FACTORS THAT INFLUENCE THE COMPETENCY OF NURSING STAFF IN MANAGING AGGRESSIVE BEHAVIOUR IN MENTALLY ILL PATIENTS AT A MENTAL HEALTH CARE CENTRE, KHOMAS REGION, NAMIBIA

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ABSTRACT

Mental illness is amongst the leading causes of disabilities and can cause disturbances in emotional, cognitive and behavioural functioning of mentally ill patients. Caring for mentally ill patients and managing their aggressive behaviour is done by mental health nurses and therefore, they should have certain competencies to competently manage aggression.

The purpose of this study was to determine the factors that influence the competency of nursing staff in managing aggressive behaviour displayed by mentally ill patients at a select mental health care centre, Windhoek, Namibia.

A convergent parallel mixed method design was applied; the quantitative study employed a convenience sampling method to engage all 61 registered and enrolled nurses to identify and describe the factors influencing their competency in managing aggressive behaviour in mentally ill patients and the qualitative study; a purposive sampling method to select 17 nursing staff to explore their perceptions regarding their competency in managing aggressive behaviour in mentally ill patients. Quantitative data were collected using structured questionnaires and analysed with Statistical Package for Social Science, Version 24, from which descriptive statistics were obtained. Qualitative data was collected through three focus group discussions, verbatim transcribed, organized into themes and categories according to Tesch's descriptive method of open coding. Trustworthiness was ensured in accordance with the principles of credibility, dependability, confirmability and transferability. Field notes were kept and a literature control was done for the purpose of triangulation.

Quantitative and qualitative data results revealed that personal factors such as theoretical knowledge, clinical skills and external factors including experience and role modelling influenced nursing competency in managing aggressive patients.

Moreover, this study concluded that the attitudes of the nursing staff during the management of aggression affected their development of competency either positively or negatively.

This study recommended that debriefing sessions, training on the management of aggression, a compulsory induction and orientation program should be favourably considered for implementation to ensure effective management of aggressive patients.

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LIST OF ABBREVIATIONS

The following is the list of abbreviations used in the study:

APA	American Psychiatric Association
CMS	Chief Medical Superintendent
CPD	Continuous Professional Development
DSM	Diagnostic and Statistical Manual of Mental Disorders
HIS	Health Information System
MHA	Mental Health Act
MOHSS	Ministry of Health and Social Services
OPD	Outpatient Department
PS	Permanent Secretary
SPSS	Statistical Package for Social Science
UNAM	University of Namibia
WCH	Windhoek Central Hospital
WHO	World Health Organization
MHCC	Mental Health Care Centre

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DECLARATION

I, Katrina Beukes, hereby declare that this study is my own work and is a true reflection of my research and that this work or any part thereof has not been submitted for a degree at any other institution.

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CHAPTER 1

ORIENTATION OF THE STUDY

1.1 INTRODUCTION

Mental health nursing as a caring profession is regarded worldwide as a specialty within nursing practice, which involves working closely with patients who display a wide range of behavioural symptoms such as aggression (Santangelo, Procter, & Fassett, 2018). In addition, the World Health Organisation [WHO] (2007) states that mental health nurses, as part of mental health nursing, are significant in the provision of care to the mentally ill patients and they are the leading care providers in most African mental health facilities. However, mental health nurses working in certain mental health facilities such as acute admission wards, are at the highest risk for verbal and physical aggression and are mostly the target of mentally ill patients' aggressive outbursts while rendering patient care (Thomas, 2016). For that reason, they have to be aware of the possibility that the behaviour of patients diagnosed with a mental illness can change at any moment, but if managed appropriately can prevent the occurrence of aggressive outbursts. (Stokowski, 2014; Al-Sagarat, Hamdan-Mansour, Al-Sarayreh, Nawafleh, & Moxham, 2016).

Mental illness worldwide is a major concern and is amongst the leading causes of disabilities (World Health Organization, 2011). According to Smith and Rylance (2016), mental illnesses can cause disturbances in emotional, cognitive and behavioural functioning of mentally ill patients. In addition, Moss (2015) explains that mental illness may cause problems such as unacceptable behaviour, having

undesirable feelings or altered thinking processes which make a person unable to perform his work-related duties and to enjoy life through socializing with other people. Hence, some patients diagnosed with mental illnesses such as Schizophrenia and substance-induced psychosis which can result in disturbances in thinking and emotions, may not always cope well with the demands of life which may then cause aggressive behaviour (Al-Sagarat, Hamdan-Mansour, Al-Sarayreh, Nawafleh, & Moxham, 2016). Similarly, in Africa, Bekelepi (2015) found that aggressive behaviour had been caused by certain mental illnesses which required nursing care and medical treatment while they were admitted in wards managed by mental health nurses.

Worldwide, studies show that aggressive behaviour of mentally ill patients can cause physical and emotional harm to others (Hopkins, Fetherston, & Morrison, 2018). According to Allen and Anderson (2017), aggressive behaviour is classified as mild such as verbal insults, moderate indicated by throwing chairs around, severe such as threats of physical aggression and extreme aggression which involve physically beating others with the intention to harm them.

Furthermore, mental health nurses worldwide are required to have certain competencies in order for them to manage aggressive patients effectively and to uphold the dignity of the mentally ill patient (Heydari, Kareshki, & Armat, 2016). Research also shows that competency refers to a combination of knowledge, skills, attitude, abilities and judgment that a nurse should possess to be competent in the management of aggression (Notarnicola, De Jesus Barbosa, Giorgi, Stievano, & Lancia, 2016). In accordance with that, Flinkman, et al., (2016) explain that skills indicate both

intellectual and practical ability and are also of the opinion that fundamental skills in nursing refer to psychomotor skills in which knowledge and behaviour are combined.

This study looked at the factors that influence the competency of nursing staff in managing aggressive behaviour of mentally ill patients.

1.2 BACKGROUND OF THE STUDY

Worldwide, aggressive behaviour in acute in-patient wards has a detrimental effect on patient care, the relationship between the nurse and the patient; and the competence of the nurse to deliver quality care (Gudde, Olsø, Whittington, & Vatne, 2015). Moreover, aggressive behaviours have been perceived as a way whereby the aggressive patient can re-gain his self-control, regulate his temper or retaliate at others (Townsend, 2014). Research studies also show that aggressive behaviour can occur daily, mostly during daytime and a rise in the number of aggressive episodes with varying levels of intensity are also noted (Iversen, Aasen, Güzey, & Helvik, 2016).

According to Stevenson, Jack, O'Mara, and LeGris (2015), this increase in aggressive behaviour can negatively influence the nursing care given to mentally ill patients in such a way that the mental health nurses either avoid the patient or force the patient to take the medication in order for him to calm down. Their study also found that patients who feel that they were not properly cared for will react with extreme aggression and that can result in a devastating cycle of aggressive outbursts and inappropriate nursing care. Similarly, Sobekwa and Arunachallam (2015) found in their study at a South African hospital that nursing care was negatively affected because of the patient's

aggressive behaviour. Despite the constant threat of aggression and its consequent behaviour, nurses worldwide still strive to deliver patient care competently and consistently (Kim, Han, Kwak, & Kim, 2015). Similarly mental health nurses in Africa, are doing their best to provide quality nursing care to patients who display aggressive behaviour, but for that, they have to be competent and have knowledge on mental illness and more specifically aggression (Bekelepi, Martin, & Chipps, 2015).

Globally, mental health nurses who have adequate competencies such as knowledge and skills about aggression and its management are in demand in mental health facilities because of the complexity of mental illnesses and the unfavourable consequences of aggressive behaviour (Anderson, Lindholm, Pettersson, & Jonasson, 2017). This is also echoed in the report by the World Health Organization (2005) which states that the provision of mental health services depends on the competence of mental health nurses which make it possible for them to provide quality care to patients with mental illnesses. The report (WHO, 2005) further highlights that competencies of nurses who are working in these mental health facilities can be insufficient and obsolete and do not bear in mind what the mentally ill patients expect from the service and state that it can be addressed through a human resources policy which outlines the competency development of mental health nurses. Furthermore the competencies of mental health nurses are also influenced by their work experience, workplace culture, peer pressure, the availability of guidelines and their personal beliefs (Bahrami, Purfarzad, Keshvari, & Rafiei, 2019).

Casey, et al., (2017) are also of the opinion that mental health nurses have to develop and maintain their competence through formal learning and skills development activities such as in-service training and short courses because they need competencies

that are relevant to their current responsibilities and functions. In line with this, Basson, Julie, and Adejumo (2014) found in a study done at a South African hospital that nurses who underwent advanced mental health training had considerably greater competency in their present responsibilities and functions. The study further states that the competencies of nurses with elementary or with the least training and therefore have insufficient knowledge and competencies to manage aggression are mostly affected. For this reason, this study sought to understand the factors that influence the competency of the nursing staff when they have to manage aggressive behaviour in the mentally ill patient.

Furthermore, worldwide, the therapeutic management of aggressive behaviour is not only done in isolated cases, but includes the overall care of the mentally ill patient (Lantta, Anttila, Kontio, Adams, & Valimaki, 2016). Research indicates that the care given to an aggressive patient has to be in line with existing ethical practices and have to uphold the rights of the patient, but such care is influenced by the perception and level of competency of mental health nurses (Hansen-Salie & Martin, 2014).

According to Moylan (2015), the management of an aggressive patient usually involves caring for him in the seclusion room after he had been forcefully physically restrained and injected. However, both nurses and patients see this type of interventions as a breach of patients' rights, but if the least coercive methods such as verbal negotiation and time-out failed, the nurse is left with no other option than to use restrictive measures such as a combination of physical and chemical restraint with seclusion (Thomas, 2016). On the other hand, some nurses in selected African hospitals perceive themselves as not adequately prepared to manage aggression and as

a result exploit physical restraint and seclusion (Jack, Canavan, Bradley, & Ofori-Atta, 2015). It is for that reason that the report of the World Health Organization (2005, p.4) states that "some of the worst human rights violations and discrimination experienced by people with mental disabilities, intellectual disabilities and substance abuse problems is in health-care settings". Mentally ill patients require care and protection while admitted in the mental health wards and to do that mental health nurses have to be competent.

To be competent in the management of aggression Bekelepi, et al., (2015) recommend that the training of mental health nurses focus on broadening their knowledge about aggressive behaviour and developing their communication skills because that will help them to be empathetic and caring towards their patients. In Africa, Nguluwe, Havenga, and Sengane (2014) support the training of nurses to broaden their competency, but also recommend teaching them about the prevention of aggression and the implementation of the prevention programs. Similarly, participants in a study conducted by Chimedza (2014) in Namibia concur that nurses have to receive training in the management of aggressive behaviour because that can lower the incidences of physical injuries to them.

In Namibia the curriculum of the undergraduate training of nurses shows that they receive an introductory course in mental health nursing. It include training on the assessment, treatment and the provision of nursing care for specific mental disorders. The mental health nursing care include persons affected by chronic illness and disabilities (University of Namibia, 2020).

The management of aggressive behaviour in mentally ill patients was reassessed worldwide due to incidences of serious harm that have been reported. The new Namibian Mental Health Care Act is in its final approval stages and it is based on the recommendations from WHO to use least restrictive measures to prevent and manage aggressive behaviour. Patients at the Mental Health Care Centre (MHCC), Khomas Region, Namibia are currently admitted under the provisions of the Mental Health Act (MHA), Act No. 18 of 1973, which makes provision for involuntary and urgent admissions (Sections 9 and 12). Patients admitted as involuntary and urgent are mostly aggressive and very difficult to manage and requires skilled nursing intervention to prevent injuries and serious harm to staff and other patients. Furthermore, incident reports between 2014 and 2015 at the MHCC, show a 50% increase in physical injuries for only nurses. Moreover, the factors influencing the ability of the nurses at the MHCC to competently and skillfully manage aggressive patients remained under-researched because no studies on the topic are available. As a result, the implementation of specific skills driven training programs and safety measures are hindered.

1.3 PROBLEM STATEMENT

The management of aggressive behaviour is most challenging for nurses working with the mentally ill patients and requires adequate skills since aggression represent a psychiatric emergency and should be resolved swiftly and in an organized way to prevent harm (Partridge & Affleck, 2017). Chimedza (2014) noted that mental health nurses in Namibia regularly experienced verbal aggression followed by threats of physical abuse from mentally ill patients. Incidence reports at the MHCC show an

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increase in physical injuries of nurses; that is 2 injuries in 2014; 4 injuries in 2015 and there were already 3 injuries from January 2016 to May 2016. No reports of incidences were submitted for 2017 and 2018. However due to this constant threat of aggression, mental health nurses also have to protect the other patients whenever an aggressive incident take place, and that protective action can put them even at more risk of being assaulted, especially if it is not managed well (Morken, Johansen, & Alsaker, 2015).

Richardson (2014) explains that because so many different types of aggressive behaviour exist, it can be a challenging problem in acute in-patient wards. For this reason, Renwick, et al., (2016) argued that mental health nurses would at some point in their career encounter aggressive behaviour and will also witness aggression directed at themselves, their colleagues and other patients. In the same vein, Fute, Mengesha, Wakgari, and Tessema (2015) report that nurses in Africa frequently experienced verbal aggression and physical aggression from mentally ill patients.

In spite of these problems, the level of ability as well as the factors that are influencing the nursing staff's ability to competently and skillfully manage patients who display aggressive behaviour remained unknown. The lack of this knowledge hinders the implementation of specific skills driven training programs and safety measures, hence the importance of this study.

1.4 PURPOSE OF THE STUDY

The purpose of the study was to determine the factors that influence the competency of nursing staff in managing aggressive behaviour in mentally ill patients at the MHCC, Khomas Region, Namibia.

1.5 OBJECTIVES OF THE STUDY

The research objectives were to:

- Identify and describe the factors that influence the competency of nursing staff at the MHCC in managing aggressive behaviour in mentally ill patients
- Explore and describe the perceptions of the nursing staff regarding their competency in managing aggressive behaviour in mentally ill patients.

1.6 SIGNIFICANCE OF THE STUDY

Every solution starts with an understanding of the situation, the internal and external factors that contribute to the situation as well as the lesson learned from how others viewed and dealt with similar situations. Thus, this study is significant in that its findings enhance in-depth understanding of various stakeholders regarding the factors that influence the competency of nursing staff in managing aggression in mentally ill patients from different perspectives. The findings of the study can also be effectively

utilised to improve the safety of the nurses and patients and thereby enhance the quality of mental health nursing care in general. Moreover, the findings of the study would serve as valuable input on future training and induction programs provided for by the WCH Quality Improvement and Training Division. Lastly, the study will contribute to the body of knowledge in as far as mental health management in Namibia is concerned.

1.7 PARADIGMATIC PERSPECTIVES

Research paradigms can be regarded as a combined cluster of assumptions, viewpoints, morals, perspectives and approaches that built an outline of understanding through which theoretical clarifications are established (Aliyu, Singhry, Adamu, & Abubakar, 2015). A paradigm also influences understanding, beliefs, values and perceptions of human beings regarding all things in life (Polit & Beck, 2014). Martin and Félix-Bortolotti (2014) explain that scientific research should be conducted within a specific paradigm that regulates subsequent research activities.

The research paradigm underpinning this study is based on pragmatism which guided the ontology, epistemology, axiology and methodology assumptions. The methods employed in this study were based on quantitative and qualitative approaches. The research instruments used were self-administered questionnaires and focus group discussions to determine the factors and perceptions with regard to the management of mentally ill patients' aggressive behaviour.

1.7.1 Ontology

Jelen-Sanchez (2017) defines ontology as a study of the form and nature of reality comprising of established strategies that can be uncovered. Ontology assumptions have to do with what reality stands for and the understanding of the researcher about what exists (Sefotho, 2015). In pragmatism reality is viewed as the practical consequences of a set of complex ideas, perceptions, experiences and practices (Creswell & Plano Clark, 2011). In this study, the researcher assumed that the nurses share knowledge, ideas, practices, work culture, peer pressure, personal experiences and societal beliefs that would affect their competency on how to manage aggressive behaviour of mentally ill patients. The ontology for this study was based on the assumptions that the perceptions of the nursing staff and focus group discussions were utilized to understand their viewpoints.

1.7.2 Epistemology

Epistemology is the study of the nature and scope of knowledge and reflects the diversity of knowledge that can be produced and the principles for explaining and defending knowledge (Siebert, Martin, & Bozic, 2016). Epistemology is also concerned with the creation and distribution of knowledge (Aliyu, Singhry, Adamu, & Abubakar, 2015). According to pragmatism knowledge is grounded in experience, develops continuously and is never entirely acquired in every aspect of it (Kaushik & Walsh, 2019). The knowledge of every single person is unique and is created by his or her personal experience (Creswell & Plano Clark, 2011). The objective of this study was to explore what the participants believed to be true about the phenomenon under

study. Thus, the epistemology of this study was based on the assumption that the participants are the creators of their own truth about the factors influencing their competency in managing patients who display aggressive behaviour. What the study participants believed to be true could be based on their perceptions, knowledge and understanding of the situation. The participants acquired knowledge through their basic training during their undergraduate courses and through continuous personal development. The participants also gained experience from their personal experiences and their understanding of those experiences and through role models in their work environment.

1.7.3 Axiology

Axiology is concerned with the nature and meaning of values and judgement in the research process and how it had been applied to uphold ethics (Aledo-Tur & Domínguez-Gómez, 2017). According to Aliyu, Singhry, Adamu, and Abubakar (2015), axiology comprises of how the researcher's own values influenced the phases of the research process. Also in pragmatism values play a large role in interpreting results and the viewpoints of researchers are both objective and subjective (Creswell & Plano Clark, 2011). According to Polit and Beck (2014), researchers involved in qualitative research attempt to bracket out prejudice and discern the essence of the phenomenon through being unbiased regarding the significance ascribed to it by those who have experienced it. They further explain that bracketing used in qualitative research requires that the researcher identify and examine her prejudice regarding her beliefs and views about the phenomenon under study and to remain objective and open-minded to the meanings given to the phenomenon by the participants.

The researcher in this study is employed at the MHCC, but avoided using her own values, biases and views to influence the findings of the qualitative part of the study. The researcher continuously identified and examined her own beliefs, views and opinions and strived to remain objective regarding the competency of nursing staff when managing aggression as described by them. For the quantitative part, this study used a convenience sampling method where the whole population was included to avoid selection biases to ensure confirmability. At the time of data collection, the researcher approached all nursing staff (N=64) employed at the MHCC, individually and asked them to participate on a voluntary basis in the quantitative part of this study. Prior to the commencement of the study, the ethical aspects were explained to the participants. Also, prior to each focus group discussion, the researcher informed the participants about the purpose of the study, the methods of data collection and approval of the study by the research ethics committees of the Ministry of Health and Social Services (MOHSS) and University of Namibia (UNAM). The questionnaire used in the study did not collect personal details whereby participants could be identified to ensure anonymity. The researcher assumed that the participants were truthful and honest in completing the questionnaire and when expressing their perceptions in the focus groups.

1.7.4 Methodology

The methodology is concerned with the process and procedures of scientific research and involved the controlled and approved methods used to generate knowledge (Martin & Bozic, 2016). Sefotho (2015) explains that methodology is the systemic

and theoretical analysis of the techniques applied to a discipline of study. According to Creswell and Plano Clark (2011, p.42) in pragmatism "researchers collect both quantitative and qualitative data and mix them". In this study, a convergent parallel mixed method design which combine both quantitative and qualitative approaches was applied. The quantitative approach was undertaken to identify the factors that influence the competency of the nursing staff in their management of aggression and was used to collect statistical data on that. The qualitative approach, on the other hand, was undertaken because the study sought to determine the perceptions of the nursing staff with regard to their competency in managing aggression. This approach was used to develop themes in order to conclude the study. Chapter 3 discusses the methodology process in detail.

1.8 OPERATIONAL DEFINITIONS

For the purpose of this study, the following terms are used and defined below:

Aggressive behaviour: Aggressive behaviour is manifested through provocative, hostile, critical and intimidating behaviour or communicating in an offensive and insulting manner (Warburton & Anderson, 2015). In this study, aggressive behaviour denotes intense self-assured actions which can cause physical and emotional harm to others and ranged from verbal aggression to physical aggression and prompts revengeful or defensive reactions.

Competency: Competency refers to a "complex integration of knowledge including professional judgment, skills, values and attitude. It is an intelligent practical skill set

that integrates or combines factors and issues in complex ways, specific to each circumstance" (Fukada, 2018, p.3). For the purpose of this study, competency is the psychomotor skills nurses use and the unique characteristics they possess to manage patients who display aggressive behaviour.

Mentally ill patient: A patient is defined in the Mental Health Act (MHA), Act No. 18 of 1973 as "a person mentally ill to such a degree that it is necessary that he be detained, supervised, controlled and treated and includes a person who is suspected of being or is alleged to be mentally ill to such a degree" (Government of the Republic of Namibia, 1973, p.573). For the purpose of this study, a mentally ill patient is a person diagnosed with a mental disorder, who is receiving care and treatment including rehabilitation services at a mental health hospital.

Mental illness: Mental illness is defined in the MHA, Act No. 18 of 1973 as "any disorder or disability of the mind and includes any mental disease, any arrested or incomplete development of the mind and any psychopathic disorder" (Government of the Republic of Namibia, 1973, p.573). In this study, mental illness refers to all mental disorders involving significant changes in thinking, emotion regulation and behaviour resulting in distress and problems functioning in social, work or family activities.

Management of aggression: Management of aggression refers to "management of behaviour that can result in harm to another person" (Smith & Rylance, 2016, p.34). Thus, in this study management of aggression refers to strategies such as interpersonal skills, de-escalation (communication) skills and containment measures used by nurses to manage aggressive behaviour in mentally ill in-patients.

Nursing staff: Signifies a person who is registered as a registered nurse or enrolled as an enrolled nurse as specified in Section 31(1) of the Nursing Act, Act No. 8 of 2004 (Health Professions Council of Namibia, 2004). In this study, nursing staff refers to the senior registered nurses, registered nurses and enrolled nurses currently employed at the MHCC.

1.9 CHAPTER ORGANIZATION

This report comprises of five chapters which are presented in line with the guideline for writing postgraduate work at the University of Namibia. After this introduction **Chapter 1**, in which the background of the study, problem statement, objectives and significance of the study, as well as paradigm perspectives and operational definitions are covered; **Chapter 2** follows with a presentation of a critical, synthesised and integrated literature review on the topic. **Chapter 3** focuses on the research methodology followed in pursuing the stated study objectives which involved the overall research process in relation with the study design, population, sample design and data collection and analysis as well as the ethical consideration made in conducting the study. **Chapter 4** presented the findings of both the quantitative and qualitative data collection process, which is then discussed in **Chapter 5** together with conclusions, limitations and recommendations.

1.10 SUMMARY OF CHAPTER ONE

The purpose of the study was to determine the factors that influence the competency of nursing staff in managing aggressive behaviour in mentally ill patients at the MHCC, Khomas Region, Namibia. This chapter provided a background to the study, explained the problem statement, and stated the purpose, objectives and significance of the study. Also, the paradigmatic perspectives and operational definitions were explained and a chapter organization was provided.

Chapter 2, will provide a comprehensive review of literature relevant for the study.

CHAPTER 2

LITERATURE REVIEW

2.1. INTRODUCTION

The previous chapter introduced the research and discussed what brought about the study and what it would investigate. This chapter explored what is already known about the topic, identifies different areas of relevance and importance through literature. A comprehensive literature review was done in the field of study of management of mental illness particularly in the area of aggression in mentally ill patients. The literature searched included the following data bases: EBScohost, CINAHL, MEDLINE, Wiley online library, Science Direct and PubMed. The following key words were used to conduct the literature search: aggression, aggressive behaviour, mental illness, skills, knowledge, competency and management of inpatient aggression. Additionally, a review of the literature regarding the factors that influence the competency of mental health nursing staff in managing aggression is also presented.

2.2. OVERVIEW OF MENTAL ILLNESS

Mental illness also referred to worldwide as mental health disorders, apply to a broad assortment of diagnosable mental health conditions that affect the mood, thinking and behaviour of patients (Procter, Baker, Grocke, & Ferguson, 2016). Townsend (2014, p.6) defines mental illness as

"maladaptive responses to stressors from the internal or external environment, evidenced by thoughts, feelings, and behaviours that are incongruent with the local and cultural norms, and interfere with the individual's social, occupational, and/or physical functioning".

In addition, the American Psychiatric Association [APA] (2013) describes mental disorders in the Diagnostic and Statistical Manual of Mental Disorders, 5th edition (DSM-5) as "a syndrome characterized by clinically significant disturbance in an individual's cognition, emotion regulation, or behaviour that reflects a dysfunction in the psychological, biological, or developmental processes underlying mental functioning" (Videbeck, 2016, p. 3).

Riebschleger, Grove, Cavanaugh, and Costello (2017) state that mental illness includes a wide range of problems, with unrelated symptoms. They further explain that mental illness has an impact on at least one in five people; hence it is a widespread health condition which affects many people. However, according to the World Health Organization (2011), most of these mental illnesses can be treated successfully.

According to the American Psychiatric Association (2013), there are more than 200 classified types of mental illness. It further states that the diagnosis of mental illness is generally made according to the classification systems of the Diagnostic and Statistical Manual of Mental Disorders (DSM) (American Psychiatric Association, 2013). Moreover, the WHO listed some mental disorders that are more prevalent, and these are depression, bipolar affective disorder, schizophrenia and other psychoses,

dementia, intellectual disabilities and developmental disorders including autism, based on the ICD-11 classification system (World Health Organization, 2011).

The interdisciplinary team at the MHCC adopted the DSM-5 classification system of APA (2013) as a tool to diagnose patients. According to the Health Information System (HIS) Division's annual report schizophrenia, substance-induced psychosis, bipolar mood disorder, major depressive disorder and intellectual disability are the top five mental illnesses with which in-patients at MHCC are diagnosed of which aggression is one of the symptoms.

2.2.1. Aggression

Knowledge of what constitutes aggression differs amongst nurses (Bekelepi, 2015). Broad descriptions of aggression and interchangeable use in literature, worsen understanding and influence management of aggression negatively. Aggression has been described as "behaviour aimed at causing harm. This might only be verbal behaviour, such as an insult, or it might be physical behaviour, in which case it is called violence" (Uys & Middleton, 2014, p. 287). Aggression is also referred to as particular conduct, whereby one person attacks another, resulting in malicious actions or defensive responses (Townsend, 2014). Consistent with these descriptions, a study done at the Helsinki University Central Hospital found that nurses have their own understanding and opinions about aggression (Laiho, et al., 2014). Aggressive behaviour in mentally ill inpatients forms an integral part of providing nursing care in mental health settings.

2.2.1.1. Types and Phases of Aggression

Several studies revealed that a broad classification of the types of aggression exists in the literature (Richardson, 2014; Townsend, 2014). However, Alyaemni, and Alhudaithi (2016), for example, observed that the types of aggression commonly reported by nurses are verbal aggression followed by physical aggression. Consistent with this observation, Denson, O'Dean, Blake, and Beames (2018) listed verbal and physical aggression amongst other categories of aggression as more prevalent. Both verbal and physical aggression is meant to hurt, punish or overpower someone (Hurskainen & Katainen, 2015).

Verbal aggression is described as an emotional response marked by verbal insults, disobedience and intimidation, carried out when the patients feel vulnerable and unsure of themselves (Videbeck, 2016). In addition to that, Richardson (2014) describes verbal aggression as a type of direct aggression which is aimed at causing harm through insults and swearing. Physical aggression, on the other hand, is described as a behaviour in which a person beats or injures another person or damages property (Denson, O'Dean, Blake, & Beames, 2018). In agreement with that, Warburton and Anderson (2015) explained that physical aggression is when people are physically fighting and injuring each other, and that can be done either through punching, biting or kicking. The types of aggression are so closely related to the different phases that it can be easily misinterpreted.

The phases of aggression are a series of sequential steps which shows how aggression increases and intensifies until it reaches a crisis point and Videbeck (2016) listed such

phases as triggering, escalation and crisis stages. According to Hallet (2018), the triggering, escalation and crisis stages of aggression are ways in which a patient responds to conflict situations.

