behaviour of patients, and law and legal issues associated with potential harm to patients. Other barriers were unhealthy attitudes of nurse managers toward issues of autonomy and frustration from managers over perceived under-performance of their subordinates (Chevalier, Steinberg & Linda, 2006:757-761; Tema, Poggenpoel & Myburgh, 2011:918-921; Ngako, Van Rensberg & Motoboge, 2012:5-7; Zarea et al., 2012:701-704; Jackson & Morrissette, 2014:140). The similarity between the external barriers revealed from the current study and those highlighted in literature from around the world buttresses the fact that solution to these barriers could be universal.

Literature from other countries did not highlight some of the external barriers identified in the current study. This could mean that the other countries have better resources for good salaries, good training and update courses for psychiatric nurses. The absence of supporting findings highlights the plight of psychiatric nurses in Nigeria, where huge workload, lack of appreciation and recognition from hospital management, and poor remuneration are considered as barriers to provision of psychiatric nursing care.

### 6.3 Relationship-related barriers to provision of psychiatric nursing care

The current study revealed the lack of support from colleagues and superiors and the “pull her down syndrome” as nurse-nurse related barriers to provision of psychiatric nursing care. These findings are similar to those revealed by Ngako, Van Rensberg & Motoboge (2012:5-7) and Tema, Poggenpoel & Myburgh, (2011:918-921), who reported ineffective communication with colleagues and lack of support from colleagues as barriers to provision of psychiatric nursing care.

The “pull her down syndrome” reported in the current study is similar to the poor supportive peer relationship among psychiatric nurses and oppression from peers which were reported by Greenall (2006:19), Mathers (2014:49-51), Fisher (2014:266-267), McAllister and Moyle (2008:20-24), and Smith and Khanlou (2013:5-10). This similarity further confirms the universality of these barriers the world over.

The findings on nurse-patient/patients’ relatives-related barriers to the provision of psychiatric nursing care, such as bullying of nurses by patients, uncooperative attitudes of patients and patients’ relatives, and inadequacy of information provision by relatives during admission procedures were also identified in previous literature. For instance, Wong (2014:215-216), Tema Poggenpoel & Myburgh, (2011:918-921), Ngako, Van Rensberg & Motoboge (2012:5-7), Innes et al. (2014:2006-2007), and Jackson and Morrissette (2014:140-142), identified the patients’ disrespectful and uncooperative attitudes towards psychiatric nurses, difficulty in obtaining patients’ vital information from the relatives, and overbearing attitudes like opposition to treatment provision of the patients’ relatives as barriers to provision of psychiatric nursing care.

This current study revealed the influence of negative relationships, such as the communication problem within the psychiatric team, lack of collaborative treatment within the psychiatric health team and conflict among psychiatric team members as barriers to the provision of psychiatric nursing care. Similar findings to those of the current study on the nurse-other members of the psychiatric team

relationship-related barriers to provision of psychiatric nursing care included exhibition of superior attitudes by psychiatrists, indecision of psychiatrists on treatment options, poor attitudes of psychiatrists and the psychiatric team towards psychiatric nurses, psychiatric health team's unwillingness to adopt current practices, and lack of/inadequate involvement in the decision-making process over patients' treatment within the psychiatric team (Mathers, 2012:49-51; Eren, 2014:365-367; Fisher, 2014:266-267; Wong, 2014:215-216; Tema, Poggenpoel & Myburgh, 2011:918-921; Holm & Severinssen, 2012:518-519; Ngako Van Rensberg & Motoboge, 2012:5-7; Van Bogaert et al., 2012:11-12; Jackson & Morrissette, 2014:140-142). Although these did not come out strongly in the current findings, it is important to highlight them because it is possible that the Nigerian psychiatric nurses are experiencing similar barriers but were not able to articulate these during the interviews.

The findings of the current study revealed deprivation of opportunity and sponsorship to attend update courses, poor response to training requests and procurement of facilities, the use of derogatory statements, passing comments on and exhibition of demeaning attitudes towards the psychiatric nurses as examples of the negative influence of the relationship between the nurse and management .