During the triggering stage, the patient experiences feelings of anxiety, fear, becomes upset and walks around impatiently (Videbeck, 2016). Moreover, Hallet and Dickens (2017) state that during this stage, a patient clearly shows that he is upset, disturbed and worried about something. The triggering stage is followed by the escalation stage during which the patient presents verbal aggression, an angry facial expression, bad temper and also rejects any attempts to calm him down (Stockley, 2015). During this stage, for example, the patient would talk in a loud and high-pitched voice, his body trembling, and he would stare at everyone angrily.

The last phase of aggression is the crisis stage. In this stage, the patient's behaviour becomes uncontrollable, resulting in physical aggression towards others, objects and even himself (Uys & Middleton, 2014). A patient in this stage would, for example, fight with other patients, throwing around chairs, breaking furniture and windows and can also cut himself with any sharp object he can get hold of. Patients can show these characteristics and types of aggression because of specific causes which can trigger the aggression.

2.2.1.2. Causes and Signs of Aggression

Worldwide, it is found that aggression in mentally ill patients is caused by factors such as the diagnosis of the patient, inpatient wards, involuntary admissions and patients

admitted with a history of violence (Renwick, et al., 2016). Firstly, Bowers (2014) found that patients diagnosed with a psychiatric illness are prone to become aggressive because these conditions may be as a result of the emotional state and cognitive impairment of the patient. He further explains that patients who experience paranoid delusions believe that people want to harm them and that can cause them to act aggressively in response, as a way of protecting themselves. In addition to that, patients who experience auditory hallucinations commanding them to hurt others or that they will be harmed are equally prone to aggression (Videbeck, 2016).

Moreover, the emotional state and cognitive impairment of the patient can also be affected when they are intoxicated with substances such as cannabis, methamphetamine or alcohol that can trigger acute psychotic symptoms such as visual and tactile hallucinations; and that can force them to act out aggressively (Nguluwe, et al., 2014). In the same vein, Baby, Swain, and Gale (2016) note that patients who have been identified as having cognitive impairment due to intellectual disability may misinterpret activities in their environment resulting in aggressive outbursts. For example, patients with cognitive impairment usually have difficulty in telling someone how they feel and aggressive behaviour can be their only way of communicating their feelings when provoked and for that reason, they can react by beating the other person.

Lastly, patients with dementia typically disregard social rules due to their impaired social judgement and poor impulse control and that can cause aggressive behaviour (Liljegren, Waldö, & Englund, 2018). Such patients would, for example, have memory difficulties and unable to recall events, names of people and places which can cause them to feel threatened and helpless resulting in aggressive outbursts.

Hallet, Huber, and Dickens (2014) argue that environmental factors such as the design of the ward and noise levels can cause frustration and irritation in the patient who already had experienced shock and dismay at being admitted into a mental health ward. They further explain that the design of the ward includes factors such as locked doors and lack of privacy which can worsen behavioural problems (Hallet, et al., 2014).

Firstly, locked doors contribute to feelings of uncertainty and insecurity that may bring about aggressive outbursts and disruptive behaviour (Gudde, Olsø, Whittington, & Vatne, 2015). In addition, Lozzino, Ferrari, Large, Nielssen, and De Girolamo (2015) explain that patients regard being kept in closed or locked wards as being in custody rather than in a therapeutic environment and that can make them hostile towards the nurses and other patients. A patient who is kept in such an environment, may, for example, feel trapped because he cannot leave the ward when he wants to and that can lead to quarrels and fights with the staff and even other patients. On the contrary, Jacob, et al., (2016) opined that wards, where the doors are not locked, can contribute to feelings of safety and bring on a reduction in patient aggression.

Furthermore, bedrooms in which patients are cramped up, can cause them to easily encroach on each other's privacy and that can make them feel nervous and anxious (Olsson, Audulv, & Strand, 2015). A study at a South African hospital affirms that patients who stay in overcrowded rooms, become upset and annoyed with each other due to the invasion of their privacy and that lead to frequent episodes of fights amongst them (Van Wijk, Traut, & Julie, 2014). Adding to that, Hallet, et al., (2014) state that

in a forensic unit where patient's living area is cramped in and they also have to stay for long periods, aggressive outbursts is unavoidable.

Lastly, in addition to locked wards and lack of privacy, noisy wards can also play a notable part in inpatient settings (Warburton & Anderson, 2015). The therapeutic ward environment can become disordered due to loud noises such as patients yelling at each other, the high-pitched sound of television sets and music played loudly and that can disturb patients and set off aggression (Olsson, et al., 2015). In addition, Van Wijk, et al., (2014) explain that musical songs played at full volume on the television sets and radios, are especially annoying to patients and provokes anger and aggression because it shows disrespect for their preferences and needs. Undoubtedly, research shows that locked doors, lack of privacy and noisy wards contribute to aggressive outburst in the inpatient ward setting and may therefore negatively affect patients admitted as involuntary.

Involuntary admissions are globally governed by mental health legislation (Birkeland & Gildberg, 2016). However, research shows that patients admitted involuntarily have a greater chance of violent and aggressive behaviour because these patients are suffering from acute symptoms such as delusions, hallucinations and intoxication (Flammer & Steinert, 2015). In line with this, Mosele, Figueira, Filho, de Lima, and Calegaro (2018) affirm that patients admitted as involuntary are usually uncooperative with no insight into their illness and are brought in by the police because they are considered a danger to others and themselves and as such have to be forced to be hospitalised. In addition, these patients are usually also against the admission and subsequent treatment, therefore these involuntary admissions may evoke feelings of

frustration and resistance in them that can lead to aggressive behaviour (Lozzino, et al., 2015).

Aggression in mental health wards is a matter of great concern because most nursing staff working in these wards encounter aggressive behaviour of a mentally ill patient at some point in their career, and witness aggression directed at other patients or their colleagues and may also be the target of assaults themselves (Stokowski, 2014). Therefore, if nurses have the necessary knowledge and skills to deal with aggressive outbursts, serious consequences could be prevented.

2.3. MANAGEMENT OF AGGRESSION IN A CLINICAL SETTING

Managing aggression is referred to as managing behaviour that can result in harm to another person and poses a significant challenge with regard to the care provided by mental health nurses (Townsend, 2014). According to Pileño, Morillo, Morillo, and Losa-Iglesias (2018), the management of the mentally ill patient within clinical settings is directed by the inter-disciplinary team consisting of a psychiatrist, medical doctors, nurses, clinical psychologists, occupational therapists and social workers. They further explain that of these, the nurses and medical doctors are paramount in the management of aggression and primarily consists of prevention measures, use of medication (chemical restrain), physical restraint and seclusion (Pileño, et al., 2018).

In an effort to manage aggression, verbal negotiation as a component of de-escalation techniques is most frequently used by nurses as a preventative measure (Gardner & Magee, 2014). Verbal negotiation, according to Moss (2015), involves talking to a

patient in a low and soft tone of voice to calm the patient down. Verbal negotiation also includes listening attentively to the patient, finding out what causes the distress and offering alternatives to solve the problem, shows that the nurse is concerned about the patient and that can prevent the escalation of aggression (Price, Baker, Bee, & Lovell, 2018).

Furthermore, offering oral medication as a way of managing aggression, has also proved to be of great help to de-escalate aggression and nursing staff prefers the use of medication instead of seclusion to control aggressive behaviour (Lantta, et al., 2016). However, often when managing an acutely mentally ill patient, verbal negotiations fail, resulting in the refusal of oral medicine and in order for the nurses to control the disruptive behaviour, injectable medication has to be given (Hallet & Dickens, 2017). According to Sobekwa and Arunachallam (2015), when the aggressive patient refuses to be injected, the mental health nurses will have to hold the patient's body firmly to restrict the movements of his limbs for them to be able to administer the injection. They further explain that when nurses control the patient in such a manner, it may result in the patient becoming more aggressive to regain self-control (Sobekwa & Arunachallam, 2015).

Additionally, when verbal negotiations fail and other intervention techniques were not available, the nurse is left with no other choice than to make use of restrictive containment interventions such as physical restraint and seclusion which can only be instituted when other least restrictive approaches such as verbal negotiation were unsuccessful (WHO, 2005). Physical restraint signifies any technique that confines or decreases the capacity of a patient to easily move his limbs and head, including

chemical restraint, but is not the usual therapy for his illness (American Psychiatric Nurse Association, 2014). Research shows that physical restraint of the aggressive patient has been used since the origination of psychiatric treatment, by nurses to manage aggressive behaviour and prevent injuries (Mahmoud, 2017; Belete, 2017). However Vedana, et al., (2018) state that nurses are mostly exposed to injuries and prefer not to use physical restraint. Consistent with that, Khalifeh (2015) explains that in a meta-analysis of studies done in mental health wards, the face-down bodily restraint method is used to inject an aggressive patient, but suggests that nurses should avoid using restrictive interventions.

Another intervention that is used in mental health wards to manage aggressive behaviour of mentally ill patients, is seclusion (Van Wijk, et al., 2014). Flammer and Steinert (2015) explain that seclusion involves placing a patient alone in a room from where he cannot exit freely because of a locked door. However WHO (2005) disapproves of the use of seclusion and explains that a shortage of resources and lack of training encourages nurses to use this intervention and advises the development of mental health infrastructures and enacting the necessary legislation to control this practise. However, a study done at a South African hospital found that 96.2% of the nurses suggested that seclusion may be used as an intervention to manage aggressive behaviour, despite possessing the necessary knowledge on the management of aggression (Bekelepi, 2015). It was also found in an Australian survey that nurses considered seclusion as a much needed intervention when patients are aggressive to ensure that both staff and patients are safe, providing that the necessary guidelines are in place to guard against human rights violations (Gerace & Muir-Cochrane, 2019).

In summary, mental health nursing care is influenced by the different approaches that are used in the mental health wards to manage aggressive behaviour. These approaches are preventative measures such as verbal negotiation, chemical restraint and physical containment measures such as physical restraint and seclusion. The outcome of the nursing care given to the mentally ill patient who displays aggressive behaviour depends mostly on the competency of the nurse. A nurse competent in these approaches will be able to provide safe care to the patient and at the same time resolves the aggressive outburst.

2.3.1. Mental Health Nursing

Mental health nursing has been described as a specialized field of practice within nursing which make use of interpersonal techniques to provide the patient or family, with therapeutic and preventative life skills that can develop their abilities and control dysfunctional behaviour (Santangelo, et al., 2018). Furthermore, Townsend (2014) explains that the nurse-patient relationship is the essence of mental health nursing, a relationship in which the nurse and the patient have to acknowledge each other as individuals with unique and remarkable characteristics. This patient-centeredness of providing nursing care to the mentally ill patients is further strengthened by using a holistic biopsychosocial model to assess patients (Maxwell, et al., 2018). In clinical settings the management of aggressive behaviour of mentally ill patients forms a necessary part of routine mental health nursing care and is essential to ensure that staff and patients feel safe and protected (Lantta, et al., 2016).

2.4. CLINICAL COMPETENCY

Effective and safe management of the aggressive in-patients requires that mental health nurses possess competencies that will enable them to provide quality nursing care (Creamer & Austin, 2016). Nursing competency has been described by WHO (1988) as "requiring knowledge, appropriate attitudes and observable mechanical or intellectual skills for the delivering of professional service" (as cited by Scanlon, 2017, p. 3). In accordance with the definition of WHO (1988), Paans, Robbe, Wijkamp, and Wolfensberger (2017) argue that the competency of nurses to manage aggressive patients have some bearing on their own safety and that of the patient. A nurse is capable to manage an aggressive patient because of skills such as de-escalation, restraining and injecting sedative medication, but if the restraint technique is not correctly applied it can lead to serious injuries and even death (Paans, et al., 2017). Also, in keeping with that, Liu and Aungsuroch (2018) found that competency has predominantly been described with reference to holistic and behavioural aspects. They further point out that the holistic definition was widely applied and depicts competency as a comprehensive compilation of universal qualities such as "knowledge, skills, professional attitudes and professional characteristics" (Liu & Aungsuroch, 2018, p. 195).

Moreover Fukada (2018) affirms that competence is solely attainable through knowledge, experience, continuous learning and acquired specialised skills. This is also consistent with Benner's Novice to Expert Theoretical Model, in which it is stated that a novice nurse only gains competence after two to three years of exposure in a particular position (Benner, 1982).

In summary, professional competence encompasses a broad range of skills and abilities acquired through continuous involvement with a specific task with uninterrupted learning.

2.5. THEORETICAL FRAMEWORK OF CLINICAL COMPETENCY

Grant and Osanloo (2015) describe a theoretical framework as the "blueprint" for the entire research study which serves as the guide on which to build and support the study and also provides the structure to define the philosophical, epistemological, methodological, and analytical approach of the study as a whole. They further state that once a blueprint is created, others will have a basic idea of what concepts and principles will be used to establish the ideas and approaches to the study.

Clinical competency is described as the ability to provide safe holistic care and an ability to accurately assess the clinical situation and applying critical thinking skills to select the best options available for nursing care of the patient (Fukada, 2018). For this reason, this study took into consideration Benner's Novice to Expert Theoretical Model.

Benner's Novice to Expert Theoretical Model came into being in 1982 and was coined by Dr Patricia Benner (Benner, 1982). The aim of Benner's model is to assist in determining the factors that influence the competency of nursing staff in managing aggressive behaviour in mentally ill patients. This study seeks to understand the factors that influence the competency of nursing staff while managing aggressive

behaviour and not an assessment of their skills. For that reason, Benner's Novice to Expert Theoretical Model (Benner, 1982), is chosen as a suitable theory to provide the structure to the entire research. In line with Grant and Osanloo (2015), Benner's Model provides a common world view or lens from which to support the thinking on the problem and analysis of data for this study.

2.5.1. Benner's Novice to Expert Theoretical Model

Benner's Novice to Expert Theoretical Model (Benner, 1982) bears in mind that competence is improved through experience and formal learning. The nurse develops competence in skills and understanding of patient care through improved clinical expertise and real-life events (Benner, 1982). The Model can be applied to develop knowledge on aggression, skills in managing it and also the development of organizational system competencies in practicing nurses working in a mental health institution. The acquisition of competency as set out in Benner's Novice to Expert Theoretical Model (Benner, 1982) is shown in the following schematic illustration:

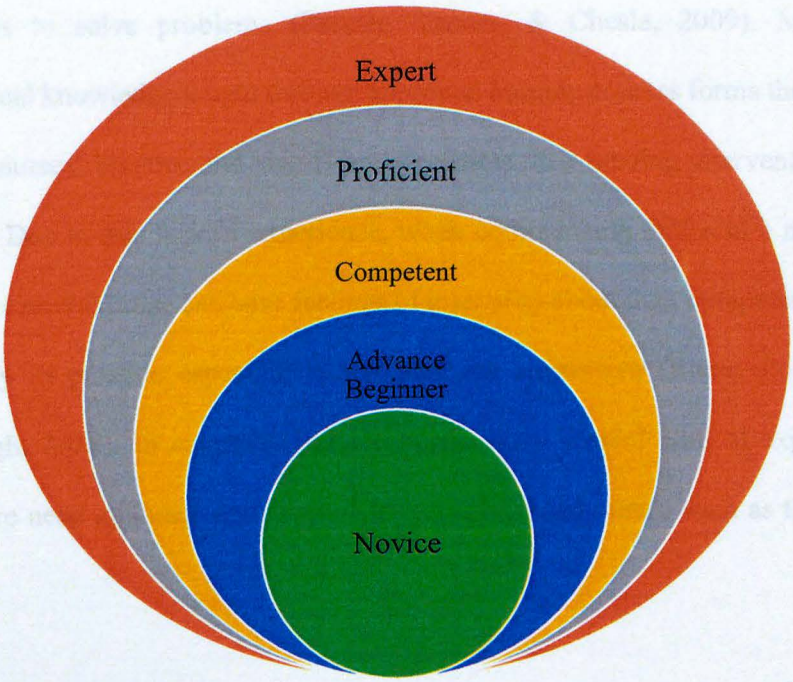

Figure 2.1: Illustration of the stages of skills acquisition within the Novice to Expert Theoretical Model

The different stages have an influence on each other, as the nurse moves from the novice to the expert level in about five years. Such movements from one stage to another results in nurses gaining knowledge, skills, perceptions, intuition and experience in their given field of practice. The successive five stages have been described as novice, advanced beginner, competent, proficient and expert (Payne, 2015).

2.5.1.1. Novice

Benner (1982) argues that a novice nurse has no experience and does not know the field of expertise, resulting in an inability to make decisions when confronted with real-life incidents such as an aggressive patient. In a situation like that, the novice nurse has no choice but to strictly adhere to guidelines and uses formally taught

practises to solve problems (Benner, Tanner, & Chesla, 2009). Meaning that theoretical knowledge taught through approved training courses forms the basis of the novice nurses' practice and significantly restricts their nursing interventions (Payne, 2015). Due to this lack of experience, when commencing duties in a mental health setting, a novice nurse can have feelings of insecurity about their competence to handle mentally ill patients especially when they are aggressive (Roets, Poggenpoel, & Myburgh, 2018). In summary, novice nurses have limited clinical experience and therefore need guidance and support from experienced nurses such as the registered nurses.

2.5.1.2. Advanced Beginner

Concerning the advanced beginners, Benner (1982) states that nurses in this stage have to be assisted in prioritising the needs of patients because their actions are still directed by guidelines. The advance beginner refers to the newly graduated registered nurse and the experienced nurse who has been transferred from another unit or has been out of clinical practice for some time (Benner, et al., 2009). Nurses in this stage, have the theoretical knowledge acquired through formal learning, but lack wide-ranging experience (Ghahrisarabi, Shouryabi, Anboohi, Nasiri, & Rassouli, 2016). Moylan (2015) explains that the advanced beginner can compile detailed patient care plans, but without considering what happens in the real situation. Their selection of patient care activities is grounded in and copy what expert nurses have previously done for the patient (Moylan, 2015). Therefore advance beginner nurses need to expand their theoretical knowledge on aggression, anger and violence in order for them to be competent to efficiently manage aggressive behaviour (Casey, et al., 2017). They

should be able to attune their theoretical knowledge on aggression and skills in aggression management to different situations to be able to effectively manage aggression (Fukada, 2018).

The key conclusion for this stage is that the perceptions of advance beginner nurses regarding the management of mentally ill patients can have a negative impact on the development of competency. Therefore, they have to be supervised by competent level nurses to safeguard vital patient care needs.

2.5.1.3. Competent

A nurse who has two to three years of experience in a specific unit is seen as competent (Benner, 1982). Competent nurses have progressed towards a richer understanding of the clinical situation, their practical capabilities and patient care management have also improved (Thomas & Kellgren, 2017). Hansen-Salie and Martin (2014) argue that factors such as theoretical knowledge, experience acquired through recurring work activities (clinical experience), experiential opportunities within the clinical environment, influence their development of professional competence. Similarly, other studies also concluded that mental health nurses need to expand their theoretical knowledge on aggression, anger and violence in order for them to be competent to efficiently manage aggressive behaviour (Casey, et al., 2017). Furthermore knowledge on aggression assists competent nurses to understand their patient's behaviour better and that makes it easier for them to engage in a one-to-one therapeutic relationship with the mentally ill patient (Berring, Pedersen, & Buus, 2016).

Therefore nurses in this stage are able to better foresee future occurrences and trends within the clinical setting enabling them to implement more effective nursing

interventions. With regard to the management of aggressive behaviour in mentally ill patients, a competent nurse is also able to recognize and notice signs and symptoms of aggression, because of an enhanced ability to identify distinct characteristics of the disorders (Payne, 2015). According to Hallet, et al., (2014), competent nurses are aware that the signs and symptoms of aggression differ between patients, because of their enhanced knowledge on the management of aggression and also acknowledged that early intervention can be an effective preventative measure. In addition, Duma and de Villiers (2014) maintain that competent nurses are obliged to apply their knowledge about aggression to each aggressive episode. Competent nurses who believe in prompt intervention when a patient becomes aggressive also disregard perceptions that patients may calm down by themselves if left alone and is of the opinion that only nurses who have insufficient knowledge about aggression can have such views (Harwood, 2017).

Despite the fact that such ability enables nurses to take preventative or de-escalation actions, George (2014) is however of the view that ethical issues continue to be a concern because nurses in this stage, still only have limited practical experience and knowledge about aggression. According to Benner, et al., (2009), a competent nurse becomes more emotionally involved and can use that as a screening tool to alert them of a potentially dangerous situation. They further state that the lack of "experiential wisdom" causes a competent nurse to make unethical decisions such as revengeful actions in response to patient aggression (Benner, et al., 2009).

The key conclusion for this stage is that competent nurses have the ability to recognise aggression in the patient at an early stage and are capable to manage it according to

the clinical situation. However, nurses in this stage have to continuously improve their competency in order to master it and to be able to move forward to a proficient stage.

2.5.1.4. Proficient

A nurse who gains more experience and who learned from these experiences will advance towards the proficient stage (Benner, 1982). Clinical experience and experiential learning opportunities within the clinical environment are fundamental in the advancement from one stage to another and the development of the nurse's competency in aggression management (Svavarsdótti, Sigurðardóttir, & Steinsbekk, 2015). A study found that nurses can learn out of clinical experience what to expect, therefore they can apply effective measures and appropriate techniques when faced with an aggressive patient (Miller & Hill, 2018). Also, Basson, et al., (2014) explain that continuous involvement with aggressive incidents can develop nurses' skills in such a way that they are able to establish therapeutic relations with patients as well as recognising significant behavioural signs promptly and instinctively. Furthermore, continuous engagement with and assessment of the aggressive patient assist the proficient nurse in recognising the signs and symptoms of the patient, to anticipate what will happen next, knowing what strategies helped previously to calm down the patient and to be able to adjust nursing interventions according to the current clinical situation (Hallet, et al., 2014). Therefore nurses with an extended period of clinical experience such as proficient level nurses, have profound knowledge and comprehension of their field of specialization (George, 2014). Conversely, however, Payne (2015); Verhaeghe, et al., (2014) maintain that although clinical experience exposes nurses to various experiential learning opportunities during which they can

gain specific knowledge and skills about aggression, they do not necessarily have a better understanding of patient behaviour than the novice nurse.

In addition, Murray, Sundin, and Cope (2019) explain that the proficient nurses' interpersonal abilities become more noticeable and coupled with the accrued experience assist them to see the current clinical situations as a whole. Furthermore, Haynes (2016) states that a proficient level nurse has a deeper holistic understanding and is able to assess incidents and to adapt nursing interventions according to the clinical circumstances. Thus proficient nurses will be able to recognize patient aggression triggers and warning signs and will also intuitively acknowledge the seriousness of the situation because of their advanced understanding and preceding experience (Girard, Russell, & Leyse-Wallace, 2018).

According to Hassankhani, Hasanzadeh, Powers, Zadeh, and Rajaie (2018), a proficient nurse has developed different skills to manage aggression and also refined it through clinical experience. They further explain that a proficient nurse can use various approaches such as risk assessment, verbal negotiation (communication skills), administering sedatives and physical containment such as restraint, time-out and seclusion to manage an aggressive patient. Proficient nurses have developed the ability to foresee the signs of aggression through continuous assessment and that enables them to intervene promptly (Sobekwa & Arunachallam, 2015).

Furthermore a proficient nurse is able to settle any given hostile event swiftly due to the skills gained during continuous engagements with aggressive patients, making her more effective in the prevention of aggression (Moylan, 2015). Research studies have found that a proficient nurse can better understand the reasons for the aggressive

outburst of the patient, because of her advanced reflective and connective listening skills (Moss, 2015). Similarly, Haugvaldstad and Husum (2016) state that the effective communication and interpersonal skills applied by proficient nurses can bring harmony in the mental health wards and reduce aggressive episodes. In addition Belete (2017) explains that because of their keen communication and critical thinking skills, proficient nurses hardly ever make use of restrictive approaches such as physical restraint.

The key conclusion for this stage is that the attitudes of nurses are moulded by their clinical experience, interpersonal approaches, knowledge, skills and individual traits which ensure a wealth of competencies for a proficient nurse. The development of these more efficient competencies will enable the proficient nurse to evolve into the expert stage.

2.5.1.5. Expert

The expert level is the final stage of skills acquisition of Benner's Novice to Expert Theoretical Model (Benner, 1982). Consistent with that, Benner, et al., (2009) affirm that an expert nurse has comprehensive knowledge and extensive experience in the clinical situation such as the ability to apply correct restraint techniques when handling a patient who displays aggressive behaviour. They further explain that the wide-range experience of an expert nurse includes continuous involvement with the aggressive patient which brings about a multitude of approaches to use when managing aggressive episodes. Studies by Wihlborg, Edgren, Johansson, and Sivberg (2017) and Danielsen (2014) concluded that through continuous engagement, nurses gain knowledge about

aggression and competency in aggression management which enables them to apply this in their daily interaction with aggressive patients. In this vein, Svavarsdótti, et al., (2015) claim that an expert nurse is globally regarded as a highly-skilled nurse in a specific specialization field.

Moreover, an expert nurse is intensely aware of the mental state of the potentially aggressive patient and that can help her to timely identify patients who are experiencing difficulty in managing their own aggression which can, if not handled properly, eventually escalate into violence (Kuokkanen, et al., 2016). Furthermore Benner, et al., (2009) explain that at the expert level, the nurse has mastered several skills, including identifying aggressive behaviours and is therefore able to promptly recognise even the smallest possible signs at an early stage and can then respond swiftly to them. An expert nurse, would notice changes in the condition of a patient such as a frown on the face, a glaring facial expression and a tight jaw which may indicate that a patient struggles to control himself (Hassankhani, et al., 2018). In addition, Hruska, et al., (2016) state that an expert nurse becomes sensitive to the unique problems of the patient because of this intense awareness and as such provides nursing care with compassion and great care to ensure that the current needs of the patient are met.

Furthermore, Wihlborg, et al., (2017) argue that in order for expert nurses to provide care with consideration of all needs of the patient, they will have to advocate for the rights of the patient and therefore will have to negotiate treatment choices with the interdisciplinary team. They further explain that expert nurses can provide considerate patient care after they have done some reflection on the care that has been given. Dube

and Ducharme (2015) assert that an expert nurse is mostly engaged in reflective practice because it has become second nature and her wide-range of clinical experience enable her to learn from it. They further explain that reflective practice occurs when a nurse recalls a clinical event, thinks about it and assess it in order to enhance and bring about personal development (Dube & Ducharme, 2015). However in order for a nurse to continue being an expert in the clinical field and to further develop clinical competencies, she will have to do self-reflection on her own abilities keeping in mind her strong and weak points and also engaged in continuous educational activities (Svavarsdótti, et al., 2015).

The key conclusion for this stage is that expert nurses operate from their broad base of clinical experience to enable them to handle aggressive patients with great care and consideration of their individual needs. Such nurses further enhance their experience through being continuously engaged with the aggressive patient, being intensely aware of the changes in the condition of the patient and strive to improve their aggression management approaches through self-reflection.

In summary, competency in accordance with the Novice to Expert Theoretical Model evolves over time and in different stages. A novice nurse lacks experience and needs guidelines to direct her actions whereas the advance beginner has accrued enough experience to easily recognise common clinical occurrences. A competent nurse, on the other hand, is able to recognise the clinical problem and makes prompt decisions. A proficient nurse sees clinical events as a whole, while an expert nurse has a deep understanding of the situation and operates from her foundation of wide-ranging clinical experience.

2.6. REVIEW OF THE FACTORS THAT INFLUENCE COMPETENCY

With a blueprint in place, this section presents the review of the factors that influence clinical competency using Benner's Novice to Expert Theoretical Model (Benner, 1982) which provides a structure for the data collection and analysis of this study. As per its purpose, the Model provides the description of characteristics and factors that facilitate the successful transition from the novice to the expert stage. Furthermore, the fundamental concepts of Benner's Novice to Expert Theoretical Model (Benner, 1982) are competency, skill acquisition, clinical/practical experience and theoretical knowledge.

In addition to Benner's Model (Benner, 1982), a number of studies concluded that the concept of clinical competency is associated with a range of factors that have an impact on the development of nursing competency and as such influence competency of nurses in managing aggression (Scanlon, 2017; Hansen-Salie & Martin, 2014). The factors that influence nurses' competency in the management of aggression include attitudes, experiential opportunities, continuous professional development, interpersonal skills, personal attributes, critical thinking, ability to conduct risk assessment and team work.

2.6.1 Attitudes

Concerning attitudes as a factor that influence nurses' competency in managing aggressive patients, Laiho, et al., (2014) state that experience of aggressive patients

also shapes the beliefs of nursing staff on aggressive patients. They further explain that some nurses believe that the patient is to blame for his/her aggressive behaviour because their actions are deliberate and they just want to harm others. These nurses also feel disheartened and struggle to show empathy with aggressive outbursts of patients (Baby, et al., 2016). Verhaeghe, et al., (2014) noted that such attitudes negatively affects nurses' capability to experience fulfilment in the delivery of patient care. This is further affirmed by Santangelo, et al., (2018) that some nurses believe that patients are able to control their own behaviour and this attitude negatively affects the nurses' competencies. On the contrary, other nurses do not have a negative attitude towards patients even though they had been assaulted, instead, they reason that the patients' mental condition is to blame for their aggressive behaviour (Yang, Hsieh, Lee, & Chen, 2016).

2.6.2 Experiential Opportunities

Several studies found that experiential opportunities within the clinical environment which include clinical supervision, mentoring, role modelling, various forms of training and the availability of guidelines also influence competency (Hansen-Salie & Martin, 2014; Walker-Reed, 2016). According to Casey, et al., (2017), effective clinical supervision and mentoring can increase the knowledge and competence of the mental health nurse because it assists them in learning to manage aggressive patients with greater confidence. Clinical supervision is the process whereby the expert nurse guides the novice nurse towards improved work performance (Anderson, et al., 2017). Similarly the expert nurse as a mentor, can supports, motivates, assists and encourages the novice nurse in her practical learning process (Walker-Reed, 2016).

Additionally, Benner's Novice to Expert Theoretical Model prescribes that in order to develop competency, role modelling is the preferred process whereby nurses can refine their acquired skills (Benner, et al., 2009). In the context of nursing competency, role modelling can be defined as learning that is imparted from an experienced nurse who carries out her duties conscientiously and with an innate skill (Hughes, Wright, & Cassar, 2018). According to Morken, et al., (2015), role models can be identified as those experienced nurses who operate at a more advanced level than the novice nurse. In this regard, Nazari, Vanaki, Kermanshahi, and Hajizadeh (2018) explain that clinical leaders, clinical supervisors and educators are all considered role models. Observing an experienced nurse skilfully managing an aggressive patient can assist the novice nurse to gain competency (Kuokkanen, et al., 2016). Clinical leaders and supervisors who are calm and confident in the face of aggression are able to transfer their skills to other nurses and therefore considered as competent (Baby, et al., 2016).

Evidence also points to in-service training as another factor that influences the competence of nurses in managing aggression (Hansen-Salie & Martin, 2014). Maddineshat, Hashemi, Besharati, Gholami, and Ghavidel (2018), concluded that in-service training of nurses is seen as an essential enabler in managing aggressive behaviours and assert that hands-on training on how to communicate effectively with the aggressive patient as well as how to handle aggression escalation can strengthen the capabilities of nurses. Also in-service training on aggression management guidelines and the availability of informational leaflets can improve competence (Wihlborg, et al., 2017).

2.6.3 Continuous Professional Development

The need for continuous professional development (CPD) and its importance in the development of diverse skills, is globally recognized (Sargazi, Foroughameri, Miri, & Farokhzadian, 2018). According to Nobahar (2016), CPD can strengthen and increase the competencies of mental health nurses, because it drives the necessity to develop more skills in the management of aggression. On the other hand, Nazari, et al., (2018) noted that CPD can assist a competent nurse to obtain comprehensive knowledge on the management of aggression. In Namibia it is expected from the nurses that their CPD activities address the emerging health needs of the country and does not refer to specific competencies. Nurses may obtain continuing educational units depending on their personal circumstances and individual needs which have to include ethics, human rights and medical law (Health Professions Councils of Namibia, 2011).

In addition to the factors that positively influence the competency of nursing staff in managing aggression, Sobekwa and Arunachallam (2015) remarked that lack of supportive structures in the form of clinical supervision and mentoring hinder competency development. Despite some negative outcomes, the development of nursing competency through practical experience, experiential learning and opportunities within the clinical environment, remains essential to improve the nurse's skills in managing aggression (Svavarsdótti, et al., 2015).

2.6.4 Interpersonal Skills

In relation to the interpersonal skills which include communication skills such as active listening and persuasive skills are also found to have an influence on the competency

of nurses (Moss, 2015). Research studies have found that a proficient nurse who is competent in active listening skills can better understand the reasons for the aggressive outburst of the patient (Truglio-Londrigan, 2016). Morever, Kuokkanen, et al., (2016) assert that listening skills can enable the nurse to verbally demonstrate concern and compassion for the patient. Listening attentively to an aggressive patient can create a feeling that they are listened to and that can nurture harmony in the clinical setting, which can defuse potential aggression (Tema, Poggenpoel, & Myburgh, 2018). Suka, Yamauchi, and Yanagisawa (2019) assert that listening attentively to the verbal responses of aggressive patients can assist nurses in persuading the patient to calm down. They further state that nurse competency in persuasive skills can prevent the escalation of aggression and overuse of restrictive measures.

2.6.5 Personal Attributes

Additional factors that can influence the competency of mental health nurses is their innate personal attributes. A number of studies show that nurses with innate individual traits such as a calm composure and professionalism, have confidence in their competency to manage an aggressive patient and that will ultimately prevent or reduce aggression (Edward, Hercelinskyj, & Giandinoto, 2017; Leistner & Carlin, 2019; Lovell & Bailey, 2017). A study with managerial nurses also found that nurses with emotional resilience and consistency in their emotions, behave professionally and are able to find ways of addressing work-related problems competently (Alan & Baykal, 2018). Moreover, nurses who are competent in delivering compassionate care during aggressive episodes, demonstrate concern for the patients and are much valued by fellow colleagues and patients (Ghanbari, Hasandoost, Lyili, Khomeiran, & Momeni,

2017). On the other hand, Haugvaldstad and Husum (2016) are of the opinion that nurses with high levels of self-confidence and a dominating and aloof approach would worsen aggressive behaviour in the mentally ill patient.

In addition, a calm composure, professionalism and gender has also been identified as possible factors that can influence the competency of nurses in managing aggression. In this regard, Verhaeghe, et al., (2014) state that it is usually assumed that male nurses are more self-assured and sufficiently skilled to manage aggressive patients. On the contrary, a mix of male and female nurses assigned to the acute in-patient wards, can bring a multitude of competencies, interpersonal approaches and individual traits into that clinical environment, which in return ensures that aggression is properly managed to result in minimal injuries to the staff and patients (Price, et al., 2018; McCann, Baird, & Muir-Cochrane, 2014).

Moreover, Benner (1982) argues that due to limited clinical experience and fear of being injured, the novice nurse mostly considers and implement interventions such as the pre-emptive use of physical restraint which she had observed colleagues have done previously. Since novice nurses have no experience when commencing duties in a mental health setting, it can cause them to have feelings of insecurity about their competence to handle aggressive mentally ill patients (Ghahrisarabi, et al., 2016).

Other studies have also found that nurses would primarily speak about their fear and anxiety when they believe they cannot deal with the aggressive episode (Stevenson, et al., 2015). In accordance with that, Sobekwa and Arunachallam (2015) argue that being unable to deal with the aggressive episode afterwards may cause nurses to feel

incompetent. In concurrence, Jacob, et al. (2016) affirmed that mental health nurses fear injury because of being assaulted previously by mentally ill patients and for that reason physical restraint is used pre-emptively even though they have the necessary competence to manage aggression. In a study conducted by Hallet, et al., (2014), both nursing staff and patients agreed that the pre-emptive physical restraint of a patient is unavoidable to prevent the patient from becoming aggressive. Furthermore, a study done at a general hospital in northern Namibia found that nurses who had been assaulted by a patient previously became infuriated and acted revengefully towards the patient (Chimedza, 2014). Nguluwe, et al., (2014) are of the opinion that anger towards patients is often expressed after physical aggressive encounters, which was aggravated by the experience of pain and the perception that patients were able to control their own behaviour.

Moreover, nurses who experience adverse feelings such as anger towards the patient are inclined to perform activities that may lead to patient aggression (Van Wijk, et al., 2014). The nursing staff would enforce ward rules strictly and do not want to negotiate with the patient regarding requests and that will most likely cause frustration and anger in the patient (Jacob, et al., 2016). According to Benner, et al., (2009), competent nurses become more emotionally involved and can use that as a screening tool to alert them of a potentially dangerous situation. They are however of the view that the lack of clinical expertise may cause the competent nurse to make unethical decisions such as revengeful actions in response to patient aggression (Benner, et al., 2009).

2.6.6 Critical Thinking and Ability to conduct a Risk Assessment

The ability to conduct a risk assessment and engage critical thinking skills are also identified as factors that can influence nurses' competency in the management of aggression. Accurate and precise continuous risk assessment can make mental health nurses aware of threats in the clinical environment (Maguire, Daffern, Bowe, & Mckenna, 2018). Also, Chan and Chow (2014) asserts that risk assessment can reduce aggression of in-patients, thus decreasing the use of restrictive interventions such as physical restraint and seclusion. They further explain that incompetency in risk assessment can be detrimental to the safety of the nurse and other patients (Chan & Chow, 2014).

Other studies also concluded that experienced nurses are more competent in critical thinking skills (Lee, Abdullah, Subramanian, Bachmann, & Ong, 2017). In addition Wihlborg, et al., (2017) assert that nurses who reflect on how they handle an aggressive incident become more adept at their critical thinking skills. However, Hansen-Salie and Martin (2014) are of the opinion that novice nurses have insufficient critical thinking skills because they cannot link theoretical knowledge with what exists in clinical practice.

2.6.7 Teamwork

Teamwork is another factor considered to influence nurses' competency. In the Report of Human Resource and Training in Mental Health, the World Health Organization (2005) consider teamwork as essential in mental health settings, because it brings

together a multitude of skills from which team members can learn. In line with the conclusion of WHO Report (2005), Ramalisa, du Plessis, and Koen (2018) explain that engaging in teamwork can create a learning environment within which mental health nurses can practice their skills, knowing that others would teach them the proper way in which to manage an aggressive patient. Furthermore, teamwork gives nurses self-confidence in the management of aggressive patients and in that way improves their competency (Hansen-Salie & Martin, 2014). Moreover, a functional team can provide a clear understanding of the role of each team member and assist them in improving communication skills (Pileño, et al., 2018; Bekelepi, et al., 2015).

2.7. SUMMARY OF CHAPTER TWO

In this chapter, a review of the literature was presented including an overview of mental illness, including types and phases of aggression; causes and signs of aggression as well as management of aggression in a clinical setting. To clearly articulate the direction of the study, a review of Benner's Novice to Expert Theoretical Model (Benner, 1982) was presented, followed by various factors that influence competency in nursing.

In Chapter 3, the research design and methodology used in the study will be discussed.

CHAPTER 3

RESEARCH METHODOLOGY

3.1. INTRODUCTION

In Chapter 2, the literature review was dealt with. This chapter describes the methodology that was followed to achieve the objectives of this study. The chapter focuses mainly on the research design, data collection methods, population of the study and sampling methods used in this study as well as the reliability, validity and trustworthiness of the research. The ethical considerations are also presented herein before closing off the chapter with a summary.

3.2. RESEARCH DESIGN

This study has been carried out using the convergent parallel mixed method design. A convergent parallel mixed method design requires that the researcher concurrently conducts both quantitative and qualitative elements in the same phase of the research process, weighs the methods equally, analyse the two components independently, and interprets the results together (Creswell, 2014). The convergent parallel mixed method design can provide detailed and comprehensive data in order to achieve the research objectives (Creswell & Plano Clark, 2011).

In this study a quantitative approach was used as part of a convergent parallel mixed method design to collect data on the factors that influence the competency of the nursing staff when they manage aggressive behaviour of mentally ill patients. The qualitative data then performed an in-depth exploration into the perceptions of the

nursing staff regarding their competency in managing aggressive behaviour in mentally ill patients.

The reason for collecting both quantitative and qualitative data was to converge (compare, validate and corroborate results) the two sets of data. This brought greater insight into the phenomena of nursing staff's competency to manage aggressive behaviour in mentally ill patients. The selected research design also obtained diverse but complementary data on the same topic and thus increased the level of understanding regarding the research problem (Creswell, 2014; de Vos, Strydom & Delport, 2011). This study's research process using the convergent parallel mixed method design, is illustrated in Figure 3.1.

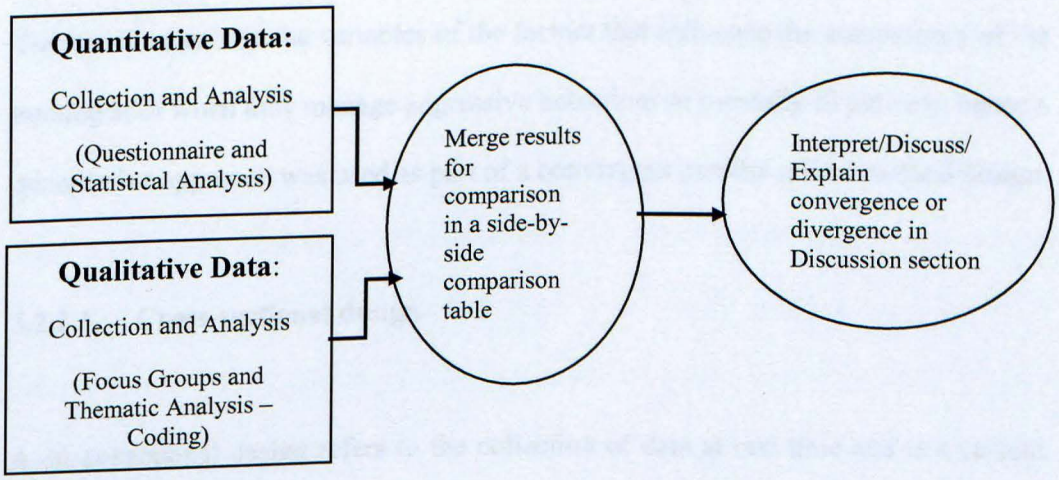

Figure 3.1: A diagrammatical representation of the Convergent parallel mixed method design

3.2.1. Quantitative approach

A quantitative approach is described as the systematic investigation of constructs through the gathering of quantifiable data and performance of statistical techniques that provide precise measurement (Polit & Beck, 2014). In quantitative research, the relationships between variables are described and examined to explain, predict and to control the constructs (Nieswiadomy, 2014). According to de Vos, et al., (2011) instruments are used to measure these variables and then statistical procedures are used to analyse the numbered data to determine, verify and justify the variables and to develop generalisations. De Vos, et al., (2011) further state that quantitative research is based on deductive rather than inductive reasoning; starting with particular suppositions and then deriving realistic conclusions from the data.

This study examined the variables of the factors that influence the competency of the nursing staff when they manage aggressive behaviour of mentally ill patients; hence a quantitative approach was used as part of a convergent parallel mixed method design.

3.2.1.1. Cross-sectional design

A cross-sectional design refers to the collection of data at one time and is a current study that involves the examination of what exists at a precise moment (Polit & Beck, 2014). In this study, the participants completed the questionnaire only at one time during the period of data collection. Factors that influence the competency of the nursing staff when they manage aggressive behaviour of mentally ill patients were determined.

3.2.1.2. Descriptive design

Descriptive research is used to gain more information regarding a particular phenomenon about which limited, or no research has been conducted and to describe, observe and presents specific details of the phenomenon (Brink, van der Walt, & van Rensburg, 2012). According to Grove, Burns, and Gray (2013), the descriptive approach can also be used to collect, organize and summarize information about the phenomenon under study. In this study, a cross-sectional design was undertaken to determine authentic information and to intensively examine the factors that influence the competence of the nursing staff when they manage the aggressive behaviour of mentally ill patients and the frequency and deeper meaning of these factors to give a thick description of it.

3.2.2. Qualitative approach

Qualitative research, on the other hand, is a methodically, interactive and subjective approach that describes the experiences of the participants and the meaning they assign to these experiences about the research objectives (Grove, et al., 2013). Contrary to the quantitative approach, the qualitative approach concerns itself with views and opinions that explain why things happen the way they do and how. According to Brink, et al., (2012), qualitative research involves the collection of verbal data from a small number of participants, organizing the data into themes and also use verbal descriptions to explain the phenomenon under study. Creswell (2014, p.18) further explains that qualitative research is exploratory and that research is conducted because "the topic has never been addressed with a certain group of people." According to

Grove, et al., (2013) exploratory studies include studies which examine phenomena, attitudes, perceptions, and ideas of a particular social group that have not been investigated as consistently and intensely as other groups. Qualitative research is also contextual in that it is conducted within a social and physical setting (Polit & Beck, 2014). An exploratory and contextual study was undertaken because not much is known about the registered and enrolled nurse's management of aggressive behaviour in mentally ill patients at the selected mental health care centre.

Collecting quantitative data as it concerns the study objective which sought to identify and describe the factors that influence the competency of nursing staff at MHCC in managing aggressive behaviour in mentally ill patients was not sufficient, hence a combination with qualitative data as a component of a convergent parallel mixed-method design, was necessary to explore why and how. Thus, in this study, verbal data about the perceptions of the nursing staff regarding their competency in managing aggressive behaviour in mentally ill patients were collected through focus group discussions, then organized into themes and categories according to Tesch's eight steps of coding and thoroughly described using quotes from the verbal descriptions of the participants.

Focus group discussions were used because it created an opportunity for the free expression and exploration through probing and capturing the participants own words (de Vos, et al., 2011). The researcher's focus was on the perceptions of nurses regarding their competency to manage aggression and this data collection method allowed the researcher to expand beyond the main questions through probing.

3.2.3. Pragmatism

Pragmatism is an array of ideas articulated by historical and contemporary researchers, employs multiple approaches and regarded both objective and subjective knowledge as valuable (Creswell & Plano Clark, 2011). Pragmatism originates from actions, situations, and consequences of those actions (de Vos, et al., 2011). According to Polit and Beck (2014) pragmatism holds that the actions of human beings cannot be separated from their past experiences and from the beliefs that have derived from those experiences. Creswell (2014) explains that no two persons have precisely the same experiences and therefore differs in the beliefs they shared. The possibility that a person will behave in the same manner in similar circumstances and ascribing the same meaning to the outcome of those actions, rely mostly on the extent to which they share similar beliefs about that specific circumstances (Creswell, 2014). Pragmatism also maintains that knowledge is acquired through experimental learning and reflections on the actions and observing and analysing the consequences of those actions (Creswell & Plano Clark, 2011). This is similar to Benner's Novice to Expert Theoretical Model.

Pragmatism makes it possible to use "multiple methods, different worldviews, different assumptions, different forms of data collection and analysis" (Creswell, 2014, p.40). The research problem is emphasized and all available approaches are employed to derive knowledge about the problem (de Vos, et al., 2011). Thus, in mixed methods research, both quantitative and qualitative data are used, to provide the best understanding of a research problem such as the nurses' competency to manage aggressive behaviour of mentally ill patients.

3.3. RESEARCH SETTING

The study was conducted at a MHCC in Khomas Region, Namibia. The MHCC is a sub-division of Windhoek Central Hospital (WCH), which is a larger specialized teaching hospital and has been in existence since 1903. It has two sections that is General Psychiatry with an Outpatient Department and five Inpatients wards, with a bed capacity of 120. The inpatients wards comprised of two exclusively male wards, a female only ward, a mix gender ward and a children's ward. The second section is the Forensic Psychiatry section comprising of five wards with a capacity of 80 beds. The majority of the patients admitted at this section are males. There are between one to four seclusion rooms situated in the General and Forensic Psychiatric wards, with the highest number of seclusion rooms at the male wards.

The MHCC, being a referral hospital receives and admits mentally ill patients from all over Namibia and they should be referred from a clinic, hospital or by a health care worker. The most common conditions managed at MHCC include schizophrenia, mood disorders, substance-related disorders, anxiety disorders etc. Mostly patients who are considered to be violent and thus a danger to others are admitted under Section 9 of the MHA, Act 18 of 1973 (Government of the Republic of Namibia, 1973). However the admissions from all over the country results in a high patient equity and with a bed capacity of only 200, the wards are overcrowded.

The registered and enrolled nurses employed at the MHCC are responsible for the provision of mental health nursing care and are committed to the promotion of mental health through the assessment, diagnosis and treatment of behavioural problems and

mental illness. The registered nurses were trained during their basic undergraduate training on how to manage a patient displaying aggressive behaviour. The enrolled nurses on the other hand were only trained on-the-job once they started to work at the MHCC. Also nurses are not trained in psychiatry in Namibia, only recently in 2017, a Post Graduate Diploma in Mental Health Nursing Care was introduced at the University of Namibia (UNAM). According to the continuing professional development (CPD) directives of the Health Professions Councils of Namibia, it is advisable that nurses should focus more on learning activities needed in the departments where they are working in line with the emerging health needs and priorities of the country (Health Professions Councils of Namibia, 2011).

3.4. POPULATION OF THE STUDY

A population in a study is defined as a whole group of persons with common characteristics of interest for the researcher (Nieswiadomy, 2014). Moreover, Grove, et al., (2013) refers to a population as all the potential individuals or groups that possess characteristics in which the researcher is interested and wants to conclude from. The population for this study consisted of 64 nurses of all categories employed at the MHCC in Khomas Region, Namibia. Of the entire population, four were Senior Registered Nurses, 37 were Registered Nurses, and 23 were Enrolled Nurses.

Inclusion criteria for the quantitative approach:

- All nursing staff members permanently employed at the MHCC.
- Nursing staff who had been involved in the clinical management of psychiatric patients.

- All nursing staff members who were willing to participate in the research study.

Inclusion criteria for the qualitative approach:

- Nursing staff who encountered and witnessed aggressive behaviour of mentally ill patients.
- Nursing staff with varying years of being employed at the MHCC.
- Nursing staff with diverse levels of experience in the management of aggression.
- Nursing staff who had been assaulted and injured previously by mentally ill patients.
- All nursing staff who are willing to participate in the study.

3.5. SAMPLE AND SAMPLING METHOD

A sample is a subgroup of a population that is selected for a particular study (Polit & Beck, 2014). Sampling describes the process of selecting a group of people with whom to conduct a study and on which the results of the study can be generalised onto the entire population (Grove, et al., 2013). In a statistical study, sampling methods refer to how members from the population are selected to be in the study and according to Taherdoost (2016), sampling is done because it is not always possible for researchers to collect data from all cases within a population.

In this study the quantitative approach used a non-probability, convenience sampling method because participants had been available at a specific place and they could contribute to the research study. The total population size was 64 which were too small

for sampling therefore the whole population was included in the study. However, concerning the senior registered nurses, only three out of four were included in the study because the researcher was also employed as the fourth senior registered nurse.

The qualitative approach used a purposive sampling method. In this study, the researcher purposely selected certain participants who had encountered, witnessed and experienced aggressive behaviour from mentally ill patients, who had diverse levels of clinical experience, who had been assaulted or injured previously and were willing to participate, and included them in the study. The sample size for the two focus groups was six registered nurses each and five enrolled nurses for the third focus group. The registered and enrolled nurses were separated in the focus groups, because of the difference in their formal basic training on mental health in which only the registered nurses is trained regarding the assessment, treatment and the rendering of nursing care for selected mental disorders. The difference in their training could also influence their responses to the questions.

The researcher requested from the supervisors at the MHCC, a list of staff members who had encountered, witnessed and experienced aggression. Each one was approached individually to ask them if they were willing to participate in the study. Although a lot of participants were willing to participate, just three focus groups with a total of 17 participants were conducted before data saturation was reached.

3.6. DATA COLLECTION

Data collection is defined by Grove, et al., (2013) as a detailed and systematic gathering of information relevant to the purpose and objectives of the study. Data collection methods assist in gathering information and determining the views and responses of people (de Vos, et al., 2011). In this study, two data collection methods were used, and these are self-administered questionnaires (see Annexure 5) and a discussion guide (see Annexure 7) during focus groups discussions.

3.6.1. Research instruments

Research instruments are the tools used for data collection and may include questionnaires and interview guides (Nieswiadomy, 2014). Quantitative data for this study were collected using a self-administered questionnaire. Literature relevant to the phenomenon under study was consulted, and after that, the questionnaire was developed by the researcher with the assistance of the research supervisor.

The questionnaire consisted of multiple choice questions and close-ended questions that were based on the Likert scale to determine the factors that influence the competency of nurses in managing aggressive behaviour in mentally ill patients (see Annexure 5). The questionnaire comprised of three sections which covered the following variables: Section A, consisted of 10 close-ended questions relating to demographic characteristics and work-related data of the participants, such as gender, age, current rank, educational level, years employed at the MHCC, training and involvement in and injury sustained during an aggressive incident. Section B,

contained 34 multiple choice and Likert scale type questions relating to the personal factors influencing the competency of nurses in managing aggressive behaviour such as theoretical knowledge of aggression, skills in and attitudes towards the management of aggression. Section C, consisted of six Likert scale type questions relating to the external factors that influence the competency of the nursing staff.

Qualitative data was collected through focus group discussions using a discussion guide and during which audio recordings were done and field notes were taken.

3.6.2. Data collection procedures

Data for the quantitative approach was collected through the application of self-administered questionnaires in November 2018. The researcher approached 64 nursing staff members individually to invite them to participate in the study and two opted not to participate. A total of 62 questionnaires were then hand delivered to each participant and 62 was received back of which one (1) was spoilt. The response rate was 98 percent. Each potential participant was presented with the permission letters from the Permanent Secretary (PS) of the Ministry of Health and Social Services (MOHSS) and the Chief Medical Superintendent (CMS) of WCH. Then, the purpose, objectives, significance, benefits and risks of the research study were explained to the participants individually. Information about how the application of the anonym principle protected their privacy in this study was also shared with each participant. Furthermore, it was also explained to each participant that participation in the study was voluntary and they had options to withdraw at any stage during the research process without prejudice.

Each participant was then provided with a consent form (see Annexure 4), an information sheet and a questionnaire (see Annexure 5). Voluntary consents were obtained from each participant who signed on the consent form. It was also explained that the questionnaire should be completed within three days. The completed questionnaires were deposited in the box clearly marked 'questionnaire box' at Room 5, Outpatient Department (OPD) which is a neutral space were participants could not be observed as to who handed in a questionnaire or not.

Three focus group discussions of six participants each were convened between November 2018 and February 2019. Focus group discussions were conducted in a conference room at the MHCC. This approach was done in line with phenomenological research where the researcher studies participants in the environment where the phenomenon of interest takes place (Polit & Beck, 2014). All the participants in a given group had the same rank, that is, two separate groups of registered nurses and one group of enrolled nurses. The reason for this separation was that the training of the enrolled nurses differs from that of the registered nurses, which could lead to a difference in perceptions. Also the enrolled nurses work most of the time under the supervision of the registered nurses which could discouraged them from talking freely when mixed with other nursing ranks. Like in the data collection for the quantitative approach, purpose, objectives, significance, benefits, risks of the research study, and voluntary participation as well as an option to withdraw was again explained to participants in the focus group discussions. After the explanation and before the start of each focus group, each one of the participants handed in a signed informed consent form (see Annexure 6). The consent form also included a written permission for the participants to be audio recorded.

Each participant also completed a demographic profile form about questions related to age, gender, current rank and years of work experience to enable the researcher to identify the characters of the participants in this approach. All discussions were recorded with a digital audio recorder, and written field notes were taken by a trained assistant. As guided by Creswell (2014), focus group discussions were conducted in a quiet room that was accessible and known to the participants. The discussions were held in English and lasted between 30 to 45 minutes. Participants attended only one session per group.