The nurse-management-related barriers to provision of psychiatric nursing care found in this study are similar to those revealed in literature from Africa and around the world, which include uncooperative attitudes of management, lack of provision of educational support for psychiatric nurses, lack of emotional and psychological support from management, and inadequate morale-boosting by management (Fisher, 2014:266-267; McAllister & Moyle, 2008:20-24; Tema, Poggenpoel & Myburgh, 2011:215-216; Ngako Van Rensberg & Motoboge, 2012:5-7). The relationship related barriers to provision of psychiatric nursing care revealed in the current study and those highlighted in literature from different countries of the world suggests that relationship related barriers are to a large extent universal.

#### **6.4 Environmental barriers to provision of psychiatric nursing care**

The findings of the current study highlighted the inadequate facilities and lack of ideal ward settings, location of the ward in the heart of the town, presence of occupational hazards and broken-down structures as the main environmental barriers to the provision of psychiatric nursing care.

The physical layout and location of the unit-related barriers to provision of psychiatric nursing care were similar to barriers to provision of psychiatric nursing care highlighted in literature from high-income economies, which were related to limitations in the work setting (Brennan, Flood & Bowers, 2006:480-; Weiland et al., 2011:679-; Yadav & Fealy, 2012:119- Innes et al., 2014:2006-2007).

Poor supply of light, movement of relatives and visitors in and out of the ward and lack of a therapeutic environment were reported to be barriers to provision of psychiatric nursing care and to have a negative influence on the psychiatric patients' recovery process and period of recovery. These aesthetic and other environmental barriers to provision of psychiatric nursing care were similar to those highlighted in literature from high-income economies, which included lack of a person/family-centred environment, poor/unfavourable working conditions, noisy and busy environment, and hazards in the physical environment (Eren, 2014:365-367; Brennan, Flood & Bowers, 2006:480-481; McAllister & Moyle, 2008:20-24; Weiland et al., 2011:679-686; Yadav & Fealy, 2012:119-120, Smith & Khanlou, 2013:5-10; Innes et al., 2014:2006-2007). The environmental barriers highlighted in this study were similar to those reported by different authors from high-income economies. This could suggest that psychiatric nurses in the hospital settings the world over experience these barriers.

#### **6.5 Organisational barriers to provision of psychiatric nursing care**

The findings revealed three main managerial tools as barriers to provision of psychiatric nursing care: the lack of human resources, inadequate facilities, and absence of policies and guidelines for provision of psychiatric nursing care.

The findings on managerial tools as barriers to provision of psychiatric nursing care are similar to those identified in literature reviewed from Nigeria and other countries (Mathers, 2012:49-51; Patton, 2013:389-391; Fisher, 2014:266-267; Happell, 2014:99-100; Wong, 2014:215-216; Klecha, Barke & Gureje, 2004:1118; Brennan, Flood & Bowers, 2006:480-481; Other organisational barriers to the provision of psychiatric nursing care were revealed in the current study, and are similar to those highlighted in literature from Nigeria and developed countries (Mathers, 2012:49-51; Patton, 2013:389-391; Happell, 2014:99-100; Klecha, Barke & Gureje, 2004:1118; Knapp et al., 2006:159-164;

Some organisational barriers to the provision of psychiatric nursing care highlighted in literature from high-income economies were in contrast to those identified in this study. They are as follows: lack of clarity of hierarchical structure, lack of or unfair incorporation of the integrated health model into provision of psychiatric care, failure of management to provide resources for planning, and implementation of intervention programmes. Others are leadership styles that are problematic, bureaucratic processes and complex management systems, the predominant use of the medical model, long shifts, too much paperwork and administrative duties, and involvement in a variety of duties within a limited time (Chevalier, Steinberg & Linda, 2006:757-761; McAllister & Moyle, 2008:20-24; Mesidor et al., 2011:285; Yadav & Fealy, 2012:119-120; Smith & Khanlou, 2013:5-10; Van Bogaert et al., 2013:11-12;). This contrast could be as a result of divergent socio-demographic characteristics of the study settings, or inability of participants in this current study to reveal these barriers.

Stripping off of some roles was observed during the covert observation. In some instances the psychiatric nurses were observed sending the patients home without prescriptions, simply because the doctor did not respond to a call by the nurses or declined to come at the request of the nurses, and they don't have prescriptive authority. This is usually the case, especially when the patients come during the afternoon shifts; the patients usually went home without medication, which allows for occurrence of relapse. This was not reported in any

study accessed and reviewed. This could be due to variation in the study population and setting. The similarity and contrast between the organisational barriers revealed from the current study and those of previous studies could be as a result of the differences in the organisational settings.

### **6.6 Public-related barriers to provision of psychiatric nursing care**

The findings revealed two major barriers to the provision of psychiatric nursing care, namely governmental and societal barriers. The governmental barriers to the provision of psychiatric nursing care included the absence of a scope of practice and policy statement for psychiatric nursing practice in Nigeria, neglect of the psychiatric sector by the government, poor salary structure and hazard allowance taking into account hazards associated with practice, and non-implementation of the hazard allowance for persons working in hazardous institutions (which includes psychiatric nurses). These findings are similar to those reported by Klecha, Barke and Gureje (2004:1118), WHO and ICN (2007:1) and Jack-Ide, Uys and Middleton (2013:4). Neglect of the psychiatric unit by the government highlighted in the findings of this study was revealed by the WHO (2007:1), who reported that in low- and middle-income economies psychiatric nursing care has received little or no attention from the government and the public, and has also been bedevilled by a number of barriers. The governmental barriers identified in the current study and those highlighted in the studies accessed and reviewed from low- and middle-income economies suggests the universality of public related barriers to provision of psychiatric nursing care in low- and middle-income economies.

Societal barriers to the provision of psychiatric nursing care, on the other hand, included stigmatisation and discrimination from members of the public. These barriers to provision of psychiatric nursing care were similar to those highlighted in literature, which include socio-cultural issues, neglect by the public, and isolation from the public (Chevalier, Steinberg & Linda, 2006:757; Zarea et al., 2012:701, 2013:126). The similarity could suggest the above barriers are universal to low-income and middle-income economies. Other societal barriers

identified in the literature from high-income economies were in contrast to those revealed in this study; these included lack of knowledge or misconceptions about what psychiatric nursing is by the public, and lack of knowledge by the public of the existence of advanced practice roles of psychiatric nurses (Chevalier, Steinberg & Linda, 2006:757-761; Knapp et al., 2006:159-164; Yadav & Fealy, 2012:119-120; Jackson & Morrissette, 2014:140-142). The disparity could be due to differences in the socio-demographics of the study populations and settings. This highlighted the fact that the participants of this study did not see professional issues as barriers to provision of care, or perhaps could not describe them as barriers to provision of psychiatric nursing care. This could suggest that societal barriers vary from country to country or from low- and middle-income economies to high-income economies.

#### **6.7 Motivators to the provision of psychiatric nursing care amidst barriers**

The current study also serendipitously discovered findings which revealed that despite all of the barriers to provision of psychiatric nursing care, the nurses remained motivated to provide care. These are the characteristics that motivate the psychiatric nurses to provide psychiatric nursing care to psychiatric patients despite the barriers to provision of psychiatric nursing care. These included the love for God and fear of God, love for the patient and psychiatric nursing, inner drive and good knowledge base.

Several literatures have reported how resilience has continued to enable psychiatric nurses to provide psychiatric nursing care despite the myriad of barriers they face in the hospital setting. For instance, Cleary, Jackson and Hungerford (2014:33) revealed that psychiatric nurses have continued to identify new ways of adapting to stress related to barriers to provision of psychiatric nursing care in the hospital setting. They recommended that psychiatric nurses should develop professional resilience that will be all-encompassing; according to them this will preserve professional identity. Similarly, Gillespie, Chaboyer and Wallis (2009:972) conducted a study among nurses in Australia which revealed that nurses showed a high level of resilience at work despite barriers to

provision of care in work settings. According to Gillespie, Chaboyer and Wallis (2009:973) their resilience was influenced by the work setting, suggesting that a favourable or unfavourable work environment impacts on the capacity of nurses to be resilient. They concluded by stating that personal characteristics help individual nurses to develop resilience at work.

Jackson, Firtko and Edenborough (2007:4) also reported that psychiatric nurses develop personal resilience which assists them in remaining in the psychiatric unit despite barriers to the provision of psychiatric nursing care. They also outlined that resilience provides psychiatric nurses with the capacity to survive and thrive in the face of barriers to provision of psychiatric nursing care. According to Jackson, Firtko and Edenborough (2007:4-6) spirituality, positive attitudes and healthy professional relationships are among the qualities that help psychiatric nurses to remain in psychiatric practice.