The researcher served as the moderator for the sessions and therefore initiated the discussions by inviting the participants to talk about their understanding of the concept of competency. The researcher further guided the discussion according to a written set of questions and possible probes, namely the focus group discussion guide (see Annexure 7). A focus group discussion guide (see Annexure7) comprised of questions aimed at exploring the perceptions of the nursing staff regarding their competency in managing aggressive behaviour in mentally ill patients, was carefully planned and developed. Furthermore, as guided by Creswell (2014), probes were used to bring about richer detail during the discussions. The discussions were structured around open-ended questions such as "How will you describe a nurse who is competent in handling an aggressive patient? How do you perceive your own ability to manage aggressive patients? How do you think your own competency developed?" Throughout the session, the researcher used her probing skills to encourage participants to talk and share ideas freely. Field notes and observations of participant's non-verbal communication were taken for data triangulation. All focus group

discussions were audio-recorded to capture participant's perceptions in their own words and thereafter transcribed verbatim. Field notes were also collected.

3.6.3. Pilot study

A pilot study is described as a "small scale study conducted before the main study with a limited number of participants" (Brink, et al., 2012, p.224). According to Grove, et al., (2013), the purpose of the pilot study is to identify unclear formulated questions and to detect possible flaws such as vague instructions and inadequate time limits in the questionnaire and the focus group discussion guide. For this study, the questionnaire and focus group discussion guide were pre-tested with five staff members at a selected private mental health hospital in Windhoek.

In line with Grove, et al., (2013), the pilot study aimed to check the questionnaire and focus group discussion guide's accuracy in capturing the intended information, clarity and understanding of the questions, its reliability and validity. Testing the readability and comprehension of the questionnaire as well as the understanding of the focus group discussion guide supported the content validity of the instruments. The responses from the questionnaire and the audio recorded focus group discussions provided the researcher with information whether all the participants understand the questions in the same way. Moreover, the pilot study was also done to determine the length of time that it would take participants to complete the questionnaire as well as to estimate the duration of the focus group discussions.

The pilot study found that the questionnaire took about 20 minutes to complete and 45 minutes for the focus group discussions. The unclear questions identified in the questionnaire by the pilot group participants were rectified and addressed accordingly. In Section B question 3.4 the word "interest" was misinterpreted as sexual interest of staff towards patients and the question was rephrased. The instructions of Section B question 1.3 were unclear and it was reworded. Thereafter a re-testing of the questionnaire was done at the selected private mental health hospital, with another four staff members who were not involved in the initial pilot study, after which there were no further ambiguities identified.

3.7. RELIABILITY AND VALIDITY

Reliability refers to the stability and consistency over time of the research instrument (Nieswiadomy, 2014). De Vos, et al., (2011) argued that the most commonly used reliability measure is Cronbach's Alpha coefficient and further explained that coefficient ranges between 0 and 1 and figures closer to 1 (0.8-0.9) indicate a highly reliable scale. In this regard, Polit and Beck (2014) also recommend reliability of 0.8 (80%) to 0.9 (90%) for research purposes, and that internal consistency of items such as individual questions in a questionnaire can be measured using statistical procedures such as Cronbach's Alpha coefficient. In this study, the reliability of the questionnaire was determined using the Cronbach's Alpha coefficient with the data obtained during the pilot study. The pilot study's overall Cronbach's Alpha coefficient for the instrument was 0.819. For the main study, the overall Cronbach's Alpha coefficient for the instrument was 0.707 and 0.798.

Validity on the other hand shows the ability of the research instrument to collect the data that it is envisioned to (Nieswiadomy, 2014). The types of validity covered in this research included face and content validity of the instrument. Face validity refers to "whether the instrument looks as though it measures the appropriate construct" (Polit & Beck, 2014, p.377). Face validity was determined through consultations with the study supervisor, experts in psychiatric nursing science and a statistician to provide feedback with regards to the validity of the questionnaire. The experts were senior nurses with vast experience in the mental health clinical field who commented and confirmed that the questions fully addressed the research objectives. The statistician helped with the layout of the questionnaire and after the pilot study, tested it for accurate data analysis.

Furthermore, Brink, et al., (2012, p.173) define content validity "as the degree to which an instrument covers the scope and range of information that is sought". The content validity of the questionnaire was supported through a comprehensive literature review that was done and the questions which were based on that as reflected in Table 3.1. Also, a pilot study was done on the questionnaire which helped to refine the questions for improved clarity and meaning. The pilot study assisted in integrating a range of questions to cover each category on the questionnaire, ensured that questionnaire items accurately address the research objectives and that the questions were presented in a consistent manner. The content validity of the questionnaire was further enhanced through reviews done by the supervisor, statistician and the research ethics committee.

Table 3.1: Content Validity Table

Research Objectives	Questions on instrument	Link to Literature
Objective One: Identify and describe the factors that influence the competency of nursing staff at MHCC in managing aggressive behaviour in mentally ill patients	• **Personal factors** 1. Theoretical knowledge of aggression 1.1 Description and Phases of Aggression: 1.1.1. A fist fight erupted between two patients without any provocation and caused serious injury. This type of behaviour can be classified as: 1. Anger 2. Verbal aggression 3. Physical aggression 4. None of the above	Warburton and Anderson (2015); Townsend (2014); Hurskainen and Katainen, (2015).
	2. Clinical skills in the management of an aggressive patient 2.3. Speak to the patient in a calm and controlled voice to avoid escalation (increase) of aggression.	Moss (2015); Lovell, et al., (2015)
	3. Attitudes towards the management of aggression 3.2. I believe that nurses should only intervene when the patient beats up other patients.	Laiho, et al., (2014); Baby, et al., (2016); Lanthén, et al., (2015); Newman, et al., (2015)

Research Objectives	Questions on instrument	Link to Literature
	• **External factors** 1. Role modelling in handling aggressive patients by a senior nurse may enable a junior nurse to promptly intervene when a patient become aggressive.	Nouri, et al., (2014); Jack, et al., (2017); Hansen-Salie and Martin, (2014; Walker-Reed (2016).
Objective Two: Explore and describe the perceptions of the nursing staff regarding their competency in managing aggressive behaviour in mentally ill patients.	How do you think your own competency has developed?	Hansen-Salie and Martin (2014); Basson, et al., (2014).

3.8. TRUSTWORTHINESS

In qualitative research, reliability and validity can be considered as the trustworthiness of the procedures and data generated (Creswell, 2014). In the qualitative part of this study, Lincoln and Guba's Framework of Trustworthiness of 1985 that included criteria of credibility, dependability, confirmability, authenticity and transferability was applied to ensure trustworthiness (Brink, et al., 2012). According to Creswell (2014) trustworthiness is also enhanced through bracketing, hence the researcher ensured that her beliefs did not influence the collection of the data and the analysis

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thereof. It was done through documenting all personal bias and expectations of the researcher in a reflective diary before the collection and analysis of the data.

3.8.1. Credibility

Credibility relates to internal validity and is concerned with the accuracy and truthfulness of the findings (Creswell, 2014). In this study, credibility was enhanced by collecting data until data saturation was reached and this was done through prolonged engagement in the field. To ensure this, the researcher spent sufficient time with the participants during the data collection process. Triangulation between field notes, observations and data was done to capture different aspects of the same phenomenon. Moreover, the researcher made all efforts to ensure that participants own words and perceptions were captured as intended. Member checking was done with four participants after the themes and categories were identified.

3.8.2. Dependability

Dependability refers to the stability of data over time and in different situations (Nieswiadomy, 2014). In this study, data were coded according to Tesch's descriptive method of open coding during the process of data analysis, and experienced research supervisors reviewed every step of the coding process, which included coding and re-coding of data (Creswell, 2014). Marginal notes were made for coding independently. Field notes were also kept and used to highlight any inconsistency concerning the information to ensure dependability. The research supervisor was also consulted

during the analysis of the data to verify the findings and to determine the acceptability of the process and procedures.

3.8.3. Confirmability

According to Polit and Beck (2014), confirmability is concerned with the objectivity and neutrality of the data, and guarantees that the findings, conclusions and recommendations will be supported by the data. The researcher examined her own values and interests that may impinge upon the research and also identified areas of potential bias and minimized their influence by bracketing them. The focus group discussions were audio-recorded and transcribed verbatim to ensure confirmability. An independent coder was also involved in assisting with the data analysis and in ensuring accuracy and non-bias of the data. For this purpose, an audit trial was kept of the process of data analysis; assigning of themes and categories and later discussed with co-coder to make sure there was no bias involved. The researcher captured her observations and experiences in field notes and reflected on it later and discussed it with co-coder.

3.8.4. Transferability

According to de Vos, et al., (2011), transferability refers to the generalisability of the data to other groups and situations. The transferability of this study was ensured through purposive sampling of nurses with diverse levels of experience and varying years of working in mental health wards. Transferability was further enhanced by collecting complete data such as demographical data and in-depth accounts of

participants' perceptions regarding their competency in the management of aggression to provide a concentrated description of rich data. Literature control was also done to establish links with other studies and the significance for the research topic.

3.9. DATA ANALYSIS

Grove, et al., (2013) describe data analysis as the process of reducing, bringing order, structure and meaning to the mass of collected data and can be done quantitatively or qualitatively or as a combination of the two. According to de Vos, et al., (2011, p. 249; p. 399), quantitative data analysis is the "technique by which researchers convert data to a numerical form and subject it to statistical analysis", while qualitative data analysis is the "process of inductive reasoning, thinking and theorising to make inferences from empirical data of social life". In this study, data from both quantitative and qualitative approaches were independently analysed in line with the convergent parallel mixed method design.

After quantitative data collection was completed, questionnaires were counted and checked for errors. The researcher approached 64 registered and enrolled nurses individually to invite them to participate in the study. A total of 62 questionnaires were then hand delivered to each participant, because two opted not to participate in the study. The quantitative data from the questionnaires were entered into a 2016 Microsoft Excel spreadsheet and thereafter imported into the IBM Statistical Package for Social Science (SPSS) Version 24 with the assistance of a statistician. The SPSS was used to analyse for basic descriptive statistics on the factors that influence competency in managing aggressive behaviour.

According to de Vos, et al., (2011), descriptive statistics describe data numerically through frequencies, measures of central tendency and measures of dispersion. In this regard, descriptive statistics such as the mean, mode and standard deviation were used to describe the demographic characteristics such as gender and age of the participants. Descriptive statistics such as frequencies and percentages were also used to analyse data regarding the personal and external factors pertaining to the competency of the nursing staff when they managed aggressive behaviour of patients.

After collection of the qualitative data, the audiotape recordings of discussions of the focus groups were transcribed verbatim into 2016 Microsoft Word Document, and field notes were typed and organized. The verbatim transcripts were also checked for mistakes against the recorded versions to ensure accurate and reliable reproduction of accounts. Then participants from the focus groups were asked to check the verbatim transcripts for accuracy. Thereafter Tesch's descriptive method of open coding was used to analyse the narrative data and field notes according to the research which sought to explore and describe the perceptions of the nursing staff regarding their competency in managing aggressive behaviour in mentally ill patients (Creswell, 2014).

The verbatim transcripts and the field notes were read carefully and repeatedly to get a sense of the whole and to reflect on the meaning. Patterns and similarities in the words and phrases used by participants in the focus group discussions were identified and significant statements were extracted, coded and organized into clusters. The data from the focus groups and field notes where then triangulated. Themes and categories

were then identified and discussed with the focus group participants for accuracy and reliability. Creswell (2014) describes this process as member checking, and it involves taking specific descriptions or themes back to the participants and determining whether such participants feel they were accurate.

Coding was also discussed with a co-coder who is an expert in the field of qualitative research and nursing and with academic knowledge to verify the codes generated by the researcher. A literature control was then carried out to determine how it relates to other studies and the relevance for the research field. Furthermore, data triangulation of the field notes and observation as well as the data which was collected from different levels of persons was done to validate data through an assortment of perceptions on the phenomenon. According to Polit and Beck (2014, p. 431), data triangulation involves "the use of multiple data sources for the purpose of validating conclusions".

3.10. RESEARCH ETHICS

Research ethics provided a set of principles that supported the researcher in conducting this study for the research to be done justly and without harm to the participants (Nieswiadomy, 2014). The researcher carried out the study in line with established ethical principles because ethical behaviour is important when researching with human beings. The fundamental ethical principles of respect for persons, beneficence and justice applied as well as the human rights protected during this study, are discussed under the following headings:

3.10.1. Permission to Conduct the Study

Ethical approval to conduct the study was obtained from the Research Ethics Committee of the University of Namibia (see Annexure 1). A letter requesting permission to conduct the study within the hospital setting was submitted to the office of the Permanent Secretary (PS) of the Ministry of Health and Social Services (MOHSS) and permission was granted (see Annexure 3). Another request was submitted to the Chief Medical Superintendent of Windhoek Central Hospital (WCH), and permission was granted.

3.10.2. Respect of Persons

The principle of respect for persons holds that persons have the right to self-determination and freedom to participate (Brink et al., 2012). The right to self-determination implies that participants have the right and competence to assess existing information, consider options against one another and make their own decisions (de Vos et al., 2011). Participants are also autonomous and may decide willingly whether they want to participate in the research study or not (Polit & Beck, 2014). In this study, participants were allowed to ask questions, were allowed time to decide whether they wanted to participate in the study or not. They were also advised that they can withdraw from the study at any time without any prejudice or penalties.

3.10.2.1 Informed Consent

Informed consent means that participants have sufficient information about the research, are capable of understanding the information, and can decide on their own whether to participate or not (Polit & Beck, 2014). Thus, it was verbally explained to the staff members that participation in the study was voluntary and that they could withdraw from the study at any time without fear of prejudice. Informed consent was obtained after the study purpose, benefits, time required, risks and voluntary participation with the option to withdraw at any time without exposure were explained. An information leaflet with all the before mentioned information was given to the participants. Written consent was then obtained on the attached consent form (see Annexures 4). The participants were also asked to give the researcher permission to audio record the focus group discussions to ensure accuracy of information of which written consent was obtained (see Annexures 6) after all information regarding the research study was explained and they were able to fully comprehend the information.

3.10.2.2 Confidentiality and Privacy

Every participant has the right to know that the data they provide would remain confidential and that they would remain anonymous. Confidentiality requires that information entrusted to another person not been disclosed (Polit & Beck, 2014). For this study, confidentiality was ensured by keeping all written and tape-recorded data in locked cabinets that only the researcher had access to and on a computer with a password only known to the researcher. No unauthorized persons had access to the data collected. A marked questionnaire box was placed in a neutral place where none

could know who participated in the study and who has not. Participants were informed to put the completed questionnaires and consent forms in the marked box. Permission for the focus groups was obtained and after each participant placed their written consent form in an envelope provided by the researcher, it was sealed. The researcher also informed and ensured the participants that the information shared during the focus groups would remain confidential.

Privacy, on the other hand, refers to the right of the participant to decide on the time, extend and also the circumstances under which personal information will be shared with and withheld from others (Grove, et al., 2013). The researcher did not gather any information about the participants without their knowledge, and they could decide on the nature of the information they felt comfortable to give or did not want to disclose. Also, questionnaires were handed out to the participants and were completed in their own time without the influence of the researcher. The questionnaires were coded with numerical numbers (1 to 62) to ensure privacy.

The focus group discussions were held in a comfortable room chosen by the participants so that they could feel free from stress or anxiety and freely share their perceptions about their competence in managing aggression. Also, the date and time of the focus group discussions were agreed upon, and discussions were held at times convenient to the participants for the study not to be intrusive in their lives. The participants' privacy was also ensured by putting a notice on the outside of the door, indicating that no unauthorized persons should enter and disturb the group discussion as well as overhearing what had been discussed. The participants' identity was

protected through not mentioning their names and codes (F1 to F3, P1 to P6) were designated to each of them.

3.10.2.3 Anonymity

Anonymity in research refers to when the researcher cannot link a stated response to a particular respondent. Also, the right to anonymity requires that the participant's confidentiality is protected to the extent that the researcher cannot link the information provided by individual respondents (Nieswiadomy, 2014). Anonymity was maintained through the omission of participant's names and all written data was presented with identity codes.

3.10.3. Principle of beneficence and non-maleficence

The principle of beneficence requires that the benefits of the research are maximized for the participants. All participants also have the right to be protected from harm and distress (Polit & Beck, 2014). Beneficence provided the participants with the opportunity to share their perceptions of their competency to manage aggressive behaviour. The principle of non-maleficence involves the absence of harm to the participants (de Vos, et al., 2011). To uphold non-maleficence, emotional and social risks had been avoided through the exclusion of sensitive questions that can cause embarrassment. Focus group discussions were held at the venues with which the participants were familiar with to avoid any feelings of insecurity and uncertainty. The focus group discussions were also conducted at a time that was convenient for the participants. In addition, the participants were provided with contact details of a retired

social worker, who worked independently and was not attached to the MHCC, to contact whenever they needed social support during the study.

3.10.4. Principle of justice

The principle of justice includes the right to fairness in the selection of participants and fair treatment during the study (de Vos, et al., 2011). Fair selection of participants was ensured because no sampling had been done which gave everyone in the population an equal chance to be included in the research study. The researcher obtained a list of staff members employed at MHCC and all nursing staff eligible for the study were invited individually and confidentially to ensure that all had a fair and equal chance to participate in the research study. All nursing staff willing to participate in the study were included and those who did not participate were treated in a non-prejudice manner. Additionally, fairness was maintained by ensuring that the criteria for the selection of participants for the quantitative and qualitative studies were clearly stated and followed. All agreements about the role of the researcher and that of the participants were respected during the course of the study.

3.11. SUMMARY OF CHAPTER THREE

This chapter provided a detailed discussion of the research methodology that was used in this study. A convergent parallel mixed method design in which quantitative and qualitative approaches were combined, assisted in gaining a deeper understanding and gathered in-depth information on the factors that influence the competency of nursing staff in managing aggressive behaviour of mentally ill patients. The two types of data

also provided validation for each other and created a solid foundation for drawing conclusions. The discussion in this chapter focused on the research design, population, sampling, research instruments, data collection procedure, data analysis and the issue of research ethics.

Chapter 4 will present the findings of the study.

CHAPTER 4

RESULTS AND DATA ANALYSIS

4.1. INTRODUCTION

The preceding chapter discussed the design and methodology of the study whereas in this chapter the findings of the study are presented. Firstly, the findings of the quantitative data from the questionnaire are presented according to the layout of the questionnaire in the form of tables and bar charts. The findings have been presented in three sections. The analysis of the study describes the demographic data of the participants in section A, followed by the analysis of the factors that influence competency in managing aggressive behaviour in section B, and finally, the factors that influence the competency of nursing staff are analysed in section C.

Next, the qualitative part of the study will present the findings from the focus group discussions according to the layout of the discussion guide. The demographic profile of the participants will be described in the analysis of the study.

4.2. FINDINGS OF THE QUANTITATIVE PART OF THE STUDY

Firstly, the findings from the quantitative part of the study will be presented.

4.2.1. Demographic and work-related data of participants

Under the demographic and work-related data are gender, age, current rank, educational level, duration of the employment period, encounters of violence, previous assaults and physical injuries, ability to physically restrain or hold down an aggressive patient as well as training in the management of aggression.

A total number of 61 nursing staff members participated in this study of whom the majority were female (n=43; 70.5%). The age of the participants (n=61) ranged from 24 years to 60 years with a mean of 43.82 years and a standard deviation of 12.13 years (95% Confidence interval 39.12 – 48.52). Of the total participants (n=61), the majority were registered nurses (n=35; 57.4%) followed by enrolled nurses (n=22; 36.1%) with only 6.6% (n=4) of senior registered nurses. The age of all registered nurses (n=39) ranged from 24 years to 57 years and of enrolled nurses (n=22) ranged from 26 years to 60 years.

The distribution of the participants (n=61) by the highest level of education was 6.6% for Postgraduate Diploma; 21.3% for Degree; 37.7% for Diploma and 34.4% Certificate. The duration of the period employed at the Mental Health Care Centre (MHCC) ranged from 4 months to 27 and a half years with a mean of 9.54 years and a standard deviation of 7.8 years (95% confidence interval 6.51 – 12.56 years). The participants comprising of enrolled nurses (n=22) were the longest employed and their employment duration period ranged from one year to 27 years with a mean of 8.20 and a standard deviation of 11.17 years.

In Figure 4.1 the frequency of how often the participants encountered violence at the workplace, are illustrated. Of the total participants (n=61), 50.0% encountered or experienced violence at the workplace on a daily basis and of these, the majority were registered nurses (n=39; 56.4%).

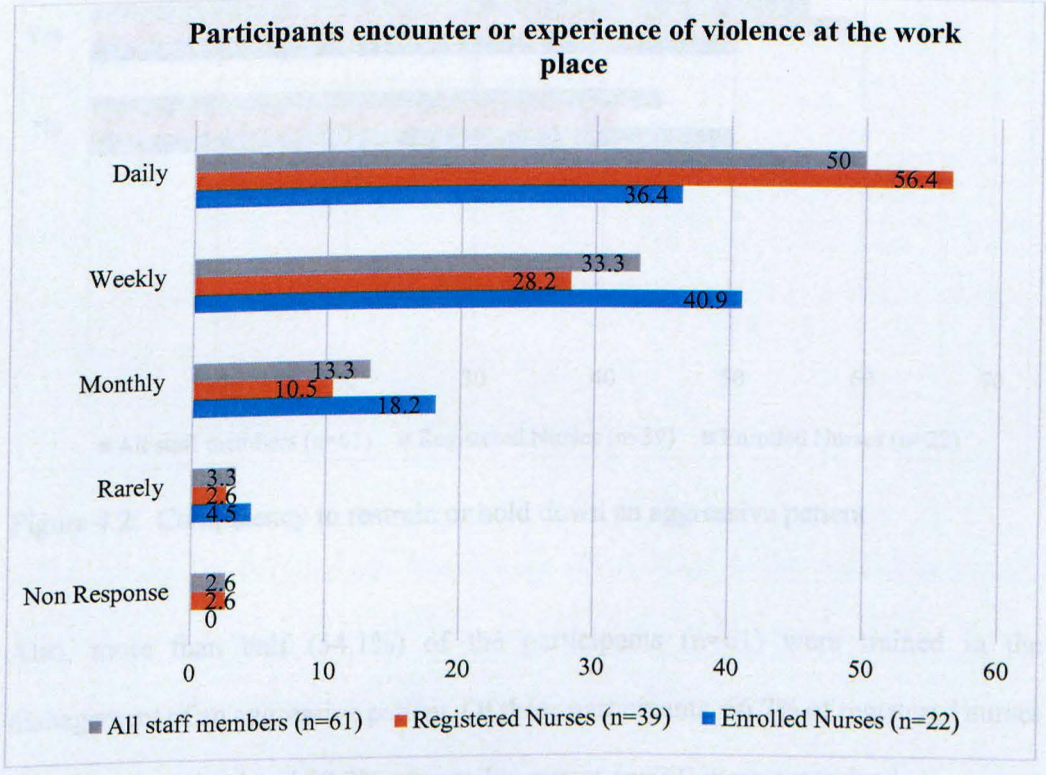

Figure 4.1: Participants encounter or experience of violence at the workplace

Of the total participants (n=61), the majority (63.9%) had been previously assaulted by a patient and of these, 66.7% were registered nurses (n=39). In total 28.0% of the participants (n=61) in this study had sustained physical injuries and of these, the majority were registered nurses (n=39; 23.1%).

Figure 4.2 shows that in this study more than half (55.7%) of the participants (n=61) could physically restrain or hold down a patient, comprising of 59.0% of registered

nurses (n=39). Only half (50.0%) of the participants comprising of enrolled nurses (n=22) said that they could restrain or hold down an aggressive patient.

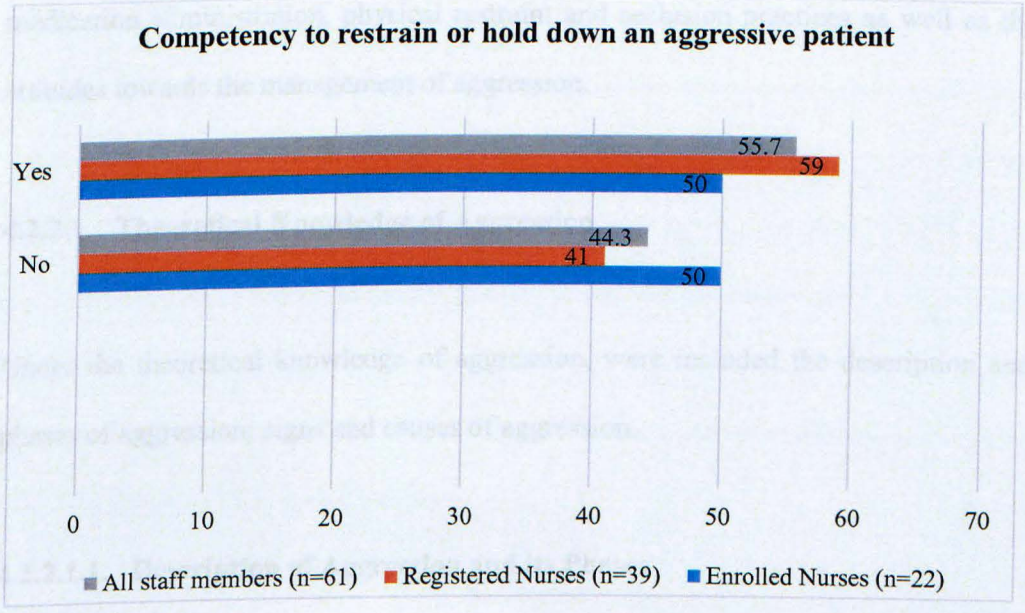

Figure 4.2: Competency to restrain or hold down an aggressive patient

Also, more than half (54.1%) of the participants (n=61) were trained in the management of an aggressive patient. Of these participants, 66.7% of registered nurses (n=39) were trained and 68.2% of enrolled nurses (n=22) were not trained.

4.2.2. Personal factors that influence competency in managing aggressive behaviour

In line with the study objectives, Section B of the questionnaire presents the personal factors that influence competency in managing aggressive behaviours which are identified as theoretical knowledge of aggression in which the participants are

expected to describe the types and phases of aggression and the ability to identify clear signs and causes of aggression. Also, part of the personal factors is clinical skills in the management of an aggressive mentally ill patient which included prevention, medication administration, physical restraint and seclusion practices as well as the attitudes towards the management of aggression.

4.2.2.1. Theoretical Knowledge of Aggression

Under the theoretical knowledge of aggression, were included the description and phases of aggression; signs and causes of aggression.

4.2.2.1.1. Description of Aggression and its Phases

In this study, the participants (n=61) were asked to select the type of behaviour displayed when a fistfight erupted between two patients and the majority (88.5%) of them classified the behaviour as physical aggression. They were also asked to indicate the type of behaviour when a patient was brought into the ward while shouting and screaming and 95.1% classified the behaviour as verbal aggression and of this 100.0 % of enrolled nurses (n=22) concurred. The participants (n=61) selected anger as the phase of aggression in which the patient is when he/she is pacing the corridor with clenched fists and an upset face (62.3%), followed by escalation (24.6%). The majority (77.0) of the participants (n=61) indicated that the face-down restraint technique means that the patient is held down on the floor with the face looking forward away from the nurse and the patient is lying on his/her chest.

4.2.2.1.2. Signs of Aggression

In Figure 4.3 the knowledge of the participants (registered and enrolled nurses) with regards to the clear signs of aggression is depicted. In this study, the participants (n=61) were asked to indicate all signs that apply when a patient is aggressive and 93.4% concurrently agreed that the patient who has an angry facial expression and talks with a loud and harsh voice shows clear signs of aggression. Also, 85.2% of the participants (n=61) indicated that a patient is aggressive when easily irritated and argumentative and of this 87.2 % of the registered nurses (n=39) concurred. More than half (57.4%) of the participants (n=61) described an aggressive patient as having a tense body posture and tightened jaw.