## **6.8 Recommendations**

The findings of the current study have implications for different stakeholders in the provision of psychiatric nursing care, including researchers and educators.

### ***6.8.1 Recommendation for managers***

The findings of the current study on the motivators have implications for managers who need to motivate staff to remain positive despite the challenges. Based on these findings, they can encourage that psychiatric nurses continue to provide psychiatric care despite the challenges by supporting them and to address all negative feelings through provision of incentives.

Base on the findings related to nurse-manager relationship and organisational barriers, it is recommended that the managers should value and respond promptly to the motivational, educational, psychological, social and career developmental needs of psychiatric nurses.



The findings of the study on the negative influence of managerial barriers and the relationship between management and the psychiatric nurses raised the need for a cordial relationship between management and the psychiatric nurses, and for management to be responsive to the needs of the psychiatric nurses and the psychiatric unit.

Base on the hospital policy related findings; it is recommended that the managers of the psychiatric unit should use the findings of the current study to identify the hospital's policies, guidelines and whatever that impacts negatively on the provision of psychiatric nursing care by the nurses and advocate for remedies.

The findings on manpower shortages and other human resources-related barriers raised the need for adoption of a realistic standard of nurse-patient ratios for provision of nursing care as compared to the current 1:13 and sometimes 1:26 ratios. As a long term strategy, management should seek to adopt the standard of 1:6 nurse-patient ratios for provision of nursing care as obtained in some countries of the world like United States of the World.

Base on the finding on stripping off of some responsibilities of the psychiatric nurses, it is recommended that management should adopt the standard of practice and scope of practice prescribed by the ANA, APNA and ISPN (2007).

#### ***6.8.2 Recommendations for policy makers***

The findings of the study on lack of a policy statement and scope of practice as barriers to the provision of psychiatric nursing care raised the need for the Nursing and Midwifery Council of Nigeria to engage the services of advanced psychiatric nurses to draft a scope of practice, procedure manual for psychiatric nurses and policy statement on psychiatric nursing for Nigeria. The international scope and standards of practice manual published by ANA, APNA and ISPN in 2007 can be used as a guide. This will address areas of conflict between psychiatric nursing and other psychiatric professionals in the hospital.

It is also recommended that the National Association of Nigerian Nurses and Midwives and other stakeholders should engage the Federal Government on labour discussions to ensure implementation of the policy on special allowances for persons whose occupations are highly hazardous.

### ***6.8.3 Recommendations for future research***

This study was a single case study. A large-scale quantitative study is recommended which will generate data that will be representative of all teaching hospitals in Nigeria.

A study using grounded theory should be conducted to allow for the development of a Nigerian Psychiatric Nursing theory or model that will guide the provision of psychiatric nursing care in Nigeria.

The researcher recommended that further research should be done using appreciative inquiry to determine the motivators or enablers to the provision of psychiatric nursing care by psychiatric nurses, so as to provide baseline data for organising workshops and training on work performance.

### ***6.8.4 Recommendation for nurse educators***

The findings on environmental, organisational and governmental barriers have implications for clinical placement of nursing students in psychiatric units or hospitals. Nurse educators should use the findings of the current study to identify clinical facilities that do not have similar organisational barriers. Conversely, the environmental and organisational barriers identified in these findings should be used by educators to advocate/motivate for improvement of psychiatric clinical facilities as clinical teaching environments.

### ***6.8.5 Recommendations for the Federal Government of Nigeria***

The findings of the current study related to remuneration and allowances as barriers to the provision of psychiatric nursing care have implications for Federal Government of Nigeria. It highlights the need for a review of the salary structure of psychiatric nurses and implementation of the policy on special allowances for

personnel working in hazardous institutions or specialties drafted during the administration of the late President Umaru Musa Yar'adua.

### **6.9 Limitations of the study**

The limitation for this study was that the hospital did not have either a policy statement on psychiatric nursing or scope of practice, which deprived the researcher of the opportunity of collecting data from this data source to enrich the data collected. The researcher therefore did not use document review as a data collection source in this research, although this was one of the proposed data collection methods.

Due to limited resources, limited study leave and delayed access to ethical clearance (three months), the period for participant observation was limited to 2 months.

### **6.10 Conclusion**

The study revealed five barriers to provision of psychiatric nursing care. These barriers were comprehensive, exhaustive and revealing. This is due to the strength of the case study methodology in providing in-depth understanding of a phenomenon within a case.

The most significant barrier of the current study was gross inadequacy of manpower-an organisational barrier to the provision of psychiatric nursing care. This is similar to the findings of previous studies. The researcher noted that over 60% of the authors cited revealed shortages of manpower and huge workload as the most important organisational-related barriers.

The findings of the study also revealed personal, relationship and environmental barriers to the provision of psychiatric nursing care. These barriers were not reported in any of the literature reviewed from Nigeria. This filled the gap in knowledge that existed in Nigerian literature.

The findings of the study revealed that barriers that were of external origin influenced barriers of internal origin. Case in point, barriers like lack of facilities

and manpower shortage were revealed to affect the motivation of the participants. The findings of the study also indicated that constructs of internal origin influence the external origin. For instance, inherent believe system like fear of God, Love for God and Love for human beings were reported as motivators to provision of psychiatric nursing care. These motivators motivated the psychiatric nurses to provide care despite the existence of barriers to the provision of psychiatric nursing care.

The choice of case study methodology was the best, because it generated adequate data to answer the research question “What are the barriers to the provision of psychiatric nursing care by psychiatric nurses in a teaching hospital in Jos, Plateau State, Nigeria”?

In this study the performance problems identified were the barriers to the provision of psychiatric nursing care to the psychiatric patients by the psychiatric nurses in a teaching hospital in Jos, Plateau State

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## Appendices

### Appendix I: Interview guide for study participants

#### Research related questions

Psychiatric nursing care includes provision of care through therapeutic communication, therapeutic relationship, milieu management and psychopharmacology among other skills.

- Based on what I have just told you about psychiatric nursing care, what would you say enables or stops you from practicing and giving such care to patients in this unit?
- Reflecting on the training you received in psychiatric nursing, how does that enable / disable you from providing psychiatric nursing care to your patients?
- Despite everything else that you have already told me, what would you say keeps you motivated to give psychiatric nursing care?
- Despite what you have told me already, what would say demotivates you from providing psychiatric nursing care to your patients?
- How has your hospital policy statement on psychiatry, scope of psychiatric practice, work roster and job description enable or hinder your provision of psychiatric nursing care.
- How has your salary, bonuses and allowances, award of excellence and performance appraisal enable or hinder your provision of psychiatric nursing care.
- How has your skills and knowledge on psychiatric nursing informed your provision of psychiatric nursing care to your patients? In your personal capacity, what motivates you, to give psychiatric nursing care? What demotivates you from providing psychiatric nursing care to your patients?
- How has your physical environment hindered your provision of psychiatric nursing care to your patients? If the physical environment is improved upon will your performance improve?

## Appendix II: Reviewed interview guide for study participants

### Research related questions

Psychiatric nursing care includes provision of care through therapeutic communication, therapeutic relationship, milieu management and psychopharmacology among other skills.

- Based on what I have just told you about the provision of psychiatric nursing care, what would you say enables you to practice and give such care to patients in this unit?
- What would you say stops you from practicing and giving such care to patients?

Additional questions:

- How has your hospital policy statement on psychiatry, scope of psychiatric practice, work roster and job description enable or hinder your provision of psychiatric nursing care.
- How has your salary, bonuses and allowances, award of excellence and performance appraisal enable or hinder your provision of psychiatric nursing care.
- How has your skills and knowledge on psychiatric nursing informed your provision of psychiatric nursing care to your patients? In your personal capacity, what motivates you to give psychiatric nursing care? What demotivates you from providing psychiatric nursing care to your patients?
- How has your physical environment hindered your provision of psychiatric nursing care to your patients? If the physical environment is improved upon will your performance improve?
- Probing question: What else have you noticed to enhance or hinder the provision of psychiatric nursing care by the nurses?