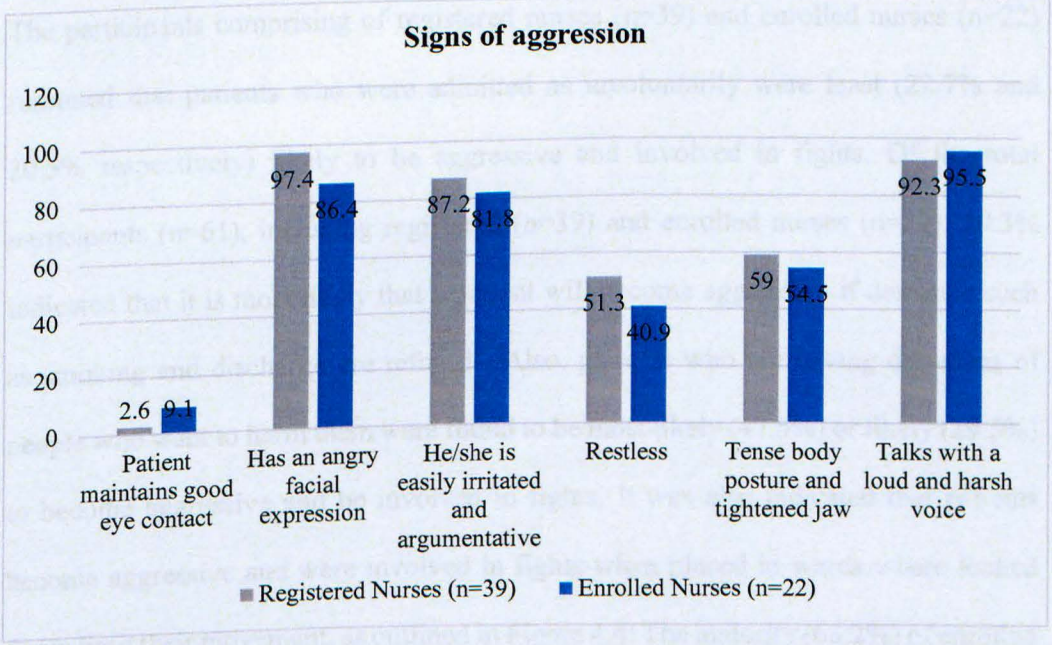

Figure 4.3: Signs of aggression (Registered and Enrolled Nurses)

4.2.2.1.3. Causes of Aggression

In this study, participants were asked to indicate on a scale from most (5) likely to least (1) likely, how likely they considered a patient to be aggressive and be involved in fights with others. The majority of the participants (n=61; 70.5%) indicated that a patient who hears voices commanding them to hurt others will become aggressive and be involved in fights with others. More so, 59.0% of the participants (n=61) considered patients known with the previous history of violence to be aggressive and with this, 69.2% of the enrolled nurses (n-22) concurred. Less than half (47.5%) of the participants (n=61) deemed substance intoxicated patients to be aggressive and fighting with others.

The participants comprising of registered nurses (n=39) and enrolled nurses (n=22) reasoned that patients who were admitted as involuntarily were least (22.7% and 20.5% respectively) likely to be aggressive and involved in fights. Of the total participants (n=61), including registered (n=39) and enrolled nurses (n=22), 39.3% indicated that it is most likely that a patient will become aggressive if demands such as smoking and discharge are refused. Also, patients who are having delusions of people who want to harm them were found to be most likely (47.5%) or likely (29.5%) to become aggressive and be involved in fights. It was also indicated that patients become aggressive and were involved in fights when placed in wards where locked doors limit their movement, as outlined in Figure 4.4. The majority (68.2%) of enrolled nurses (n=22) were of the opinion that wards with locked doors which limit patient's movements can cause aggression, whereas 23.1% of registered nurses (n=39) remained uncertain.

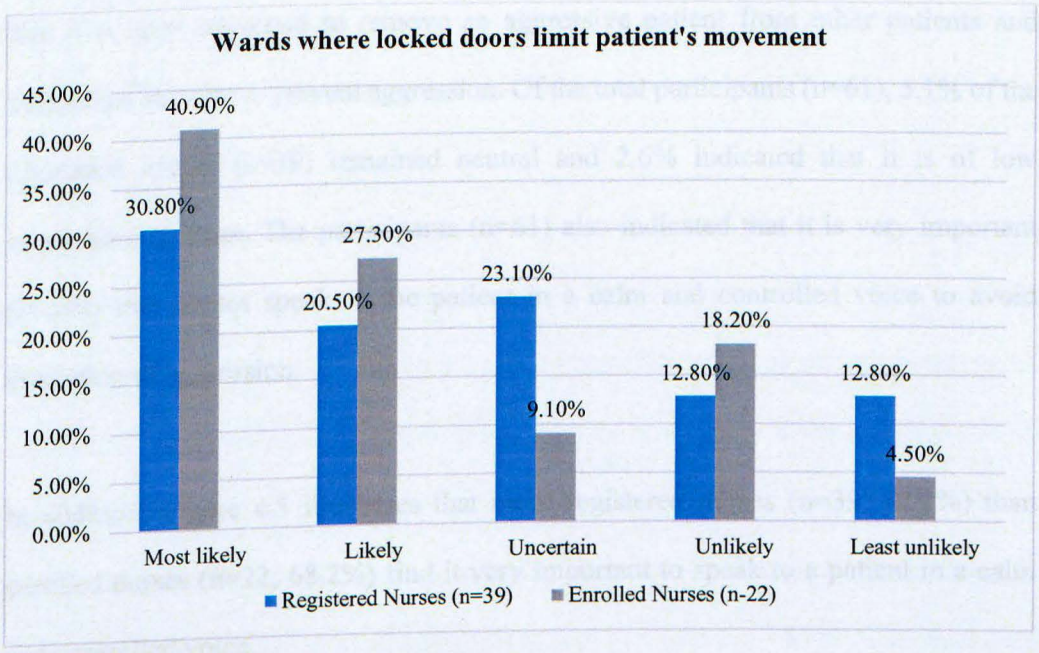

Figure 4.4: Wards were locked doors limit patient's movements

4.2.2.2. Clinical Skills

Clinical skills entail prevention, administration of medication, physical restraint and seclusion practices. In this study, clinical skills were included on the questionnaire under section B, to determine the competency of the nursing staff at the MHCC about their management of aggressive behaviour in mentally ill patients. Therefore, participants were asked to indicate the importance of such skills in the management of aggression as per the following sub-sections.

4.2.2.2.1. Skills in Prevention of Aggression

On a Likert scale of very important to not important at all, the participants in this study were asked to indicate to what degree they thought the statements were important in

the prevention of aggression. The majority (85.2%) of the participants (n=61) agreed that it is very important to remove an aggressive patient from other patients and bystanders in order to prevent aggression. Of the total participants (n=61), 5.1% of the registered nurses (n=39) remained neutral and 2.6% indicated that it is of low importance to them. The participants (n=61) also indicated that it is very important (77.0%) that nurses speak to the patient in a calm and controlled voice to avoid escalation of aggression.

In addition, Figure 4.5 illustrates that more registered nurses (n=39; 82.1%) than enrolled nurses (n=22; 68.2%) find it very important to speak to a patient in a calm and controlled voice.

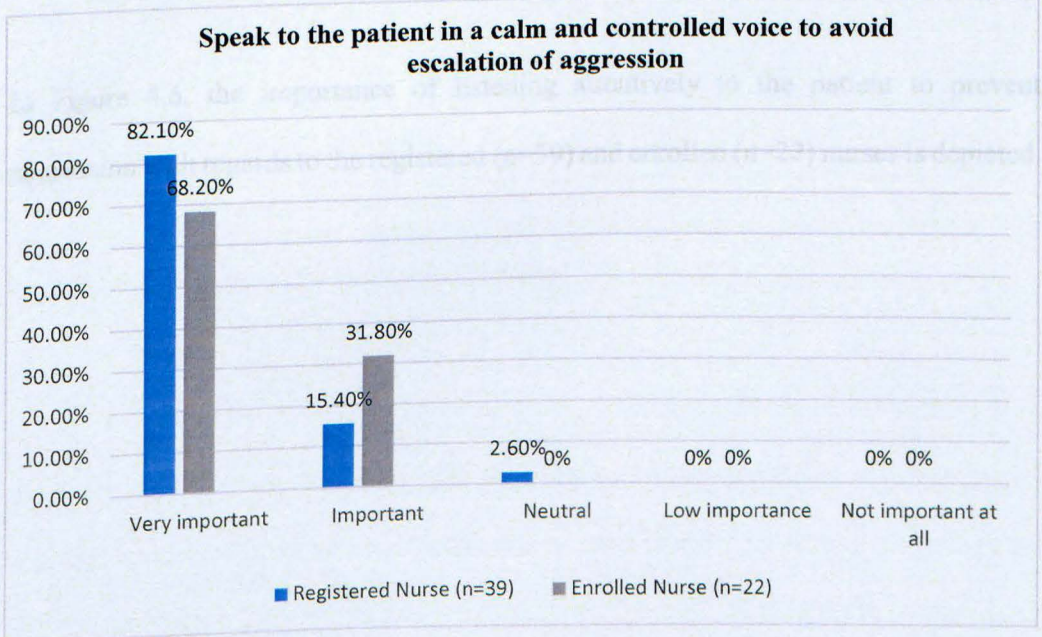

Figure 4.5: Calm and controlled voice

The participants (n=61) also indicated that it is very important (67.2%) to find out what helped the patient previously when he/she was aggressive in order to prevent

aggression. Less than half of the participants (n=61); consisting of registered nurses (n=39), find it very important (46.2%) to focus their full attention on the patient to show that they care about him/her, 10.3% remained neutral and 7.7% indicated that it is of low importance to them.

Also, half of the participants (n=61) consisting of enrolled nurses (n=22) agreed that it is very important (50.0%) to give the patient their full attention and others remained neutral (27.3%). The majority of the participants (n=61), inclusive of registered (n=39) and enrolled (n=22) nurses, that is 85.25%, indicated that it is important (important or very important) for the nurses to listen attentively to what the patient has to say in order to prevent escalation of aggressive behaviour; only 1.64% find it of low importance while 13.11% were neutral.

In Figure 4.6, the importance of listening attentively to the patient to prevent aggression with regards to the registered (n=39) and enrolled (n=22) nurses is depicted.

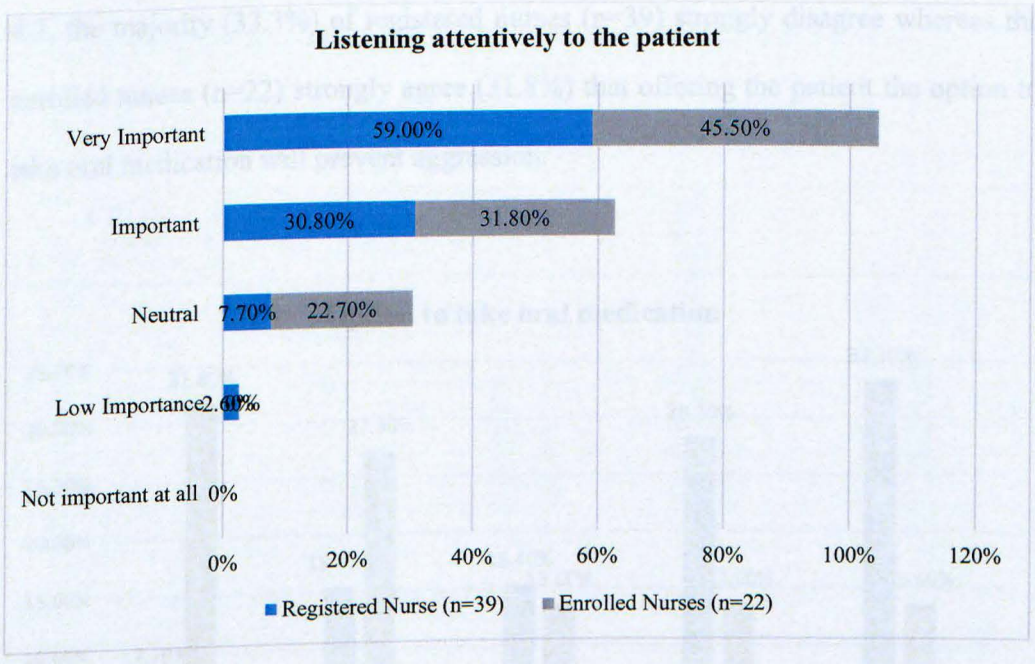

Figure 4.6: Listening attentively to the patient

Also, the majority of the participants (n=61) find it important (31.15%) or very important 52.46%) to assist the patient with his/her current problem to show concern and to manage aggressive behaviour.

4.2.2.2.2. Medication administration skills

On a Likert scale from strongly agree to strongly disagree, participants in this study were asked to indicate to what degree did they agree that the statements relating to medication as indicated on the questionnaire, will assist with the management of aggression. Only 62.3% of the participants (n=61) strongly agreed that medication is an effective approach when dealing with aggression. However, 9.1% of enrolled nurses (n=22) disagree that medication is an effective approach in the prevention of aggression. A total of 23.0% of the participants (n=61) disagree that offering a patient oral medication to calm down can prevent aggressive behaviour. As reflected in Figure

4.7, the majority (33.3%) of registered nurses (n=39) strongly disagree whereas the enrolled nurses (n=22) strongly agree (31.8%) that offering the patient the option to take oral medication will prevent aggression.

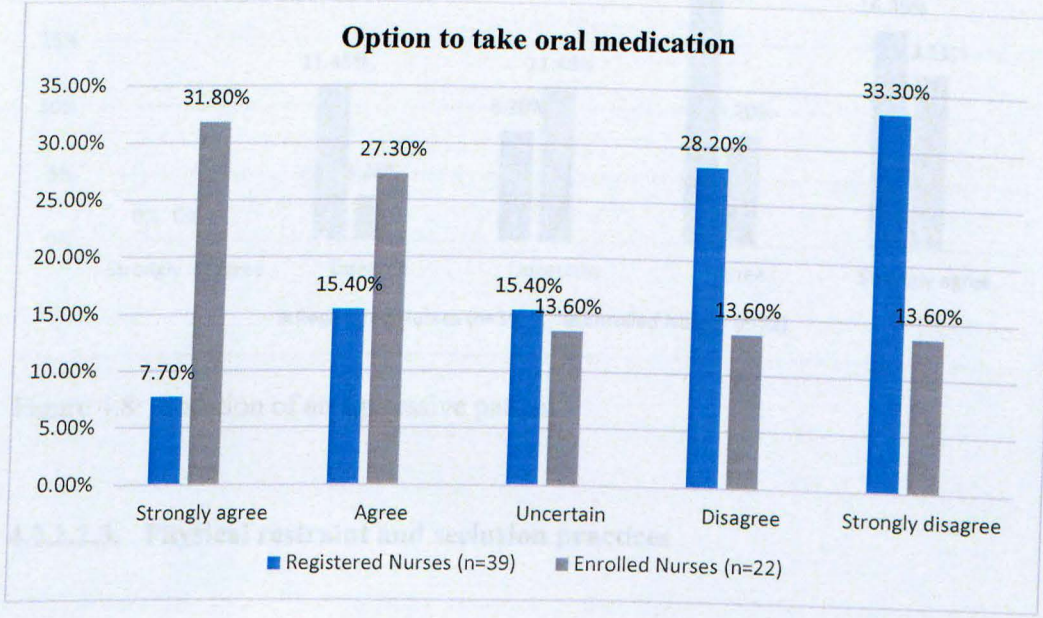

Figure 4.7: Option to take oral medication

Furthermore, all participants (n=61), inclusive of registered nurses and enrolled nurses agree that the sedation of an aggressive patient held no risk for the health of the patient. It is illustrated in Figure 4.8 that the majority (27.87%) of registered nurses (n=39) agree that there are no risks involved when an aggressive patient is sedated.

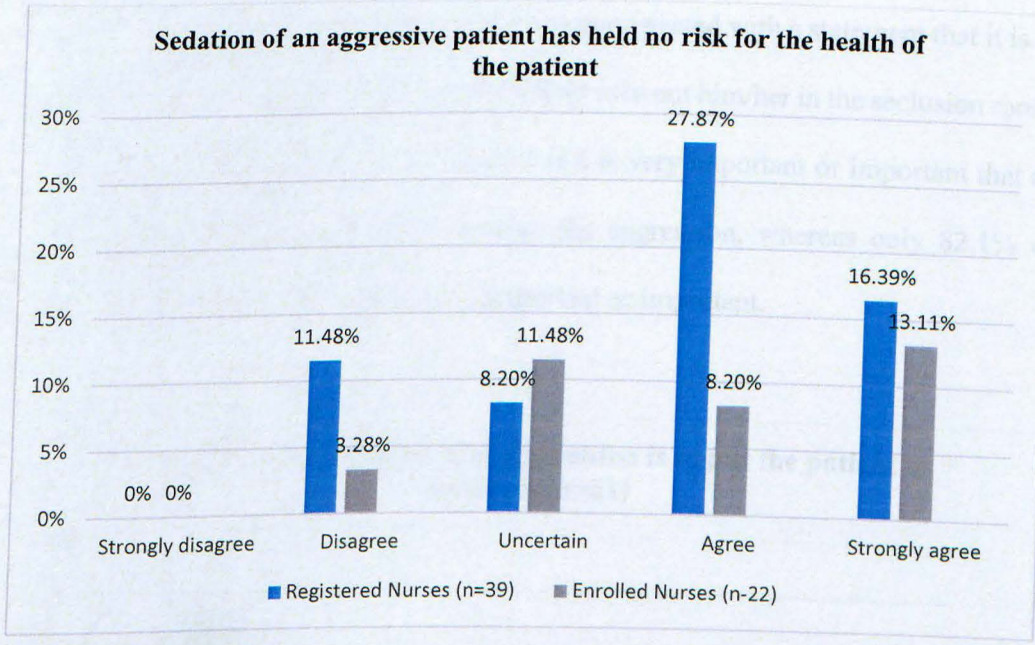

Figure 4.8: Sedation of an aggressive patient

4.2.2.2.3. Physical restraint and seclusion practices

On a Likert Scale from very important to not important at all, participants were asked to indicate to what degree the statements relating to their skills in preventing aggression and secluding a patient as indicated on the questionnaire will assist with the management of aggression. Some of the participants consisting of registered nurses (n=39) considered it very important (38.5%) that the use of force is the most effective method to restrain an aggressive patient and 20.5% indicated that it is of low importance to them. The participants consisting of enrolled nurses (n=22) indicated that it is important (36.4%) to use force to effectively restrain an aggressive patient, others remained neutral (18.2%). All participants, that is n=61, considered that when it is required to physically restrain an aggressive patient to be able to sedate him, it is very important to work together as a team.

In Figure 4.9, the total participants (n=61) were presented with a statement that it is an effective way to deal with an aggressive patient is to put him/her in the seclusion room. All the enrolled nurses (n=22) indicated that it is very important or important that an aggressive patient is secluded to manage the aggression, whereas only 82.1% of registered nurses (n=39) found it very important or important.

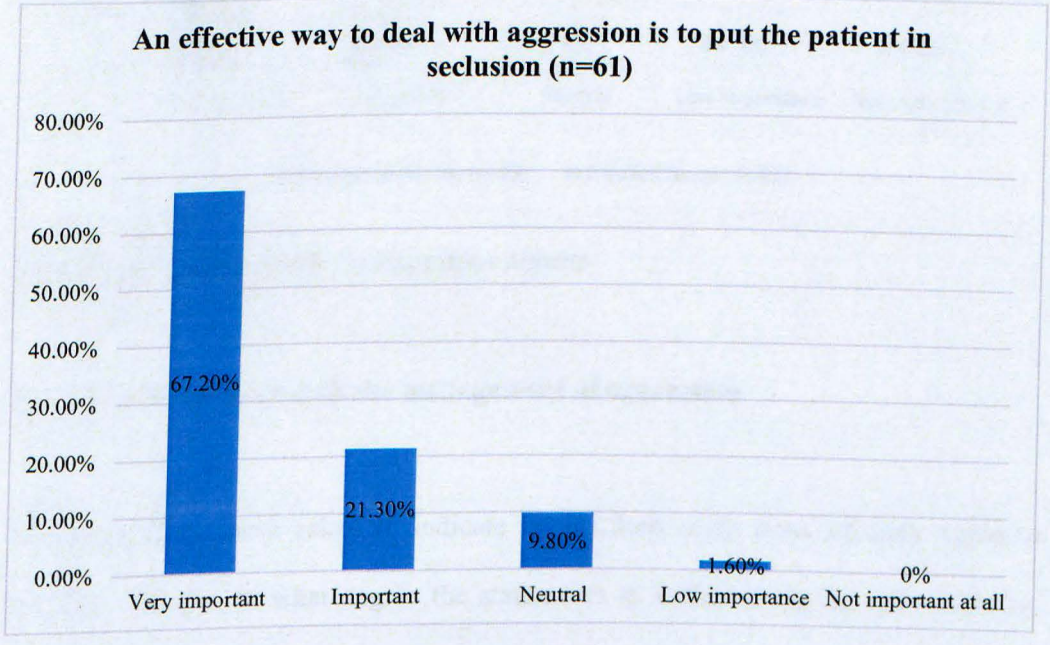

Figure 4.9: An effective way to deal with aggression is to put the patient in seclusion

Before an aggressive patient is secluded, a body search for hazardous objects should be done. It was found as depicted in Figure 4.10 that 96.7% of the participants (n=61) indicated that it is very important to search the body of an aggressive patient for hazardous objects before he/she is secluded; and of these participants, the majority (100.0%) of the registered nurses (n=39) concurred.

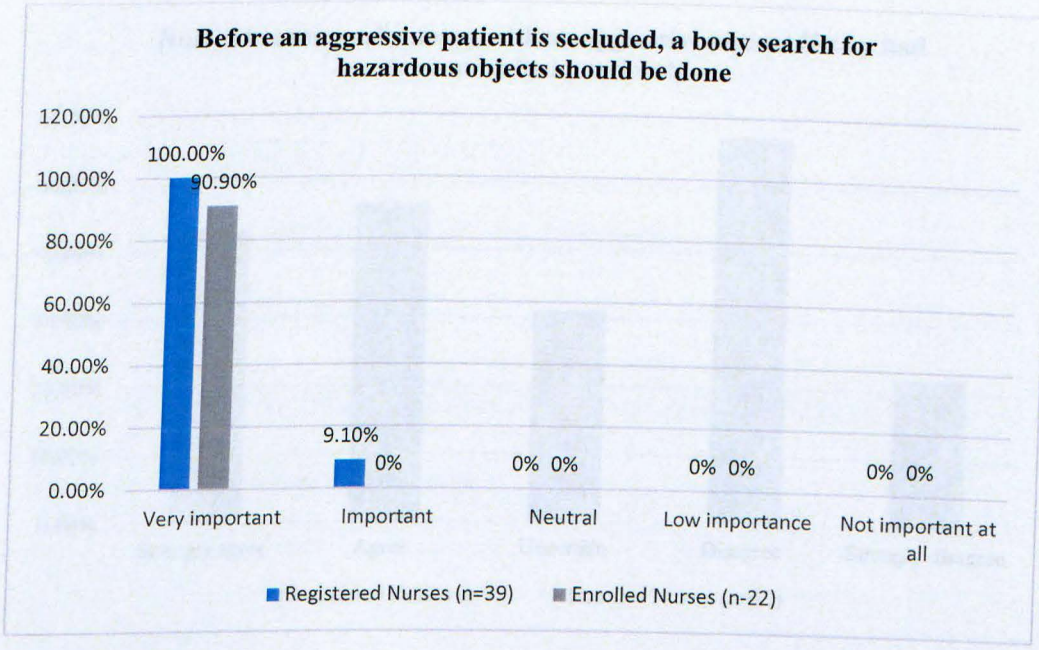

Figure 4.10: Body search for hazardous objects

4.2.2.3. Attitudes towards the management of aggression

The participants were asked to indicate on a Likert scale from strongly agree to strongly disagree, to what degree the statements as indicated on the questionnaire, under section B, describe attitudes towards the management of aggression. The participants (n=61) strongly agree (54.1%) or agree (36.1%) respectively that various meaningful ward activities can be used to reduce agitation and potential aggression.

However, the participants (n=61) equally agree (26.2%) or disagree (26.2%) that nurses can become easily angry with the aggressive patient if they had been assaulted previously. Of these participants, 33.3% of registered nurses (n=39) agree, whereas 36.4% of the enrolled nurses (n=22) disagree with the statement as reflected in Figure 4.11.

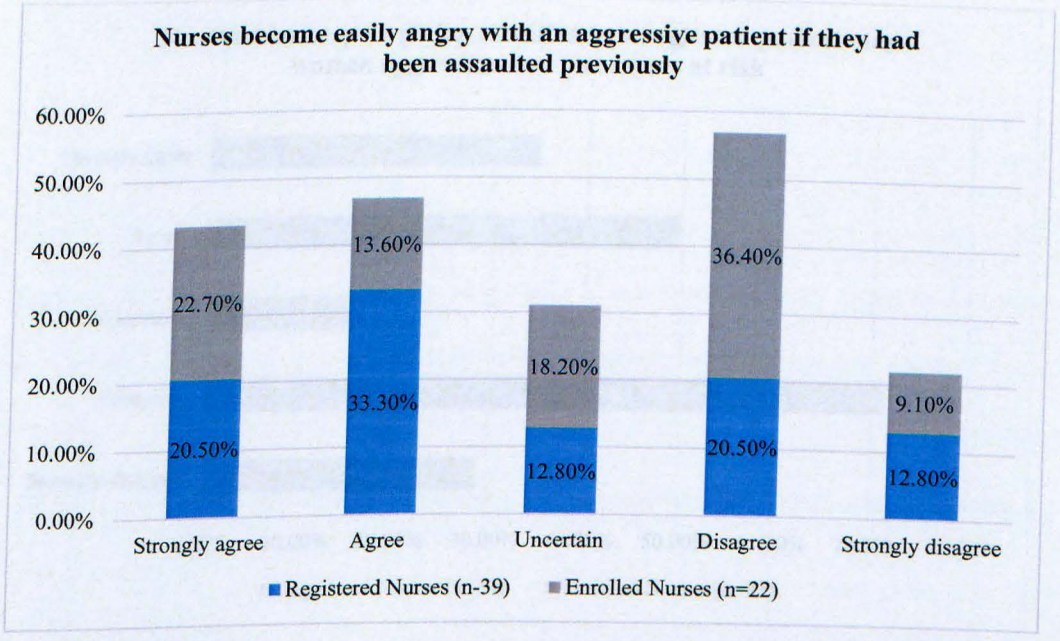

Figure 4.11: Nurses become easily angry with an aggressive patient if they had been assaulted previously.

In addition, more than half (54.1%) of the participants (n=61) disagree or strongly disagree that nurses who keep on giving attention to an agitated patient may worsen aggression and put other nurses at risk. As depicted in Figure 4.12, the majority (48.7%) of registered nurses (n=39) disagree with the statement, whereas the majority (31.8%) of enrolled nurses (n=22) agreed.

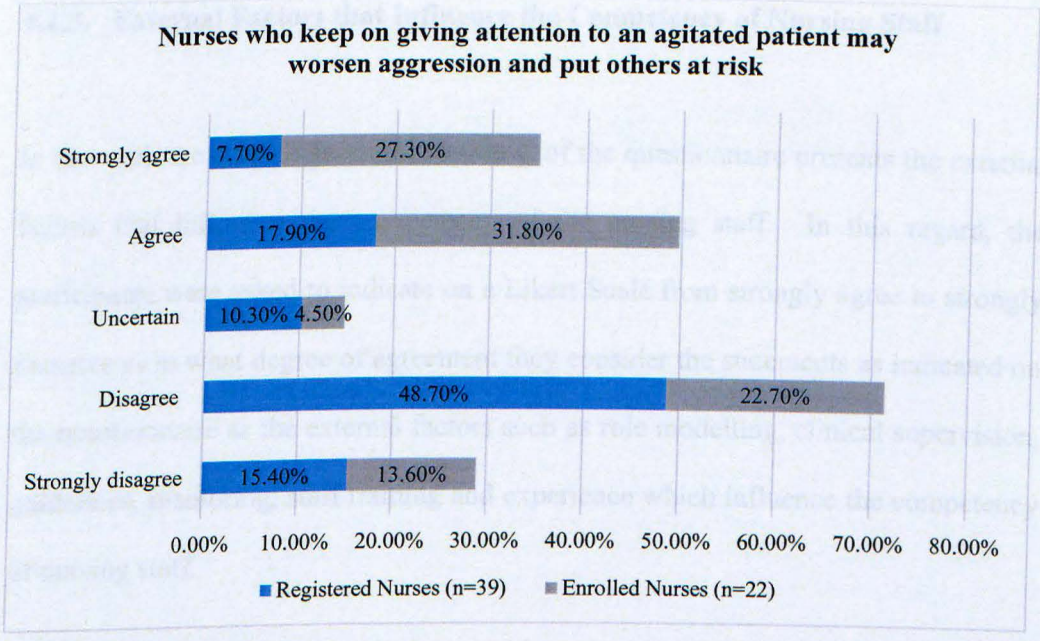

Figure 4.12: Nurses who keep on giving attention to an agitated patient may worsen aggression and put others at risk.