## Appendix III: Interview guide for key informants (managers)

### Demographic data

Unit: male [ ] female [ ]

Age:

Number of years in the unit:

Research related questions:

Psychiatric nursing care includes provision of care through therapeutic communication, therapeutic relationship, milieu management and psychopharmacology among other skills.

- Based on what I have just said about psychiatric nursing care, what would you say enables the psychiatric nurses in this hospital to practice and give such care to patients?
- What would you say stops or hinders them from practicing and giving such care to patients?

### Additional questions

- How has your hospital policy statement on psychiatry, scope of psychiatric practice, work roster and job description enabled or hindered the psychiatric nurses from providing psychiatric nursing care.
- How has the salary, bonuses and allowances, award of excellence and performance appraisal enabled or hindered the psychiatric nurses from provision of psychiatric nursing care. What forms of positive reinforcements (incentives) do you use to allow nurses provide psychiatric nursing care? Probing: would you say the nurses see these as enabling or hindering and why?
- How has the physical environment enabled or hindered the psychiatric nurses from the provision of psychiatric nursing care to their patients? If



the physical environment is improved upon how will it improve the performance of the psychiatric nurses?

- Probing question: What else have you noticed to enhance or hinder the provision of psychiatric nursing care by the nurses?

## Appendix IV: Observation guide

Category	Includes	What the researcher will note(descriptive and reflective notes)
Therapeutic communication/relationship	Use of language that patient can understand, communication skills, tone of communication, use of smiles, building of rapport, respect for patients privacy, involving patient in care provision, calling patient by his/her name.	How the nurse introduces herself, exchange pleasantries, use expressive words and gestures, the level of involvement of the patient in communication, does the nurses allows for, listens to and response to patients feedback , is communication conversational or instructional, is the patient called by name during provision of care, is rapport building obvious during communication.
Milieu management	Structure, safety, norms, noise, ward layout.	Do the nurses manipulate the environment to meet individual patient's needs

		and cater for their safety, is it done according to the standards, does the ward layout have protective devices to allow for patients safety, are ward norms spelt out to clients.
Psychopharmacology	Dosage of drugs, side effects of drugs, toxicity of drugs, nurses responsibility.	Do the nurses educate client on side effects of drugs before administration, do they discharge other responsibilities related to drug administrating like encouraging clients to take copious amount of fluid.

Note: This checklist is based on the objective of the study; any observation relevant to the study will be made at the field.

## Appendix V: Informed consent form

**Research title:** Barriers to the provision of psychiatric nursing care by psychiatric nurses in a teaching hospital in Plateau State, Nigeria.

**Researcher:** Mr. Gimba, Solomon Musa

I ----- (name) hereby affirm that I understand fully what the study is all about, the benefits, risks, my level of involvement and I am willing to participate. The researcher informed me that I can withdraw from the research at any time and that everything I say will be treated with utmost confidentiality and anonymity and no information will be divulged, it will strictly be used for research purposes only.

I also understand that the findings of the research will provide data that can be used to review policy statements and guidelines on psychiatric practice in our hospital as well as provide data that will influence the provision of psychiatric nursing care in the hospital and guide the training of nursing students in relation to tackling identified barriers.

The researcher assured me that the information shared with him will be used for research purposes only and will not be used against me. I have been told that I can ask any question during the research process.

The researcher informed me that the research interview will be done at a time and venue convenient to me.

I have been informed that if I have further questions or concerns about this research I can contact Prof Marc Blockman.

[mark.blockman@uct.ac.za](mailto:mark.blockman@uct.ac.za)

0214066496.

Date----- participants' signature-----

Date----- researchers' signature-----

Date-----

witness' signature-----

Gimba, Solomon Musa (researcher)

Duma, Sinegugu (supervisor)

kingimba@yahoo.com

sinegugu.duma@uct.ac.za

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## Appendix VI: Research information sheet for individual interview

**Research title:** The barriers to the provision of psychiatric nursing care by psychiatric nurses in a teaching hospital in Plateau State, Nigeria.

**Researcher:** Mr. Gimba, Solomon Musa

Dear sir/madam

I am a student of university of Cape Town. I will like to invite you to take part in this research which will seek to describe and explore the barriers that hinder psychiatric nurses from providing psychiatric nursing care in your hospital as a requirement for the award of a master's degree by the University of Cape Town. This study has been approved by the University of Cape Town Research Ethics Committee (ref no.) and the Research Ethics Committee of the Hospital. The study is in fulfillment of the requirement for the award of Master of Science in nursing.