The participants (n=61) also strongly agree (39.3%) or agree (34.4%) respectively that a therapeutic one-to-one relationship between the nurse and the patient can reduce the incidence of patient aggression. Of the total participants (n=61), 20.5% of the enrolled nurses (n=22) remained neutral. A total of 88.5% participants (n=61) indicated, through either strongly disagree (47.5%) or disagree (41.0%) that they do not believe that an aggressive patient should be left alone to calm down by him/herself. Of these participants, 56.4% of registered nurses (n=39) strongly disagree and 63.6% of enrolled nurses (n=22) disagree. Furthermore, the participants (n=61) either strongly disagree (45.9%) or disagree (37.7%) that nurses should only intervene when the aggressive patient beats up other patients. Over half of the participants consisting of registered nurses (n=39) strongly disagree (56.4%) that an aggressive patient should be left to beat up other patients.

4.2.3. External Factors that Influence the Competency of Nursing Staff

In line with the study objectives, section C of the questionnaire presents the external factors that influence the competency of the nursing staff. In this regard, the participants were asked to indicate on a Likert Scale from strongly agree to strongly disagree as to what degree of agreement they consider the statements as indicated on the questionnaire as the external factors such as role modelling, clinical supervision, guidelines, mentoring, staff training and experience which influence the competency of nursing staff.

4.2.3.1. Role Modelling

The majority (91.8%) of the participants (n=61) as illustrated in Figure 4.13, strongly agree to agree that role modelling in handling aggressive patients by a senior nurse might enable a junior nurse to promptly intervene when a patient becomes aggressive. In the same vein, 92.3% of the registered nurses (n=39) and 90.9% of the enrolled nurses (n=22) strongly agree or agree to the statement; while only 5.1% of the registered nurses (n=39) and 4.5% of the enrolled nurses (n=22) were uncertain while others disagree (2.6%).

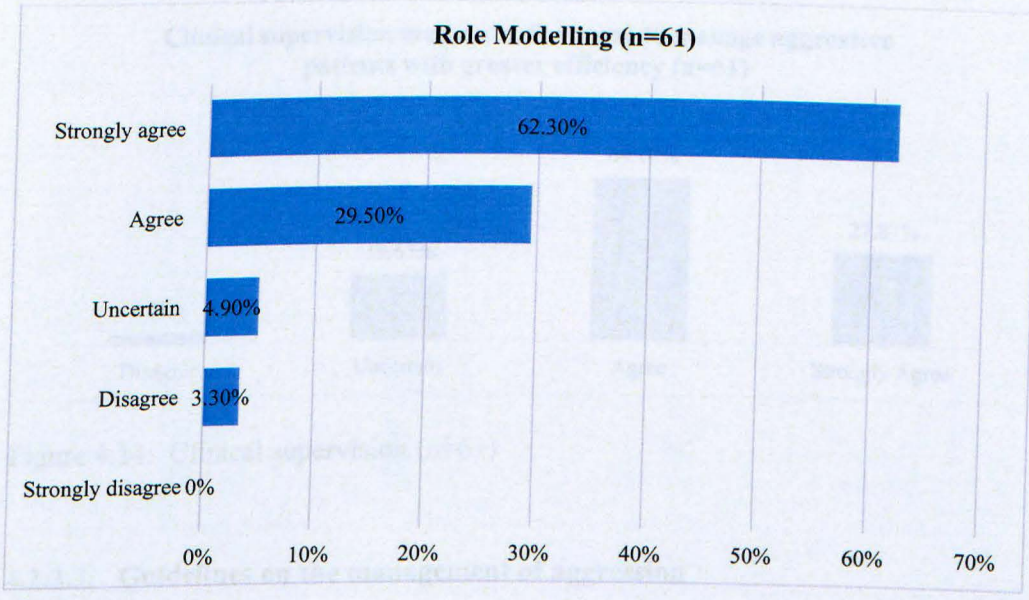

Figure 4.13: Role modelling (n=61)

4.2.3.2. Clinical supervision

A total of 49.18% of the participants (n=61) who were in agreement with the fact that clinical supervision may assist the nurse to manage aggressive patients with greater efficiency were registered nurses (n=39) including the senior registered nurses, while 11.48% of the same rank, were uncertain about it. In Figure 4.14, the overall participants (n=61) were shown with regard to their agreement with the statement that clinical supervision may assist the nurse to manage aggressive patients with greater efficiency.

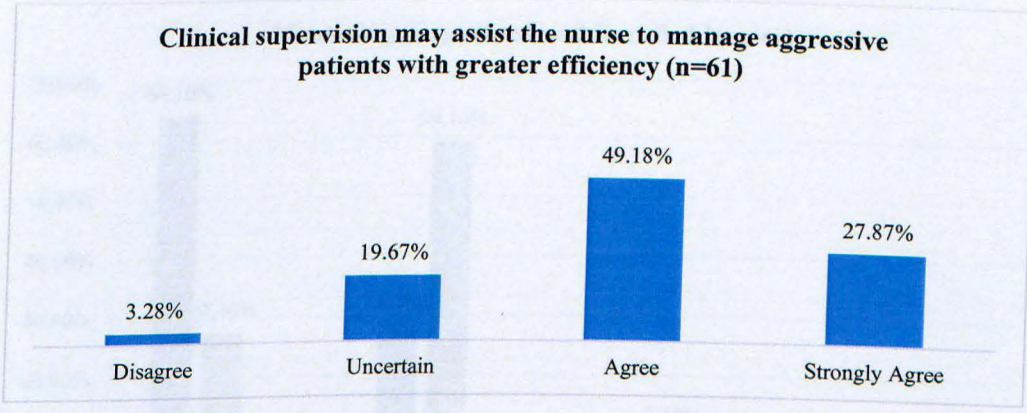

Figure 4.14: Clinical supervision (n=61)

4.2.3.3. Guidelines on the management of aggression

A total of 98.36% participants (n=61) agreed that guidelines on the management of patient aggressive behaviour assist the nurse in gaining crucial skills needed to deal with aggression, of which 67.2% strongly agree while 31.1% agree. Of the participants who strongly agree to the statement, 69.2% (n=39) were registered nurses (n=39), while 63.6% (n=22) of them were enrolled nurses (n=22).

4.2.3.4. Mentoring

Over half (50.82%) of the participants (n=61), inclusive of registered and enrolled nurses, strongly agree that mentoring may prepare the inexperienced nurse to handle aggressive episodes of patients more effectively. It is depicted in Figure 4.15 that the majority (64.1%) of the registered nurses (n=39) strongly agree to the statement and the majority (59.1%) of the enrolled nurses (n=22) agree.

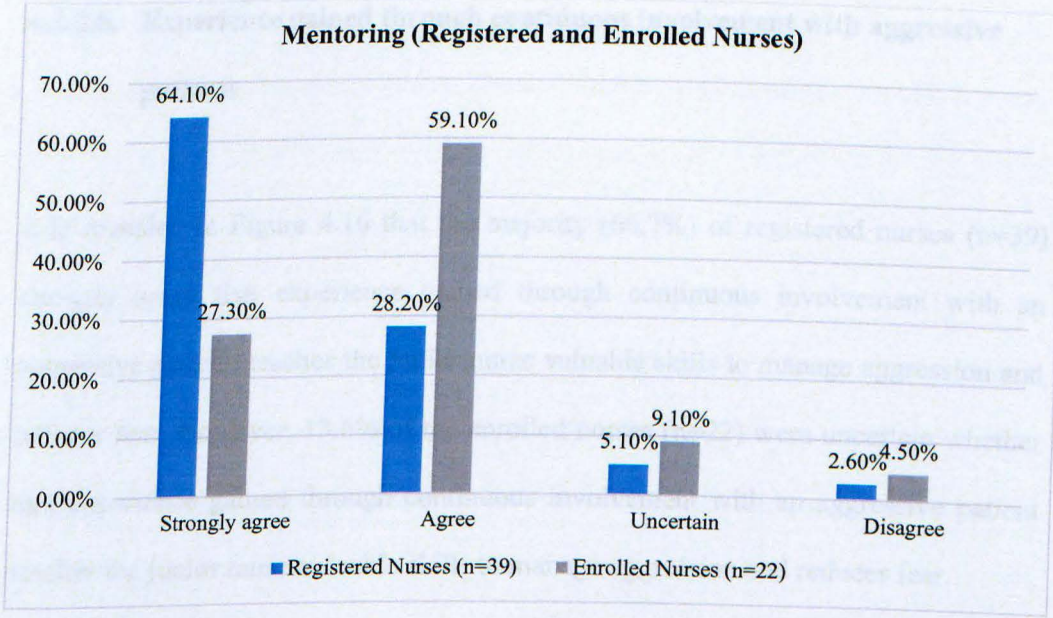

Figure 4.15: Mentoring (Registered and Enrolled Nurses)

4.2.3.5. Staff training

The majority (96.8%) of the participants (n=61) agreed that staff training on the prevention and management of aggression results in the effective management of patient aggressive behaviour, of which 68.9% strongly agree, and 27.9% agree. Of those who were in agreement, at least, 59.02% were registered nurses (n=39) and only 4.92% of the enrolled nurses (n=22) disagreed. However, 2.6% of the registered nurses (n=39) and 4.5% of the enrolled nurses (n=22) were uncertain with regards to the statement.

4.2.3.6. Experience gained through continuous involvement with aggressive patients

It is revealed in Figure 4.16 that the majority (66.7%) of registered nurses (n=39) strongly agree that experience gained through continuous involvement with an aggressive patient, teaches the junior nurse valuable skills to manage aggression and reduces fear. However, 13.6% of the enrolled nurses (n=22) were uncertain whether that experience gained through continuous involvement with an aggressive patient teaches the junior nurse valuable skills to manage aggression and reduces fear.

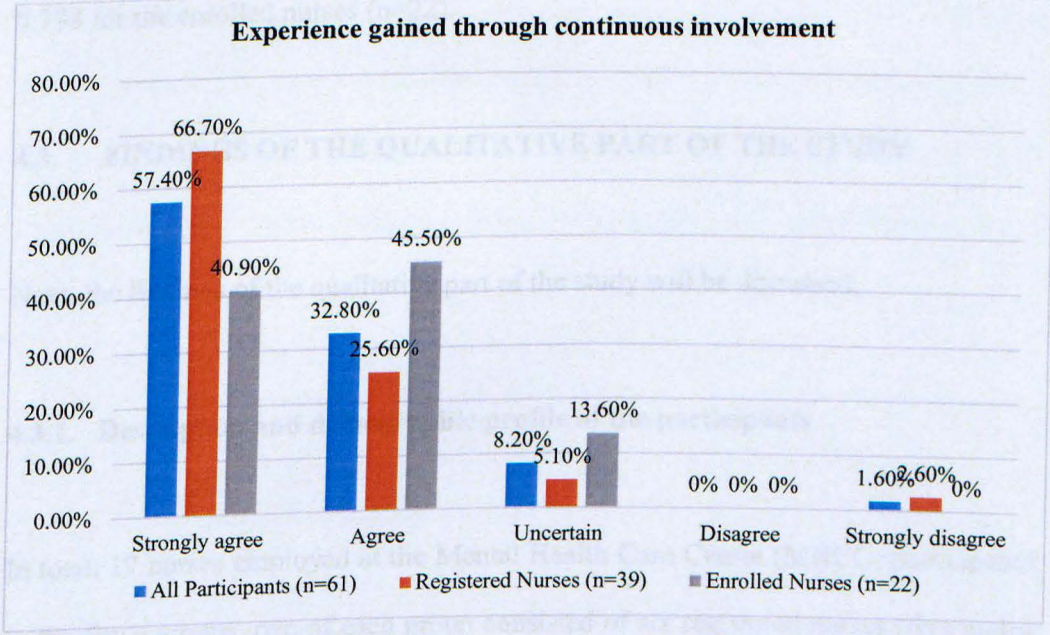

Figure 4.16: Experience gained through continuous engagement

In summary, Section A of the questionnaire included the demographic and work-related data of the participants and it revealed that the majority of the participants were female (71.8%) and employed as registered nurses (n=39) at the MHCC. Section B of the questionnaire which entailed the personal factors which amongst others include the

attitude towards the management of aggression. The attitude statement under the attitude section of the questionnaire showed that the registered (n=39) and enrolled (n=22) nurses were in disagreement regarding nurses who become easily angry with an aggressive patient if they had been assaulted previously.

Section C of the questionnaire which consisted of the external factors that influence the competency of the nursing staff. The participants (n=61) were all in agreement that amongst others; role modelling, clinical supervision, mentoring and experience influence their competency. Also, the overall Cronbach's Alpha coefficient for the instrument was 0,707 for questionnaires completed by the registered nurses (n=39) and 0.798 for the enrolled nurses (n=22).

4.3. FINDINGS OF THE QUALITATIVE PART OF THE STUDY

Next, the findings of the qualitative part of the study will be discussed.

4.3.1. Description and demographic profile of the participants

In total, 17 nurses employed at the Mental Health Care Centre (MHCC) participated in the focus groups, two of each group consisted of six registered nurses (five males and seven females in total) and a third focus group, comprised of five enrolled nurses (all female), were held. Purposive sampling was done to select the 17 nurses who participated in the focus group discussions. Participants who were confronted by patients displaying aggressive behaviour, with varying years of experience and who had been assaulted and injured previously were included in the qualitative study.

First, the demographic profile of the registered nurses will be presented. A total of 12 registered nurses, six per group, participated in two focus groups and the majority of the participants were female (58.3%). Of the participants, 25% were senior registered nurses and 75% registered nurses. The age of the senior registered nurses ranged from 46 years to 58 years with a mean of 52.66 years and they had gained experience of between 2 to 8 years with a mean of 4.33 years in their current job. Also, the age of the registered nurses ranged from 33 years to 57 years with a mean of 48.11 years and they had gained experience of between 2 to 26 years with a mean of 12.97 years in their current job.

Next, the demographic profile of the enrolled nurses will be presented. Only five enrolled nurses participated in the third focus group and they were all female (100.0%). The age of the participants ranged from 28 years to 55 years with a mean of 44.40 years and they had gained experience of between 8 months to 27 years with a mean of 9.04 years in their current job.

4.3.2. Perceptions about their competency in managing aggressive behaviour in mentally ill patients

The objective of the qualitative part of the study was to explore and describe the perceptions of the nursing staff regarding their competency in managing aggressive behaviour in mentally ill patients. The main themes and categories which emerged from the accounts of the participants are outlined in Table 4.1 below and are presented with illustrative quotations from the transcribed data as discussed during the focus groups.

Table 4.1: Overview of the main themes and categories

1	**Theme 1:** Competency to manage aggressive behaviour in mentally ill patients. **Categories:** • Defining the concept competency • Holistic nature of competency • Application of skills • Characteristics and abilities of a competent nurse.
2	**Theme 2:** Attributes contributing to the nursing staff's ability to manage aggressive behaviour. **Categories:** • Work-related and personal factors. • Clinical/practical and interpersonal skills.
3	**Theme 3:** Development of personal competency. **Categories:** • Continuous engagement. • Clinical practise experience • Contribution of continuous professional development (CPD) engagement. • Influenced by role models. • Driven through teamwork engagement.

4.3.2.1. THEME 1: Competency to manage aggressive behaviour in mentally ill patients

This theme includes the four categories of perceptions; namely defining the concept competency; the holistic nature of competency; application of skills; and the

characteristics and abilities of a competent nurse. The focus group and codes used to identify the participants are "f" for focus group and "p" for a participant, followed by a number.

4.3.2.1.1. Category 1: Defining the concept competency

Competency was described by the participants as their ability to use their skills and to apply their theoretical knowledge. According to the participants, competency enabled them to perform well when executing tasks such as managing an aggressive patient. In their own words, the participants stated as follow:

> *"So, what I understand is that competency is your effectiveness of using your training and your skills and your experience over the years in handling the aggressive patient" (f1, p6).*
>
> *"For me the way I understand the term competency, it's just your ability to use your skills, your ability to control and to manage aggression in a patient or amongst patients" (f1, p2).*
>
> *"Competency is your ability to do something, to be able to execute a specific task" (f3, p1).*

4.3.2.1.2. Category 2: Holistic nature of competency

The participants, through the discussions, narrated that they consider competency as holistic in nature. They then explained that the holistic nature of competency as follows:

"According to my view, I think to define competency is when you are having self-confidence in yourself on what you are doing. You know what you are doing. You are having self-confidence" (f3, p3).

"What I understand, it [competency] means the effectiveness, the responsibility and the accountability of the nurse" (f1, p6).

"Competency means that you should know when you are not able to handle the aggressive patient alone and to ask for assistance from fellow colleagues" (f1, p1).

The holistic nature of competency is also considered as showing compassion to the patient; treating them in a humane manner and with dignity, as explained by the participants:

"So by executing your tasks, using your abilities, using your skills and everything, your core point should be that you must know and always remember that you are dealing with another human being and that you treat them the way you would want to be treated in that situation" (f1, p6).

"You will not treat each patient the same because it depends on his state of aggression, how you will treat him" (f1, p4).

"You should be polite with the patient and should work together with him to help him to calm down" (f3, p4).

4.3.2.1.3. Category 3: Application of skills

The application of skills was also alluded to by the participants in their discussions about what competency means to them. The participants explained that they applied

their skills in the execution of their duties but first had to interpret and understand the task at hand. For them, competency is what helped them to apply their skills in such a way that the best outcome for the patient was achieved. Furthermore, competency enabled them to execute tasks such as managing aggressive behaviour of mentally ill patients within the legal framework:

> *"If you can also take them physically and separate them and follow the procedures, legal procedures from there. You restrain and seclude if it's prescribed and the doctor is the one prescribing." (f1, p6).*
>
> *"So, you have to use your skills. I am going to restrain this patient. If the patient is maybe prescribed some medication, you can give him medication. If he is violent to other patients, you can seclude him... in a safe place where he is not harmful to himself and also not harmful to other patients" (f1, p3).*
>
> *"If the patient need sedation to calm down, I will phone the doctor to give a telephonic order of what medication I can give to the patient and then I will inject the patient" (f3, p2).*

In addition to that, participants were also of the opinion that competency is usually associated with a range of skills which can be used in different situations. In their own words, participants explained as follow:

> *"The other skill is also to talk to the patient, to convince the patient and also to find out what makes a patient be aggressive" (f1, p3).*
>
> *"[Competency] is ability how to approach an aggressive patient. You have to know what to do. You don't provoke the patient. Take your own initiative to do things because we have been already trained how to handle an aggressive patient" (f1, p4).*

"A competent nurse will be prepared at all times. She will be prepared with a blanket. If the patient is aggressive, she will (pause) plan a blanket, but without the patient knowing that she is having a blanket. In case the patient comes to attack, the nurse is prepared to cover the patient's head with a blanket to control the situation, the patient" (f3, p3).

"[Competency] is the skills that you put into the time that you are handling the aggressive patient" (f1, p6).

Participants further argued competency is more than just having skills but an ability that can make it possible to transfer the acquired skills to fellow colleagues:

"When you have those skills to do the job, you can also teach your fellow workers" (f2, p3).

4.3.2.1.4. Category 4: Characteristics and abilities of a competent nurse

A nurse who is competent in managing aggressive behaviour of a mentally ill patient should possess the necessary theoretical knowledge. The participants took the stance that nurses can only manage an aggressive patient if they were trained on how to do that and were competent enough to apply that knowledge:

"So, I will consider the nurse is well trained. He knows his work. He has the ability to deal with that situation and he got the proper training." (f1, p3).

"To know something is different from being able to execute what you know. You apply what you know. That's another matter on its own. So, I would describe that nurse as someone who can execute her skills well" (f1, p5).

"I think a competent nurse (pause) in the management of an aggressive patient, is a nurse who is able to identify whatever is causing that aggression. He is also supposed to be knowledgeable in the different ways of managing aggression" (f1, p5).

"The nurse should be able to identify possible aggression and stop it before it even starts. Like for example, sometimes we see in our wards, you could see this patient has this underlying aggression, but we failed to pick it up and act on it before it starts. So, for me, a competent nurse should be able to identify [aggression] before it starts. A competent nurse is someone who is able to minimize the destruction which could have resulted from aggression" (f1, p2).

Certain personal attributes that are traits and characteristics were regarded as intrinsic to a competent nurse. The participants insisted that a competent nurse should possess personal attributes such as a calm composure, showing professionalism in all interactions with the patient, and being confident in what she does. They were of the opinion that a nurse who maintain a calm composure when faced with aggression, is one who is competent in managing aggressive patients:

"A competent nurse is a person who has to be calm when he is giving the direction how to handle that aggressive patient" (f2, p2).

"The nurse self is calm" (f1, p4).

"You have to be as calm as possible to be able to control the aggressive patient. It will only make the situation worse, if you and the patient are screaming at each other" (f3, p1).

"A characteristic of a competent nurse will be not to show the patient that you are afraid" (f3, p5).

Adding to the personal attributes of a competent nurse, the participants ascribed showing professionalism in all interactions with the patient as a good characteristic. They explained in their own words below that self-respect is equally important to win over the trust of an aggressive patient:

> *"And also have a level of professionalism, dignity and should be someone that the patients look up to. Someone that the patients can even listen to and whom they know, they can respect and show respect to. They are not really ill at that point and time and you are that nurse that they can talk too and you can talk to them and they will listen to you. Like one patient said, I feel so happy when mister D (name mentioned) is on duty. His got that presence of a father, that strictness. Things like that are also very much needed in a competent nurse" (f1, p6).*

Another characteristic pointed out by the participants was that a competent nurse should have confidence in her own abilities to manage aggressive outbursts of mentally ill patients. This self-confidence should show in the manner a competent nurse directs others in how to deal with the clinical situation. The participants explained:

> *"I would describe a nurse as confident. He or she is the person in charge or take the charge and give directions to the other staff members on how to handle this patient" (f2, p5).*
>
> *"The nurse should (pause) have confidence in herself, also in what she is doing" (f3, p3).*

Traits such as being a leader, a role model, a supervisor and a teacher were also ascribed to a nurse who is considered to be competent in the management of aggression. In their own words the participants explained:

"A competent nurse is somebody in the ward, she's the leader of the ward. She's a supervisor. She's also a role-model of the ward. She's the one who knows how to handle aggressive patients. In the process, she can also teach others how to do it in the future" (f2, p3).

"She should be a nurse who knows how to lead others; take a lead in this type of situations and then at the end of the day minimal harm or destruction of the infrastructure should be the outcome" (f2, p6).

"A competent nurse is a person who is leading by example. Let me say if you are given a group of new staff members, for example, you have to do and they follow" (f2, p1).

Participants further argued that an assortment of skills is needed to successfully manage the aggressive behaviour of mentally ill patients. They pointed out that communication skills are a must-have to be considered a competent nurse. According to the participants, listening skills and openness are some of the communication skills that are intrinsic to a nurse who is competent in managing aggression. They explained:

"The person must also listen to what the patient or client is going to say, so he's able to detect any escalation of aggression" (f2, p.4).

"I'll first listen to the story of the patient so that the patient can calm down and gain trust in you because if you don't listen to the patient, the patient will become angry. So I'll listen to the patient's side of the story and if it is not manageable then, I will call manpower" (f3, p3).

"I will listen to the patient to find out what cause the aggression and then talk to the patient about it" (f3, p2).

Moreover, participants noted that practical skills enable a competent nurse to deal with an aggressive patient whenever the need arises. They specifically mentioned skills such as knowledge on how to approach a patient, being physically prepared and ready, as helpful in the management of aggression. It will also make it possible for a competent nurse to manage an aggressive patient as stated below:

"The nurse must be observant and see the (pause) signs of aggression and have to know how to approach the patient also" (f1, p3).

"A competent nurse is a person who is giving the tactic on how to handle the aggressive patient" (f2, p2).

"The nurse must also be physically fit, in case we need to restrain the patient, physically or mechanically" (f1, p5).

4.3.2.2. THEME 2: Attributes contributing towards the nursing staff's ability to manage aggressive behaviour

Participants narrated their perceptions about their own skills by describing how they were able to manage an aggressive patient. They described what they have done at that precise moment when they were faced with an aggressive patient. This theme includes two categories as narrated by the participants, and these are work-related and personal factors; and clinical/practical and interpersonal skills.

4.3.2.2.1. Category 1: Work-related and personal factors

The participants observed that while they were rendering care to the aggressive patient their ability to manage the patient effectively is influenced by certain work-related factors such as insufficient manpower, human rights issues, physical assaults and inconsistent practical training sessions, were foremost. In their own words, participants narrated that:

> *"I'm there holding next to Mr. A. (name mentioned), just because I felt that they are so few and our colleagues are not here, I must just help them. That's a risk that I'm taking, I know. I consider this type of risk-taking a lack of my competency." (f1, p2).*
>
> *"You know the patient is protected by human rights. It might happen that while you are handling the patient, the patient got injured and the relatives come to know about it. Then they want to take steps against you who handled the patient. They might be victimizing you that you have beaten the patient and if the patient sustained injury deriving from admission or whatever and then you will be held accountable for that. In our ministry it's something that is an offence and a charge can be laid against you. There is nothing that can protect you" (f1, p5).*
>
> *"I had been stabbed with a roll-on bottle on my hand. I was stabbed on my back. I was rolling in that courtyard with that patient" (f1, p6).*
>
> *"I think we should also practice. We need to have regular practices. If we came together as a group and rehearse what we have been trained on, then we can be more skilful and will know what to do" (f1, p3).*

Some of the participants also have the self-awareness to acknowledge that their own personal characteristics such as the inability to control their temper and lack of physical strength also interfered with their competency to manage aggression:

"I don't know whether my ability is really to that standard because there are times instead of calming down, sometimes me myself I lose temper also and I start shouting also. Not always but sometimes even this morning I did it" (f1, p2).

"I lack the physical strength to handle aggressive patients. Yeah...it looks funny, but that's a very common problem and I don't risk been physical with patients" (f1, p5).

4.3.2.2.2. Category 2: Clinical/practical and interpersonal skills

During the focus group discussions, the participants explained how their interpersonal skills helped them to manage aggression in mentally ill patients. The participants emphasized that being calm despite the circumstances they found themselves in, has helped them to diffuse aggressive outbursts from the mentally ill patients. It was when they were calm, that they could focus on the behaviour of the patients and could assist them to deal with the aggression:

"You as a nurse, you have to be as calm as possible, for you to be able to calm this patient." (f3, p1).

"The other skill that I would possess, is trying to be calm. When the patient is very high, I will not be at the same level as the patient, but to be calm when he is high" (f2, p6).

"Personally, when I'm dealing with an aggressive patient, I have to be calm" (f2, p2).

Also, skills such as verbal negotiation, persuasion and active listening have helped them whenever there was a need to calm down an aggressive patient; hence they found such skills to contribute to their competency in the management of aggression. In their own words, the participants stated that:

"I try to negotiate and see what I can find out, what makes the patient so angry. Why is the patient so aggressive? And try to negotiate for him to stay or what we want to do with him or to help him and not trigger or escalate the aggression further" (f2, p5).

"And then listening skills should also take a central stage, to listen to what a patient is saying" (f2, p6).