**Benefits:** There are no direct personal benefits to you for participating in the study. The indirect benefits of the study includes: generating data that can be used to review policy statements and guidelines for psychiatric practice in the hospital which will improve the provision of psychiatric nursing care by the psychiatric nurses in the hospital and data that will guide the training of nursing students in relation to tackling identified barriers.

**Time:** The interview will take about one hour.

**Costs:** There will be no cost that will be incurred by you.

**Ethical considerations in the study:** Your participation in the study is voluntary and everything you say will be treated with utmost confidentiality and anonymity and no information will be divulged. Your indication of interest to participate in the research is very important to me and at any time you wish to withdraw from the research, you are free to do so. Should you have questions or want clarification on anything you do not understand, please feel free to ask at any point in time while the research last.

An audio tape will be used to record our conversation and notes will be written. All information collected will be kept safe in my computer by use of a personalized password to prevent access by any unauthorized people it.

Your name will not appear anywhere throughout the research process, rather pseudonyms will be used to identify your responses and as soon as the research is over all identifying information will be destroyed. If at any point in time you want me to delete any information you provided, feel free to inform me.

Thank you for accepting to read this letter. If you are willing to participate in this study, kindly complete the consent form.

For any queries and concerns you can contact the following:

A/Professor Sinegugu Duma

[duma.sinegugu@uct.ac.za](mailto:duma.sinegugu@uct.ac.za)

+27824492635

Professor Marc Blockman

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Gimba, Solomon Musa

08065486138

[kingimba@yahoo.com](mailto:kingimba@yahoo.com)

## Appendix VII: Research information sheet for participant observation

**Research title:** Barriers to the provision of psychiatric nursing care by psychiatric nurses in a teaching hospital in Plateau State, Nigeria.

**Researcher:** Mr. Gimba, Solomon Musa

Dear sir/madam

I am a student of university of Cape Town. I will like to invite you to take part in this research which will seek to describe and explore the barriers that hinder psychiatric nurses from providing psychiatric nursing care in your hospital as a requirement for the award of a master's degree by the University of Cape Town. This study has been approved by the University of Cape Town Research Ethics Committee (ref no.) and the Research Ethics Committee of the Hospital (ref no.) The study is for fulfillment of MSc degree in nursing.

**Benefits:** There are no direct personal benefits to you for participating in the study. The indirect benefits of the study includes: generating data that can be used to review policy statements and guidelines for psychiatric practice in the hospital which will improve the provision of psychiatric nursing care by the psychiatric nurses in the hospital and data that will guide the training of nursing students in relation to tackling identified barriers.

**Time:** The observation will last for at least 2 months.

**Costs:** there will be no cost that will be incurred by you.

**Ethical considerations in the study:** your participation in the study is voluntary and everything you say will be treated with utmost confidentiality and anonymity and no information will be divulged. Your indication of interest to participate in the research is very important to me and at any time you wish to withdraw from the research, you are free to do so. Should you have questions or want clarification on anything you do not understand, please feel free to ask at any point in time while the research last.

An audio tape will be used to record your conversation with your patients; one another and the members of psychiatric team and notes will be written.



Observation on patients' behaviours will not be used. All information collected will be kept safe in my computer by use of a personalized password to prevent access by any unauthorized person.

Your name will not appear anywhere throughout the research process, rather pseudonyms will be used to identify your responses and as soon as the research is over all identifying information will be destroyed. If at any point in time you want me to delete any information you provided, feel free to inform me.

Thank you for accepting to read this letter. If you are willing to participate in this study, kindly complete the consent form.

For any queries and concerns you can contact the following:

A/Professor Sinegugu Duma

[duma.sinegugu@uct.ac.za](mailto:duma.sinegugu@uct.ac.za)

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Gimba, Solomon Musa

08065486138

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Appendix VIII: Ethical clearance from Human Research Ethics Committee,  
Faculty of Health Sciences.



UNIVERSITY OF CAPE TOWN  
Faculty of Health Sciences  
Human Research Ethics Committee



Room E52-24 Old Main Building  
Grootte Schuur Hospital  
Observatory 7925  
Telephone [021] 406 6338 • Facsimile [021] 406 6411  
Email: [shuretta.thomas@uct.ac.za](mailto:shuretta.thomas@uct.ac.za)  
Website: [www.health.uct.ac.za/research/humanethics/forms](http://www.health.uct.ac.za/research/humanethics/forms)

05 February 2014

**HREC REF: 089/2014**

**A/Prof S Duma**  
Health & Rehab  
F-Floor, OMB

Dear A/Prof. Duma

**PROJECT TITLE: THE BARRIERS TO PROVISION OF BASIC PSYCHIATRIC MENTAL HEALTH CARE BY PSYCHIATRIC NURSES IN A TEACHING HOSPITAL IN PLATEAU STATE, NIGERIA**

Thank you for submitting your study to the Faculty of Health Sciences Human Research Ethics Committee for review.

Please note that the student cannot be the PI, we have therefore changed it to reflect the supervisor's name. The student will be recognised on all communications.

It is a pleasure to inform you that the HREC has **formally approved** the above-mentioned study.

**Approval is granted for one year until the 28<sup>th</sup> February 2015**

Please submit a progress form, using the standardised Annual Report Form if the study continues beyond the approval period. Please submit a Standard Closure form if the study is completed within the approval period.

(Forms can be found on our website: [www.health.uct.ac.za/research/humanethics/forms](http://www.health.uct.ac.za/research/humanethics/forms))

***We acknowledge that the student, Mr Solomon Gimba will also be involved in this study.***

Please note that the ongoing ethical conduct of the study remains the responsibility of the principal investigator.

Please quote the HREC reference no in all your correspondence.

Yours sincerely

Signed by candidate

**PROFESSOR M BLOCKMAN**  
**CHAIRPERSON, FHS HUMAN ETHICS**

Federal Wide Assurance Number: FWA00001637.

Institutional Review Board (IRB) number: IRB00001938

This serves to confirm that the University of Cape Town Human Research Ethics Committee complies to the Ethics Standards for Clinical Research with a new drug in patients, based on the Medical

HREC ref 089/2014

Research Council (MRC-SA), Food and Drug Administration (FDA-USA), International Convention on Harmonisation Good Clinical Practice (ICH GCP) and Declaration of Helsinki guidelines.  
The Human Research Ethics Committee granting this approval is in compliance with the ICH Harmonised Tripartite Guidelines E6: Note for Guidance on Good Clinical Practice (CPMP/ICH/135/95) and FDA Code Federal Regulation Part 50, 56 and 312.

HREC ref 089/2014

## Appendix IX: Ethical clearance from Hospital under study

# JOS UNIVERSITY TEACHING HOSPITAL JOS, NIGERIA

Phone: 073-450226 - 9  
E-mail: juth@infoweb.abs.net

JUTH/DCS/ADM/127/XIX/ 5966

Ref:.....



Cables & Telegram: JUTH  
P.M.B. 2076

Jos,  
12<sup>th</sup> February, 2014

Date:.....

**Gimba Solomon Musa**  
Department of Nursing Science,  
University of Jos.  
Jos-Nigeria.

### RE: ETHICAL CLEARANCE/APPROVAL

I am directed to refer to your application dated 25<sup>th</sup> November, 2013 on the research proposal titled:

**"The Barriers to the Provision of Basic Psychiatric Mental Health Care by Psychiatric Nurses in a Teaching Hospital in Jos, Plateau State"** and your appearance before the Ethical Committee on 6<sup>th</sup> December, 2013.

Following recommendation from the Institutional Health Research Ethical Committee, I am to inform you that Management has given approval for you to proceed on your research topic as indicated.

You are however required to obtain a separate approval for use of patients and facilities from the department(s) you intend to use for your research.

The Principal Investigator is required to send a progress report to the Ethical Committee at the expiration of three (3) months after ethical clearance to enable the Committee carry out its oversight function.

Submission of final research work should be made to the Institutional Health Research Ethical Committee through the **Secretary in Administration Department**, please.

On behalf of the Management of this Hospital, I wish you a successful research outing.

Signed by candidate

**Hajia R. Danfillo**  
For: *Chairman, MAC*