"My personal view is that when handling an aggressive patient, I have to use my persuasive skills to try and convince the patient about the dangers of being aggressive towards others and to try to involve that particular patient, explaining the importance of communicating your unhappiness to the staff member and even to co-patients. I will try to make sure that I'm not talking to this patient or communicating to him in a group or a group of people. I'll also try to call the patient out and then sit with him and then talk and find a solution" (f1, p1).

"I will try to talk to the patient in a very calm, soft voice, to defuse the aggression or try to defuse the aggression, before we go to that point where the patient is really now so aggressive that he will hurt himself or others" (f2, p5).

"Talk with her or him in a low voice and built that trust with him or her. It's only when you are going to manage to deal with that aggressive outburst" (f2, p2).

It was further narrated in the focus groups that the participants possessed various clinical/practical skills such as keeping their distance; removing other patients from the scene; not turning their back on the patient and seclusion of the patient, which they used to manage aggression.

"He was still angry. I'm keeping my distance. I can't, I will not go to him, only when the team is there, will I approach him, but I will not go alone" (f1, p4).

"Tell the patients to go outside so that you can handle the patient in there. Then tell the other patients or people who are nearby to stay away from that place. Don't just jump and grabbed the patient" (f1, p1).

"Sometimes the patient is near you. Near-near standing next to you. Now you also have to change the position where you are. Do not turn your back to the patient. The patient must not be in front of you. You must be in front of the patient so that you can also go out or get a chance to go out and get help" (f2, p3).

"Especially when you see the patient is out of control, at least you have to call for manpower so that you can put the patient in seclusion" (f2, p2).

According to the participants, they could only manage aggressive behaviours after they did a risk assessment of the environment. Also, their ability to assess the behaviour of patients helped the participants to recognize the triggers of aggression:

"First you have to watch the situation and check also the environment. Then you also have to check whether the patient is amongst other patients, Really you have to wait and check and you have to foresee what will happen next" (f1, p1).

"The way she comes in, first you check for weapons on the patient and then from there you (pause) talk to her" (f3, p2).

"Me personally, the skills that I have will start with first finding out, if I can figure out the trigger that triggered the aggression of the patient and then see if I can address that. That should be my starting point to address the trigger" (f2, p6).

After the risk assessment was completed, the participants had to make choices concerning the intervention techniques that will work the best to manage aggressive patients. Mostly they selected those options based on the type of aggression shown by the patient as narrated in the following extracts:

"If the patient is verbally aggressive, he's just talking-talking. I must not interfere every time, I must wait and listen to the patient, what the patient is talking and if the patient is high, I must be calm and listen. And I must assess for physical aggression, if the patient is near or even when far. If the patient is near, I can check what I can use, maybe I got a blanket to throw over the patient if I'm alone. But if there is somebody next to me, a fellow worker, I can just ask help to manage the patient or the situation. But it always depends on how far the patient is from me" (f2, p3).

"You think fast, you observe the patient and in what aggression is the patient; you assess the level of aggression. Is he just talking or just swearing? Or just

want attention and then you talked to the patient in a soft, calm way to calm or de-escalate the situation but if you see the patient is just physically really aggressive, you need help. At times he can just be angry. Then you also talked to him to calm him down, but when you see he's physically angry, at least then you have to get help from others." (f2, p4).

"And then physical aggression, you also make sure you don't approach a patient as such alone and just go straight to him. You always have to manoeuvre your movements around the patient, is one of the skills" (f2, p6).

Furthermore, it was frequently mentioned by the participants during the focus group discussions that they had to continuously conduct risk assessments. The participants were fully aware of the risks involved when working with aggressive patients and talked about how they constantly had to assess the clinical environment for any risks that can cause harm to the patient and themselves. In their own words, they explained how they conducted risks assessments which helped them to manage aggressive behaviour of patients:

"This patient is aggressive. Is he in an open space? Are there dangerous objects around the patient or is he in confinement where I know it's just aggression but he cannot reach a dangerous object? If he is in an open space with a lot of potentially dangerous objects then I also have to go, to see how I can remove those objects" (f2, p6).

"Remove everything that is there. And if the patient is that aggressive, the easiest way is to immobilize the patient with either a blanket or whatever I can get, to immobilize the patient not to harm himself or others around him, but the main thing is to be calm" (f2, p5).

"Sometimes while you are busy in a small room, they just come in and start talking and is verbally aggressive. That's why it is always very important to lock the doors if you're alone as a staff member in the department, especially at the male ward. Even at the female ward. It's also dangerous to leave the doors open if you know you have aggressive patients around you" (f2, p3).

4.3.2.3. THEME 3: Development of personal competency

The participants in this study explained that various factors as set out in the following categories assisted in the development of their competency. This theme include five categories of perceptions which are continuous engagement; clinical practise experience; contribution of continuous professional development (CPD) engagement; influenced by role models; and driven through teamwork engagement.

4.3.2.3.1. Category 1: Continuous engagement

Continuous engagement with an aggressive patient was considered as indispensable in the development of the participant's competency. In their own words, participants explained:

"I think me personally how I get this skill to handle an aggressive patient. It all came from experience. The time that I'm been here and as the saying goes that practice makes perfect. So, I have a lot of situations of aggressive patients and from handling them, I think that is where my competence came from. I've learned a lot" (f2, p6).

"The competence that we have gained, for me is through involvement. Indulging in the activities that are happening" (f2, p1).

"You have to have experience because by working here, I get a lot of experience how to handle aggressive patients" (f2, p4).

"As he already mentioned, experience. You worked many years here at psychiatry. At least you know how to handle them. If the patient is near, a blanket. If the patient is far, find out what causes the aggression and then you handle the patient. When the patient is really out of control you have to get help" (f2, p3).

"Our competence has developed in such a way because we are more exposed to these aggressive patients on a daily basis. We know how to handle these patients. We have the skills now and then we know if we need some manpower; maybe a patient has physical strength, we don't underestimate patients, because we know that this one is very strong. Like I said we gained some skills because we always have contact, physical contact with the aggressive patient. So, this contact makes us, our skills to be developed. We had experienced" (f1, p3).

"After I was assaulted, I learned a lesson that day. Okay, analyse the situation first. I have learned to stop the aggression before it escalates" (f1, p6).

In addition, the participants explained that the experience of rendering care to the aggressive patient in the wards, not only taught them clinical skills but also assisted them to come up with innovative ways on how to manage aggression. The participants stated in their own words:

"Sometimes you end up doing something that you have not done before, but from that day you know it's something that is helpful. So that is how I developed over the years. At times giving personal experience as for myself, there was a time when I was new here. I didn't know how to stay with aggressive patients and then one day, I had to give medication and then I put the trolley against the wall and my back to the patients. One of the patients came from behind and just grabbed my throat. From (pause) there I learned that it's not okay for me to give my back to the patients and put the medicine trolley against the wall. It should be the other way around. My back to the wall and facing the patients. So, as I'm saying that through experience, practical, real practical situations, I've gained a lot of experience on how to handle the aggressive patients" (f2, p6).

"But that did not come overnight it's through doing it yourself. And then the experience, if you do it yourself the experience comes" (f2, p5).

4.3.2.3.2. Category 2: Clinical practise experience

Participants were outspoken on how clinical practise experience facilitated the development of their competency. They shared how their exposure to different situations in which they have to manage an aggressive patient has taught them to first analyse the situation and then take a variety of actions not just to manage the patient, but also the clinical situations and prevent the escalation of aggression:

"I have learned how to analyse the situation before I react. I have learned how to manoeuvre the situation before I react and jump in" (f1, p6).

"I also learned how to actually managed aggression, how to prevent aggression from happening, especially with the patients that we had admitted in the ward" (f1, p5).

"I also learned not to provoke the patient, because there are some staff members who like to provoke patients. When they see his already aggressive than they start provoking him. I also learned to be calm; not to show the patient I'm afraid and not to keep him out of your eye side" (f1, p4).

"I learned a lot about the aggressive patient. If I see a patient becomes aggressive, then I will start to talk to the patient in a calm tone of voice" (f1, p1).

Working daily with aggressive patients, made the participants fully aware of negative feelings that can be brought on by their behaviour. They experienced situations in which their judgement regarding an aggressive mentally ill patient is influenced by information provided by relatives of the patient. Participants further noted that through clinical practise experience, they learned to also give the patient a chance to explain his side of the situation:

"I have also learned never to judge. Always never just assume what the relatives or what whoever is bringing a person is saying is true. If the person can talk, let them give their side of the story, so that you can come to a conclusion. Never jumped to conclusions and never just assumed; and another thing never just judged" (f1, p6).

"If a patient comes or if a patient is admitted, don't be judgmental. I'll rather want my patient to feel that this is going to be his/her house for the next few days" (f3, p1).

4.3.2.3.3. Category 3: Contribution of continuous professional development (CPD) engagement

Various learning activities such as workshops, in-service training, self-teaching, peer training and formal education facilitated the development of the participant's competency. Thus, participants explained:

> *"I learned through personal growth by attending workshops on how to prevent, how to handle aggressive patients" (f2, p4).*
>
> *"And as she mentioned through training also. We were trained. Seminars. Doctors are always giving us topics on how to handle aggression. We also read books and ask others on how to handle an aggressive patient" (f2, p3).*
>
> *"Reading books, watching videos and also attending workshops. We taught each other. I remembered we were taught in training here by one of the seniors what to do and how to do it. We also taught each other. So, it is nice that our group here we teach each other. We show each other what to do and if one person sees from the other one, then you also do. And that is how I gained the skill and the competence to handle an aggressive patient" (f2, p5).*
>
> *"I have improved in the fact that I finally did mental health, like the study now, the subject. You know, because when we were enrolled nurses, we've just really strolled through. When I went to UNAM I really learned a lot from the subject. So, I learned a lot really and I'm taking that which I got and applying it in my daily work and on my shift" (f1, p6).*

4.3.2.3.4. Category 4: Influenced by role models

Role models within the clinical environment helped the participants to gain competency in the management of aggression. They gave an account on how they were able to learn how to manage aggression through observing the senior, more experienced nurses when they dealt with an aggressive patient. When faced with an aggressive patient, they were able to recall the incident and then adhered to it and applied what they had observed. The participants narrated:

"At the beginning here, I didn't know some of the tactics and so on. I learned through example from my seniors that I found here and also (pause) on hand experience" (f2, p6).

"At least my competence came from my seniors which I found here. I remember exactly the first day when I entered this department, I found an aggressive patient. When the patient was running, I was also running away. So then with time I also saw what others were doing" (f2, p2).

"Personally, I gained competence through what I saw my seniors did when I came here. The second day that I started here the police who assisted with an aggressive patient, carried guns and the patient grabbed the gun of one of the officers. That day I observed what my seniors did. So, it is really through role modelling that I've learned" (f2, p5).

"And learning also from the colleagues" (f2, p1).

"I gained mine by working with experienced people. Working with people that were working here for a very long time" (f3, p1).

Another participant explained that the years of working in the mental health wards not only brought about a wealth of clinical experiential learning, but also enabled him to teach the less experienced nurses how to manage an aggressive patient:

> *"So now in the future, we are also teaching other young ones how to handle these patients, because we are already exposed and we went through proving it and we know the technique and then we also take those techniques to the others. We shift it to the younger ones, the ones coming for training. They learned from us" (f1, p3).*

4.3.2.3.5. Category 5: Driven through teamwork engagement

The participants were outspoken about the influence teamwork had on the development of their competency. They explained that teamwork which involved the coordination of the team when they had to physically restrain a patient and being fully involved when handling an aggressive patient helped them to develop pertinent skills to manage aggression:

> *"To work as a team. We listen to each other. We let one colleague of ours go in the ward or in the courtyard where there is a very aggressive patient and then we work as a team. We plan on what to do when we go there. We know that this one is going to cover the patient; this one is going to hold the patient or just to be ready. So, when we are going to the courtyard, we are already ready. We will not be standing, looking at each other or not knowing what to do. We need to work as a team" (f3, p3).*
>
> *"One person will be in charge and the others will just follow to de-escalate the aggression" (f2, p5).*

"Together with the colleagues. You cannot do or handle a patient who is aggressive alone" (f2, p1).

"We know that this one is very strong so here we have to call in the reinforcement so that they can assist us to restrain the patient, maybe the patient needs to be restraint" (f1, p3).

"So, teamwork is very important when you are handling an aggressive patient. You really need to have teamwork" (f2, p2).

"My own competence has developed only in such a way that now I know that teamwork is very important" (f1, p2).

4.4. SUMMARY OF CHAPTER FOUR

This chapter provided an in-depth discussion and description of results with regards to the demographic data of the participants, the factors that influenced the competency of the nursing staff in the management of aggressive behaviour of mentally ill patients, their attitude and perceptions towards it.

Chapter 5, will present a detailed discussion on the findings of the study.

CHAPTER 5

DISCUSSIONS, CONCLUSIONS, LIMITATIONS AND RECOMMENDATIONS

5.1. INTRODUCTION

In this chapter, the findings of the research will be discussed in-depth. The findings will be compared to other studies in the field and findings in other countries in Africa and the world. The discussion includes the answering of the research objectives of the study and will show whether the qualitative results confirmed the quantitative results. After the discussions, conclusions will be drawn from the important findings to meet the aim and objectives. Recommendations will be made based on the outcome of the study. The limitations of this study will also be discussed.

5.2. INTERPRETATION OF RESULTS

This section first presents a schematic side-by-side comparison for merged data which displays the mixed methods question "To what extent do the qualitative results confirm the quantitative results as a way of conveying the merged results". The quantitative and qualitative results are presented in a summary table so easily to compare them. Thereafter a discussion of the research results will follow.

Table 5.1: Comparison of information from questionnaire and focus group discussions data in a side-by-side joint display

	Quantitative Data (Questionnaire)	**Qualitative data (Focus Group Discussions)**
1. Personal Factors that influence competency in the management of aggression		
1.1 Theoretical Knowledge of aggression and competency	• Participants have good knowledge about verbal and physical aggression, signs and causes of aggression. • Lack of knowledge about the phases of aggression. Participants were unable to distinguish between escalation and anger phases.	• Participants showed a good understanding of the concept of competency.
1.2 Clinical/practical skills	• Good communication skills.	• Participants have good communication skills such as verbal negotiation, active listening and persuasion which was improved through experience. • Has good ability to conduct risk assessments.
1.3 Practices/strategies	• Knowledge about medication	• Good clinical/practical

of nurses when managing aggression	administration between registered and enrolled nurses differ. • Good knowledge of physical restraint and seclusion practices	skills/strategies such as keeping a distance; removing other patients from the scene; not turning their back towards the patient.
1.4 Attitudes towards the management of aggression	• Positive attitude towards managing aggression through meaningful ward activities; therapeutic one-to-one relationships; not leaving patient to calm down by himself. • Negative attitudes - disagreement about anger towards patient when previously assaulted; giving attention to an aggressive patient.	• A nurse competent in managing aggression shows a calm composure. • Positive attitude: Learned from physical assaults. • Insufficient manpower lead to risk taking and decrease the safety of nurses.
2. External Factors influencing the development of competency of the nursing staff		
2.1. Role modelling and mentoring	Most participants agreed that role modelling and mentoring influenced their management of aggression.	Participants agreed that role modelling developed their competency.
2.2. Training	Most participants agreed that training resulted in the	Engagement in CPD activities and in-service training enhanced the knowledge and

	effective management of aggression.	skills and improve the competency of the nursing staff.
2.3. Teamwork	All participants agreed that working together as a team assisted them in managing an aggressive patient.	The participants agreed that engagement in teamwork developed their competency.
3. Development of competency in managing aggression		
3.1. Experience gained through continuous involvement with aggressive patients.	The participants agreed that experience gained through continuous involvement with aggressive patients taught them valuable skills.	Experience and prolonged engagement with patients displaying aggressive behaviour taught the nursing staff how to manage aggression and refine their competency.

5.3. DISCUSSION OF THE RESULTS

After merging the two data sets, the mixed method results were interpreted to answer the mixed methods research question: To what extent do the qualitative results confirm quantitative results on the factors that influence the competency of the nursing staff in managing aggressive behaviour in mentally ill patients at the MHCC in Khomas Region?

Hereunder, the demographic profile of the participants of both the quantitative and qualitative approaches is discussed, before the actual study results. The following discussion below highlights the similarities in the themes identified in this study.

5.3.1. Demographic characteristics and work-related data of the participants

The demographic and work-related data consisted of gender, age, current rank, educational level, duration of the employment period, encounters of violence, previous assaults and physical injuries, ability to physical restraint or hold down an aggressive patient and training in the management of aggression.

With regard to the gender, the majority of the participants were found to be female (71%), in line with the overall gender disaggregation of the nurses' population at Windhoek Central Hospital (WCH) and the Mental Health Care Centre [MHCC] (Windhoek Mental Health Care Centre, 2018). The human resource office at national level could not provide information on the gender and age of the nursing staff employed in the government owned hospitals, because they do not keep statistics. The female participants were also the majority in the qualitative part of this study. Nursing is worldwide accepted as a female-dominated occupation and this study's findings reflect that (Başkale & Serçekuş, 2015). Despite being a female-dominated occupation, nursing is also a labour some job which requires physical strength, especially when restraining aggressive patients. According to Zafra (2015), male nurses are generally favoured in disciplines where their physical power is needed like mental health nursing.

The majority of participants age ranged from 24 years to 60 years, which is in line with the staff establishment informational list for November 2018 which shows that the age

of nursing staff at the MHCC ranged from 24 years to 59 years (Windhoek Mental Health Care Centre, 2018).

Concerning rank and educational level, the majority of the participants were registered nurses (54%) of which 38% were trained in Diploma in Nursing Science. In Namibia, nurses were generally trained to obtain diplomas and certificates and only recently to obtain degrees (University of Namibia, 2020). Before the introduction of the degree course, most registered nurses were predominantly trained in diploma courses which means that the majority of nurses trained in Namibia are diploma holders. Also, more registered nurses than enrolled nurses are employed at the MHCC, indicating that the majority of the nurses have knowledge about aggression management (Windhoek Mental Health Care Centre, 2018).

With regard to duration of employment, the findings of this study revealed that participants worked on average for 9.54 years (4 months to 27 years); compared to other studies (Yang, et al., 2016) in which nurses only worked for 19 to 24 months. Being employed for this length of time in the same speciality field, can be an indication that the participants either learned from their long years of engagement with aggression in mentally ill patients or were unable to learn from it. Although most of the registered and enrolled nurses are employed at the MHCC for an extended period, the findings of this study show that only a marginally number of them can restrain or hold down an aggressive patient. Benner's Novice to Expert Theoretical Model is also of the same opinion that being employed for a long period in the same field does not necessarily say that the nurse had learned from it (Benner, et al., 2009).

Concerning the frequency of violence at the workplace, the findings of this study show that participants experienced violence on a daily (50%) basis, but still lesser than what had been experienced by countries such as Australia and Norway ((Hyland, Watts, & Fry, 2016; Iversen, et al., 2016). In the focus group discussions the participants narrated that they experience more verbal aggression than physical aggression. Studies have shown that verbal aggression is very common in acute mental health wards (O'Rourke, Wrigley, & Hammond, 2018).

The majority (65%) of the participants in this study, had been previously assaulted, but only 28% had sustained injuries. Studies reported high rates of physical assault (98.5%) and physical injuries (53%) sustained by nurses (Tomagová, Bóriková, Lepiešová, & Čáp, 2016; Partridge & Affleck, 2017). Although the assault rate of participants at the MHCC was high, sustaining physical injuries remained low.

This study shows that more than half (55.7%) of the participants can restrain or hold down a patient. The enrolled nurses are the longest employed at the MHCC; however, the results show that only half (50%) of them could restrain or hold down an aggressive patient. This could be that they were not trained because only (54%) of the participants in this study were trained in the management of aggression. Some of the enrolled nurses were recently appointed at the MHCC and worked for only 8 months as indicated in the qualitative part of this study. The current induction and orientation programme for newly appointed nurses does not include training on the management of aggression which is needed for nurses who have to provide care to mentally ill patients who display aggressive behaviour.

An acceptable level of knowledge on the management of aggression is crucial to minimize the prevalence and seriousness of aggressive incidents (Duma & de Villiers, 2014). Concerning training in the management of aggression, slightly more than half (54.1%) of the participants were trained. This means that the participants have been trained on the management of aggression, either through in-service training, workshops or as part of their basic degree or diploma training. It is a concern that only slightly more than half of the nurses were trained, because nurses who render care to the aggressive mentally ill patient have to know how to deal with aggression. It is evident in studies that a lack of training and not enough practice in those skills can lead to mismanagement of aggression and the overuse of restrictive interventions (Ramezani, Gholamzadeh, Torabizadeh, Sharif, & Ahmadzadeh, 2017).

In summary, the key findings regarding the demographic and work-related data show that most of the participants were female, unable to restrain an aggressive patient and had been insufficiently trained in the management of aggression, which had an influence on their competency.

5.3.2. Personal factors that influence competency in the management of aggression

In answering both objective one and two, the following factors highlighted were converged, or were agreed upon from the side-by-side table (see Table 5.1). Personal factors which consisted of theoretical knowledge such as description, phases, signs and causes of aggression, clinical/practical skills such as prevention of aggression, practices such as physical restraint and seclusion practices, the administration of

medication and attitude towards aggression management were included. It also included the participant's understanding of the concept of competency, their ability to engage in learning activities and learning from their clinical practice experience. This is in line with Benner's Novice to Expert Theoretical Model (Benner, 1982) that personal factors influenced how nurses respond when they have to take decisions regarding the care of patients.

5.3.2.1. Theoretical knowledge

In both quantitative and qualitative results participants agreed that theoretical knowledge on aggression and the understanding of the concept of competency, influenced the competency of nursing staff to manage aggressive behaviour of mentally ill patients. Furthermore the participants shared during the focus group discussions that a nurse who is competent in managing aggressive patients should have the necessary theoretical knowledge about aggression obtained through formal or in-service training. The participants reiterated that nurses need to have knowledge on the identification of the various forms of aggression and the management thereof. A nurse can only manage an aggressive patient if she had been trained on how to do that and is competent enough to apply that knowledge. In a narrative review (Heckemann, et al., 2015) on the effect of aggression management training programmes for nursing staff, the participants strongly valued academic training in the skills that are needed to deal with specific clinical situations such as aggression. In this study, the knowledge of the nursing staff regarding aggression is reflected through their understanding of the description of the types and phases of aggression and the physical restraint technique as well as signs and causes of aggression.

Concerning the description of aggression, participants in this study could correctly recognise or identify the description of verbal aggression (95.1%) and physical aggression (88.5%) which is in line with the findings of Warburton and Anderson (2015) that nurses could accurately describe the types of aggression.

Whereas regarding the phases of aggression, the majority (62%) of participants incorrectly selected anger as the phase of aggression during which a patient is pacing the corridor with clenched fists and an upset face. Meaning that the majority of participants were not able to distinguish between the escalation and anger phases. This shows that the participants had limited knowledge and limitied ability to identify the different phases of aggression. Lack of knowledge about the phases of aggression can lead to the selection of unjustifiable restrictive measures such as patients being restraint and put in seclusion unnecessarily (Berring, Pedersen, & Buus, 2016). It means that if nurses cannot recognize the phases of aggression, they cannot de-escalate the aggression. Not being able to de-escalate aggression increases the likelihood for it to escalate into extreme aggression (Misitano, 2017). Once the patient is aggressive, nurses have to physically restrain and seclude the patient and, in the process, can sustain physical injuries. With regard to the physical restraint technique, the majority of participants had good knowledge about the face-down physical restraint technique, similar to what was found in a study by Cunha, et al., (2016).

Concerning the signs of aggression, the majority of participants in this study could correctly identify the clear signs of aggression, as described by Belete (2017). This means that the participants had good knowledge about the signs of aggression, despite slightly more than half (54.1%) being trained in the management of aggression. When

nurses observed that patients show signs of aggression they immediately intervene through talking with the patient and in doing so de-escalate the aggression. This means that the majority of participants displayed a good level of skills because they were able through applying their enhanced communication skills to prevent aggression outbursts. It can also be that when the nursing staff attended in-service training and workshops as alluded to in the focus group discussions, it mostly focused on defining aggression, the signs thereof and communication skills.

Regarding the causes of aggression, overall, the majority of participants could correctly identify the reasons why patients become aggressive. Surprisingly, only 48% considered substance intoxication as a cause of aggression, despite being one of the top five mental health disorders that are been treated at the MHCC according to the statistics reported in the annual report (Windhoek Mental Health Care Centre, 2019). These results are in line with a study done by Stewart and Bowers (2015) that substance intoxicated patient did not have an increased likelihood to become aggressive than patients with other diagnoses.

Although the majority of participants consider involuntary admissions as a cause of aggression, 21% of them regarded patients admitted as involuntarily as the least to become aggressive. This is despite these patients being considered as dangerous to themselves and others and thus forced to be admitted under court orders. Also, 15% of the participants were uncertain whether involuntary admissions contribute to the aggressive behaviour of the patient or not. This can be so because the MHCC is a referral hospital and when patients arrived in the wards, they are already sedated. As a result of the sedation, the patient is no longer aggressive. It may then be difficult for

some participants to consider the patient as dangerous and to see the reason for them to be admitted as involuntary. On the other hand, only a limited number of patients were involuntarily admitted at the MHCC, indicating that the participants were not much exposed to this type of admissions.

Concerning the concept competency, it has multiple descriptions and a variety of elements have been associated with it. On the question of what is competency, the participants responded that it is the ability to use their skills and apply their theoretical knowledge effectively. It means that competency is the ability to perform well when executing a task such as managing an aggressive patient. In an article about the meaning and clarification of the concept of competency, Stan (2014) describes competency as a combination of knowledge and skills in which nursing actions are grounded.

Competency had also been described as holistic in nature by the participants in this study. Qualities and behaviours such as self-confidence, willingness to perform one's responsibilities with a good understanding of what they had to do and treating patients humanely have been ascribed to competency. Drisko (2015), in an article about holistic competence and its assessment, concludes that competency includes components such as knowledge, skills, viewpoints, performances, decision-making and ethical values. Furthermore, the participants noted that the holistic nature of competency includes showing compassion for patients and treating them with care and concern for their well-being. This finding is echoed by Munkejord and Tingvold (2019) in their research on competency. In their study, they find that competency includes the ability to show true interest in the patient, which implies that the nurse respect and truly care for the patient and that is a reflection of the nurse's competence.

The participants also shared that they understood that competency is the skills that nurses acquired through working in the mental health wards and through that refined their own ability and skills to suit the clinical situation. This means that the nurse has an assortment of skills which can be applied when they had to manage a clinical situation such as aggression. The participants also narrated that competency involves how one understands and interpret the task at hand whilst applying the skills to manage the aggressive patient and in that way ensuring that the patient receives quality care. These findings are in line with research (Bahrami, Purfarzad, Keshvari, & Rafiei, 2019) on the components of nursing competencies in caring for older people, which described competency as the ability to know a given task and having the skills to do it well, to be able to take good care of the patient.

5.3.2.2. Clinical/practical and Interpersonal skills

According to Benner's Novice to Expert Theoretical Model (Benner, 1982), nurses developed clinical/practical and interpersonal skills over the years which they then use to execute their tasks such as managing aggression. The qualitative results confirmed that skills such as communication skills (verbal negotiation, active listening and persuasion); risk assessment and interpersonal skills (calm composure); quantitative results showed that clinical/practical skills which include the prevention of aggression, helped the participants to manage aggression effectively.

Overall, participants in this study agreed that aggression can be prevented through communication skills such as talking to the patient in a calm and controlled voice and

control of the immediate environment surrounding the patient such as removing other patients and bystanders from the scene. This is similar to what was found by Gardner and Magee (2014) in a literature review regarding patient to patient aggression.

Verbal negotiation, is another technique which can be employed to resolve aggressive behaviour in mentally ill patients. In this study, the participants explained how they use their verbal negotiation skills to settle down a potential aggressive patient. They have found that verbal negotiation helped them to better understand why a patient behaved uncontrollably. Through negotiating with the patient, they can build a trust relationship between them, which make it easier for the patient to accept what the nurse expects from him to do. It also serves as a means of communication for the nurse to share information with a patient.

In this study, the majority of the participants (67.2%) considered it very important to find out what helped a patient to calm down when he was previously aggressive. It means that based on the knowledge on what can calm a patient, the nurse then negotiates with the patient to help him to control his aggressive outburst. Lovell, Smith, and Johnson (2015) found in their study that verbal negotiation to de-escalate aggression was considered the best way of managing aggressive behaviour of mentally ill patients.

According to the participants, listening actively to the aggressive patient made it possible for them to identify triggers of aggression and helped them to choose the best intervention technique for the situation. As per the quantitative part of this study, participants find it very important (54.1%) or important (31.1%) to listen attentively to the patient to prevent aggression. Listening attentively shows that the nurse cares about the patient, it fosters trust in the abilities of the nurse, which in turn help them

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to feel safe. According to Chan, Tsang, Ching, Wong, and Lam (2019), active listening is helpful in that it assists the attending mental health nurse to better understand the aggressive behaviour of the mentally ill patient.

Persuasion is another communication skill which is not a new concept in mental health. Participants in this study prefer to use persuasion when a patient is aggressive to find a solution that is acceptable and in the best interest of the patient. Persuasion is used by doctors to convince patients to accept the medication they prescribed, nurses to persuade patients to take their medication and psychologists to talk patients into changing their behaviour to improve their mental condition. A report (Shannon, 2015) on the use of coercion in clinical mental health practice, described persuasive communication skills as an effective tool to guide a patient to be cooperative during an aggressive outburst. In his report, it is explained that persuasive communication such as persuasive messages is used to target certain behaviour such as restlessness and agitation, to convince the patient to be cooperative and to accept help from the nurse.

In agreement with Benner's Novice to Expert Theoretical Model (Benner, 1982), participants also had the perception that nurses who can communicate effectively with the patient, family and other team members can use this ability to advocate for the patient and bring about changes in the management of a mentally ill patient. In research (Wilson, Rouse, Rae, & Kar Ray, 2018) on mental health inpatients' and staff members' suggestions for reducing physical restraints, it was revealed that nurses who can verbally communicate factual information to other team members and could give clear instructions to them, were able to manage aggression effectively. Such communication skills prevented injuries to the staff and the patient because each one

knows exactly what is expected from them during an aggressive outburst from the patient.

Self-awareness of destructive responses makes it possible for mental health nurses to recognize when they should adjust their reactions to prevent escalation of aggression. Angry responses of staff members can aggravate aggression in mentally ill patients; making it more difficult to manage aggressive behaviour. The participants explained that they were fully aware of their reactions towards patient aggression and how it affects their own ability to manage aggression. Also, in the quantitative part of this study, the participants indicated that they considered it very important (59.0%) or important (24.6%) not to argue with an aggressive patient or threaten them with seclusion. Furthermore, the participants shared how very important it is, not to do anything to make the situation worse like yelling at the patient and other staff members or to start an argument with the patient. They were in agreement that it is a must better to speak with confidence and authority to resolve the aggressive episode. According to Benner's Novice to Expert Theoretical Model (Benner, 1982), nurses gained more competency through self-awareness and also developed interpersonal approaches that can help them to deal with situations such as patient aggression.

Lindsay and Schwind (2015) concluded that self-awareness makes nurses considerate and thoughtful when interacting with a patient, which prevent them from acting hastily on the patient's aggressive outbursts. Mental health nurses can only manage aggressive patients effectively if they are aware of their own emotions and are able to control it.

The participants in this study further emphasized how their ability to assess the ward environment for any risks that can cause harm to the patients and themselves are very

helpful to them. This means that objects such as chairs, brooms and trolleys used for cleaning purposes that can serve as potential weapons, will then be removed to ensure safety. Participants explained that when conducting a risk assessment, a competent nurse would lookout for specific clues not only in the environment but also in the patient self and use that knowledge and past experiences to take the necessary steps to neutralize the risks. They also narrated that they would assess patients for signs of aggression. If the patient is already aggressive, they would check for dangerous objects in the environment and on the patient self. At this point, the researcher observed as noted in the field notes how the participants' behaviour showed, for example nodding the head that they agreed on what should be looked out for during risk assessment to prevent aggression.

Continuous risk assessment while caring for the mentally ill patient gives the patient a sense of safety and security and thus reduce the risk of aggressive behaviour (Coffey, et al., 2019). Risk assessments helped nurses to identify in which level of risk the patient is. The nurses use this information to select the type of intervention to manage aggression. The participants shared that it is safer to first observe the situation before initiating any intervention especially when alone. In research on the perceptions of nurses about practices regarding health and safety, O'Keeffe, Tuckey, and Naweed (2015) agree that nurses should not take risks. Risk-taking is not an indication of competency of nurses, but rather a decision that is taken without proper assessment of the situation. Nurses have to exercise caution and first conduct a thorough risk assessment, maintain a safe distance and remove other patients from the scene when managing aggression.

In addition to the findings of the quantitative part of this study in line with a convergent parallel mixed methods design, the results of the qualitative part showed that interpersonal skills such as a calm composure had a significant influence on the competency of the participants while they manage aggressive behaviour of patients. The participants shared how their ability to stay calm when faced with patient aggression had helped them to manage aggressive behaviour more effectively. They learned that their mind must be calm and focused on the patient to prevent reaction that will escalate into aggression. A calm composure also assisted the participants to remain objective, to make decisions based on the type of aggression displayed by the patient which made it possible for them to eventually resolve the aggressive episode competently.

When nurses were calm, they were able to give attention to the immediate needs of the patient and negotiate and persuade him to cooperate. In their responses in the quantitative part of this study, the majority of the participants (77.0%) indicated that it is very important for the nurses to speak to an aggressive patient in a calm and controlled voice as it prevents escalation of aggressive behaviour of patients. This means that when nurses project a calm composure to an aggressive patient, it not only includes their behaviour and attitude but also their tone of voice. A nurse with a calm composure are not overwhelmed by what is happening but are able to control her own emotions and take a step back to assess the situation to see how to deal with an aggressive patient. The calmness of a nurse even though inwardly nervous, gives an impression to the patient that the nurse is in charge of the situation and that assist patients in regulating their own feelings (Walton, Lindsay, Hales, & Rook, 2018). When the emotions of the nurse spiral out of control, more restrictive measures to

control the situation are implemented. A calm and professional attitude while managing aggression was reiterated by Lanthén, Rask, and Sunnqvist (2015) in a study done on psychiatric patients' experiences with mechanical restraints. In that study, those patients felt that even though they had been restrained, it was a meaningful experience, because the staff were able to deal with their own emotions and were able to execute their tasks skilfully. In Benner's Novice to Expert Theoretical Model (Benner, 1982), nurses become more adept at controlling their own emotions as they gain competence which is predominantly an attribute of the proficient and expert stages of skills acquisition.

5.3.2.3. Practices/strategies of nurses when managing aggression

The quantitative and qualitative results revealed that the nurses adopted certain practices/strategies to manage aggression. These practices/strategies include physical restraint and seclusion practices; medication administration; keeping a distance; removing other patients from the scene; not turning their back towards the patient; approaching an aggressive patient and being prepared for the unforeseen.

The participants in this study learned physical restraint and seclusion practices through their experience with aggressive patients and showed good knowledge on how to apply these measures effectively. At least 36.1% of the participants considered it very important while 23.0% thought it was important that the use of force is the most effective method to restrain a patient. In Namibia, the MHA, Act No. 18 of 1973, Section 69, lays down certain conditions for mechanical means of restraint. The Act specifically refers to the use of bodily restraint and stipulates that it can be applied to prevent the patient from injuring himself or others (Government of the Republic of

Namibia, 1973). At the MHCC, physical restraint is only applied to restrict body movements when medication is refused during an aggressive episode, hence the majority of the participants find it important because it is a helpful intervention when injectable medication had to be administered. Similarly, Cusack, McAndrew, Cusack, and Warne (2016) find in their study that some sort of force had to be applied when physically restraining an aggressive patient, to gain control over the patient and to be able to manage the situation. This means that the participants have good knowledge about physical restraint, because they were trained and they taught themselves and are now skilled in physically restraining a patient.

The majority (89%) of the participants considered seclusion as an important and effective way to deal with an aggressive patient. Seclusion rooms are frequently used at the MHCC to manage aggressive patients safely. Studies show that seclusion is an acceptable and appropriate method of containment and that mental health wards operate effectively when seclusion rooms are available (Pettit, et al., 2016). However, when secluding an aggressive patient, nurses have to be vigilant to prevent potentially dangerous situations. Therefore, the majority (97%) of the participants deemed it very important to search the body of an aggressive patient for hazardous objects to safely seclude an aggressive patient.

In an article on safety in psychiatric inpatient care, Slemon, Jenkins, and Bungay (2017) wrote that mental health nurses are paramount in ensuring a safe environment for themselves and the patients through consistently conducting risk assessments. These nurses need to follow safety guidelines and policies such as the bodily search of a patient before being secluded. An internal ward directive on the body search of patients at the MHCC also requires from the nursing staff to do that to prevent harm to patients and staff. Besides, seclusion seems to be preferred by most of the nursing

staff at the MHCC and is done skilfully focusing on the safety of the patient. The guidelines endorsed by WHO, however, specifies that the least restrictive measures should be applied in mental health settings (World Health Organization, 2005). This means that a patient should only be secluded when de-escalation techniques such as verbal negotiation failed and not as the preferred intervention in cases of aggressive behaviour.

Concerning the administration of medication, there is a difference in the responses between the registered and enrolled nurses regarding the offering of oral medication to an aggressive patient. The majority (61.5%) of registered nurses strongly disagreed or disagreed and the majority (59.1%) of enrolled nurses strongly agreed or agreed that offering oral medication is helpful when a patient is aggressive. This means that the knowledge about the effectiveness of oral medication differs between the registered and enrolled nurses. However, the results also suggest that the participants who were employed at MHCC for more than 27 years learned through their clinical experience that aggressive patients mostly refuse oral medication. Also Benner's Novice to Expert Theoretical Model (Benner, 1982), shows that as nurses gain more experience, they make less use of theory and their actions are based on what worked previously in similar situations.

The results are consistent with the findings of Jaeger, Hüther, and Steinert (2019) that refusal of medication is a common trend amongst aggressive and involuntary admitted patients. Therefore it is better to inject the patient with a sedative medication to speed up the calming effect to prevent escalation of aggression. It also means that the difference in opinion amongst the registered and enrolled nurses can be as a result of

the training they received concerning the management of aggression. The findings of this study showed that 66.7% of registered nurses were trained in the management of aggression whereas only 31.6% of enrolled nurses were trained. In a study (Fröhlich, et al., 2018) nurses reported after they had received training on the management of aggression, that their knowledge and confidence had improved which helped them to better understand patient aggressive behaviour. However the difference in opinion is in keeping with Benner's Novice to Expert Theoretical Model (Benner, 1982), that no two nurses would be likely to manage aggression in similar ways even though they had the same experiences, if they did not have the necessary theoretical knowledge to begin with.

Also, the participants stated that they have learned over time to use different practices/strategies such as keeping a distance; removing other patients from the scene; not turning their back on the patient; as well as secluding the patient to manage aggression. In the responses of the participants in the quantitative part of this study, the majority of them considered it very important (85.2%) to remove an aggressive patient from other patients and bystanders. This means that they are aware and have learned through experience that an aggressive patient can become more aggressive to impress the onlookers. Participants have also learned through experience that other patients can team up with the aggressor and cause a widespread commotion in the ward. In the focus group discussion they explained that their competency in managing aggressive behaviour are strengthened by their ability to recognize the triggers of aggression.

5.3.2.4. Attitudes towards the management of aggression

In both quantitative and qualitative results participants agreed that their attitudes can influence their management of aggressive behaviour in mentally ill patients. The participants generally had a positive attitude concerning the management of aggression through meaningful ward activities, timeous intervention with aggressive patients and therapeutic one-to-one relationships between the nurse and the patient.

Specifically, about meaningful ward activities to reduce aggression, this study shows that the majority of participants strongly agreed (54.1%) or agreed (36.1%). This means that the participants were aware of the effect that ward activities have on the outcome of care. Keeping patients engaged in activities while admitted in the wards, prevent boredom which can cause frustration and ultimately aggressive outbursts. Consistent with the findings of this study, Groenendaal, Loor, Trouw, Achterberg, and Caljouw (2019) agreed that a variety of activities promote the overall health of the patient and encourage socialization with others. Engagement in stimulating activities such as sport and drawing can help aggressive patients to control their behaviour. A study (Eldal, et al., 2019) on the experiences of patients in mental health wards, patients revealed that being involved in ward activities helped them to keep in touch with their own identity and nurtured feelings of self-worth.

Furthermore, participants in this study strongly agreed (39.3%) or agreed (34.4%) that a therapeutic one-to-one relationship between the nurse and the patient can reduce the incidence of patient aggression. Meaning that participants agree that nurse-patient therapeutic relationships can bring about better insight into the behaviour of a mentally

ill patient. Patients feel valued when the nurses takes time out of their busy routine work to sit and talk with them. This also fosters trust in the nurse which is much needed when the patient displays aggressive behaviour. According to Kornhaber, Walsh, Duff, and Walker (2016), therapeutic relationships with patients, are fundamental to in-patient care and not only make the hospital stay worthwhile for them, but also prevent aggressive outbursts from them. Even though the majority of participants in this study were in agreement, a considerate number of them remained uncertain (18.0%).

However, with regard to nurses who become angry if they were previously assaulted, the participants had different believes. Some participants strongly agreed (21.3%) or agreed (26.2%) and others disagreed (26.2%) or strongly disagreed (11.5%) that being assaulted causes them to be angry with the patient. This variation in the attitude of the participants can be because the majority (63.9%) of them had not been assaulted previously by an aggressive patient. This means that the participants that were assaulted before agreed that they would be angry with the patient. It seems that the participants need to work through their feelings of anger in the form of de-briefing, to better understand the aggressive behaviour of patients. A study (Wolf, Delao, & Perhats, 2014) on the experience of nurses who were physically or verbally assaulted while rendering care to patients found that it can have a multitude of effects such as fear and anger, on nurses. The nurses expressed fear of coming to their workplace, even more so after they sustained physical injuries. According to their findings, it seems the involvement in a similar incident during which the nurses were assaulted, had the potential to trigger feelings of anger and dismay to the point where they had to receive counselling.

The majority of the registered nurses who have participated in this study, disagreed (48.7%) or strongly disagreed (15.4%) that giving attention to an aggressive patient may worsen aggression and put other nurses at risk, whereas the majority of enrolled nurses strongly agreed (27.3%) or agreed (31.8%). This variation in agreement amongst the participants means that they need support to better understand the nursing care of the aggressive patient to ensure and provide quality patient-centred care to them. Patient-centred care can only be provided if the nurses were able to work through these types of negative perceptions during debriefing sessions. It also seems that participants not only need training but also skills to enable them to learn from experience. In addition, even though the enrolled nurses have been the longest employed at the MHCC, it seems that they lack the ability to learn from their experience and also lack observation and awareness skills, therefore need to be more involved in in-service training sessions. These skills can be acquired through observing role models managing aggression and clinical practice experience in keeping with Benner's Novice to Expert Theoretical Model (Benner, 1982). A study in Egypt showed that when patients were not satisfied with the care they received, they displayed their dissatisfaction through aggressive behaviour (El Malky, El Wahab, El-Amrosy, & El Fiky, 2016). Care during which the patient's interests are put first shows that the nurse is concerned about the patient, which in return can prevent or reduce aggression. The study in Egypt concluded that mental health nurses be trained on the management of aggression to improve the quality of care rendered to mentally ill patients.

This study further found that the majority of the participants either strongly disagreed (89%) or disagreed (84%) with the statement that aggressive patients should be left

alone to calm down by themselves. This means that the participants are very concerned about the safety and overall care of aggressive patients. It also seems that the participants are well aware that if the patient is left alone, there is a very high likelihood that the aggression can escalate to a point where the patient can hurt himself and others. Newman, O'Reilly, Lee, and Kennedy (2015) agreed that concern for the patient's well-being shows that nurses care about them. Patients appreciate the nurse's considerate attitude and being able to participate in their care planning to help them control their aggressive behaviour. As nurses accrued experience over the years, they become more involved with the patient, are emotionally attuned and ethically sensitive to the needs of the patient, consistent with Benner's Novice to Expert Theoretical Model (Benner, 1982).

Furthermore, the majority of the participants strongly disagreed (45.9%) or disagreed (37.7%) with the statement that nurses should only intervene when the patient beat other patients. It seems that they have a deep concern for the health of the patient and does not want anything unfortunate to happen to them in keeping with Benner's Novice to Expert Theoretical Model (Benner, 1982). This also shows that the participants are aware that they are responsible for the safety of every patient in the ward and that an aggressive patient can cause serious harm to other patients, if left unchecked. The results of this study are consistent with the findings of a study by Salzmann-Erikson, Rydlo, and Wiklund (2016) that nurse-patient interaction can bring about harmony during which patients have less chance of being in close contact with disruptive social situations and that can prevent the escalation of aggression. Contrary it is noted that 27.3% of enrolled nurses agree that they should only intervene when the aggressive patient beat up other patients. It means that the attitudes of the enrolled

nurses were negative concerning patient care, which can influence the care rendered to the aggressive mentally ill patient and ultimately their competency. This is also contrary to what Alshowkan and Gamal (2019) found in their study on the nurses' perceptions of patient safety in psychiatric wards. In their study the nurses viewed it as very important that patients should be protected either from other patients or themselves and therefore they should intervene immediately in cases of aggression.

5.3.2.5. Ability to teach others and engage in learning activities

With regard to the qualitative results, the participants perceived themselves so confident in their competency to the point that they feel able to teach other staff members regarding the management of aggressive behaviour in mentally ill patients. Teaching other nurses primarily depends on the perception of nurses regarding their own competency. Thus, when the nurses feel they are competent in the management of aggression, they are eager to teach others. A study (Ma, et al., 2018) found that if nurses perform a task frequently, they developed skills in that specific task to such an extent that they feel confident to transfer their skills to other nurses.

A competent nurse is also the one that needs to direct and guide each team member on how to manage the aggressive outburst. In a study (Dafny, 2016) on the perceptions of nurses regarding violence, strategies and support, nurses suggested various techniques to manage aggression. These nurses suggested that nurses should plan how to protect themselves and also direct and teach others about keeping a safe distance from an aggressive patient and to avoid gestures and approaches that can be interpreted as provocative. Studies recommend that a competent nurse should take the lead in guiding

other staff members how to do a task such as negotiating with an aggressive patient (Barkhordari-Sharifabad, Ashktorab, & Atashzadeh-Shoorideh, 2017).

The participants in this study also said that they learned from each other. This means that they consider teaching each other as a valuable tool to improve their competency, thus they actively engaged in peer training. Peer teaching creates a safe environment within which a nurse can learn without feeling exposed when not able to perform the task. Vuckovic, Karlsson, and Sunnqvist (2019) in a study on peer learning found that nurses shared their knowledge and immediately after the performance of a task, gave feedback on how it was executed.

5.3.2.6. Ability to learn from experience

In the qualitative results, the participants shared that while caring for aggressive patients, they have experienced physical assaults which influenced their competency. As per the quantitative findings of this study, 66.7% of registered nurses who participated in this study were previously assaulted and 23.1% of them sustained physical injuries. However, participants in this study felt that they learned from the physical assault experience and it actually improved their competence. They shared that they had been kicked, punched in the face, bitten and spit at. This means that they had to endure these acts of violence from mentally ill patients and as a result suffered serious injuries and emotional problems.

Brophy, Keith and Hurley (2018) reported that physical assaults have a multitude of consequences ranging from physical to emotional problems such as loss of self-confidence resulting in underperformance. Other nurses in the same study felt that they are unable to provide proper care, not because they are incompetent, but due to the

aggressive behaviour of patients. Similarly, it was found in a study done in South Africa on the experiences of psychiatric nurses of violent behaviour by female psychiatric patients with mental illness that being physically assaulted not only has negative implications but also create opportunities for those nurses to learn from and it developed their competencies (Maluleke & van Wyk, 2017).

In summary, the overall findings of this study concerning theoretical knowledge show that participants have good knowledge about what constitute aggression, the face-down physical restraint technique, signs and causes of aggression. However, with regard to the different phases of aggression, the participants mostly lack the knowledge to distinguish between the different phases. Also, insufficient training in the management of aggression and limited exposure to certain causes of aggression lead to a difference in opinions amongst the participants. In addition the differences in opinion can also be that the participants are in various stages of compentency according to Benner's Novice to Expert Theoretical Model (Benner, 1982) which shows that nurses in different stages of competencies, do not approach a clinical situation in the same way.

The findings of this study also show that the participants' perceptions on their competency to manage the aggressive mentally ill patients, depend on how they defined competency. They defined competency as holistic in nature, inclusive of the ability to use a variety of skills effectively and possessing certain qualities such as self-confidence.

The overall findings for the clinical/practical and interpersonal skills, on the other hand, show that participants know how to prevent aggression and how to physically

restrain and seclude an aggressive patient; that means that they have good skills. Disagreements amongst the registered and enrolled nurses about the effectiveness of oral medication when a patient is aggressive can be as a result of differences in their knowledge about medication, because of their level of basic training and whether they were trained or not in the management of an aggressive patient. In Benner's Novice to Expert Theoretical Model (Benner, 1982), nurses with an extended period of practical experience accrued profound knowledge and developed skills through integrating formerly learnt experiential knowledge.

Finally, the findings of this study show that the participants differ in their attitudes towards the management of aggression. This variation in attitude towards the management of aggression depends on whether the participants previously experienced patient assaults or not and also insufficient training. This is in line with Benner's Novice to Expert Theoretical Model (Benner, 1982), that nurses developed an insight into a clinical situation and learn ways to cope with it through experience gained, through training, attitudes and how they act in response to various practical occurrences such as aggression. Notwithstanding their differences in attitude, the findings of this study show that the participants are having the same perception with regard to teaching others and engaging in learning activities.

5.3.3. External factors influencing the competency of nursing staff to manage aggressive patients

External factors included role modelling, guidelines on the management of aggression, mentoring and training which include continuous professional development (CPD).

The majority of the participants agreed that role modelling, guidelines on the management of aggression and mentoring influenced their competency with regards to the management of aggression. In addition the participants shared that teamwork shaped their competency in managing aggression.

Although a passive process, role modelling, enables the nurse to move from the novice level to the expert level as described in Benner's Novice to Expert Theoretical Model (Benner, 1982). Through observing role models it seems that nurses uncover the knowledge that has been rooted in the actual performance of a task and can relate theory into practice (Benner et al., 2009). This means that the participants in this study also learned how to manage an aggressive patient through observing experienced and competent nurses and acquired competencies through imitating what they had observed. Observing a senior nurse executing a task and doing it correctly, later on, create a sense of self-worth and gratification in a nurse as well as giving rise to a desire to improve even more. Role models were pointed out as helping the participants in this study with gaining competency in the management of aggression. According to Benner's Novice to Expert Theoretical Model (Benner, 1982), novice nurses depend on what they have seen others did for the patient and will then imitate that to enable them to manage an aggressive patient. This is in line with the quantitative part of the study, in which the majority of the participants (62.3%) strongly agreed that role modelling enable junior nurses to promptly intervene when a patient becomes aggressive.

Mentors are also role models, but they actively guide the novice nurse to gain competency and pass on informal knowledge and confer skills regarding the management of aggression. In an article, Thomas and Kellgren (2017) wrote that mentoring can also support the experienced nurse to continue to grow according to the

skills acquisition levels of the Benner's Novice to Expert Theoretical Model (Benner, 1982).

In both the quantitative and qualitative results, the participants agreed that training as an external factor also influenced and developed their competency to manage aggressive behaviour of mentally ill patients. This training includes learning activities such as workshops, in-service training, self-teaching, peer training and formal education. Training improves skills and the quality of care to the aggressive mentally ill patient. It also assists nurses to stay informed about recent developments in the care of aggressive patients. Benner's Novice to Expert Theoretical Model (Benner, 1982) shows that training helps nurses to prioritize and to recognise what is important when managing aggression. Just as participants in this study felt that training developed their competency, a study on the continuous training of nurses found that in-service training had several benefits (Price & Reichert, 2017).

Hung, Lam, and Chow (2019) found that knowledge is fundamental for the expansion of expertise which in return, lead to the individual growth of the nurse and results in improved competency. Therefore, continuous professional development (CPD) is significant in making sure that nursing staff execute their tasks with great care and efficiency. A case study (Manley, Martin, Jackson, & Wright, 2018) on the effectiveness of CPD, concluded that it is worthwhile if provided by expert nurses who used factual and practical knowledge originated from actual situations in nursing practice. CPD not only develop the competency and skills of nurses but due to the diversity of the knowledge provided, it also improves service delivery. Similar to the findings of this study, it was found that CPD also contributes to the development of nurses' competency. The desire to be competent compel nurses to attain and improve

their knowledge and gain more skills. Furthermore, the research by Lamb and Norton (2018) concludes that continuous personal development and training by an expert nurse is the only means by which nurses can sustain their competency.

The results of the study also showed that clinical supervision, guidelines in the management of aggression and teamwork influenced the competency of the participants in managing aggression. Although the majority of participants agreed that clinical supervision also influenced their competency, at least 19.7% remained uncertain about it. This finding suggests that the participants who were supervised during their earlier years in the mental health wards acknowledged that such exposure developed their competency to manage aggression. The uncertainty about clinical supervision came about as a result of them not being supervised when initially commencing work in the mental health wards. A study (McCarron, Eade, & Delmage, 2018) on the experience of clinical supervision for nurses and healthcare assistants in a secure adolescent service found that clinical supervision presented nurses with the opportunity to voice their concerns and to be listened to, making it a valuable experience for them. Through clinical supervision, a nurse is given support and also learning opportunities are provided which help the inexperience nurse to develop competencies in the management of aggression. Supervision of the novice nurse leads to improved work relations and teamwork, resulting in the provision of quality care to the aggressive patient.

Concerning guidelines on the management of patient aggression, the majority (98%) of the participants strongly agreed or agreed that it facilitates the acquisition of crucial skills that are needed to manage aggressive behaviour in mentally ill patients. Meaning

that the participants attained their competency through the implementation of the guidelines and involvement in the review thereof.

Lake and Turner (2017) reported in their study that clinical guidelines assist mental health staff to work closely together and act as a team, because it informs them of the steps that are important to ensure that the mentally ill patient receives optimal care. Guidelines have to be established and reviewed based on current evidence in research and made available in the clinical settings. The availability of guidelines on the management of aggression would then assist nurses with the development of their competencies in patient care such as the management of aggression. Guidelines are also essential in guiding and regulating the management of aggression.

The participants shared that teamwork which involved the coordination of the team while physically restraining a patient and being fully involved when handling an aggressive patient assisted them in developing pertinent skills to manage aggression. Participants argued that managing an aggressive patient through physical restraint cannot be done by one nurse and it requires a team effort to prevent injuries to either the nurse or the patient. Working in well-organized teams help nurses to perform their duties efficiently. Engaging in teamwork is also valuable in that team members encourage and teach each other skills which improve the competency of the nurses. Besides, the participants in this study, observed that teamwork during the management of aggression, not only involved themselves but also the doctors and security staff. It means that each person within the team has their unique function to provide the best possible care to the aggressive mentally ill patient. This is supported by the response

in the quantitative part of the study, in which all the participants strongly agreed that teamwork is needed to restrain an aggressive patient to inject a sedative medication.

In the same view, Maagerø-Bangstad, Sælør, and Ness (2019) found that mental health nurses thought that teamwork foster a working culture within which tasks can be executed knowing other nurses are present to assist if the need arises, especially when managing an aggressive patient. In this regard, teamwork helped mental health nurses to cope with demanding mentally ill patients, mainly when they were aggressive. Team work also provides the support nurses need to adapt with ease after they experienced a difficult situation such as been assaulted by an aggressive patient and strengthened them to continue providing compassionate patient care. A study (de Souza, Peduzzi, da Silva, & Carvalho, 2016) on teamwork in nursing, showed that teamwork is primarily a much-valued experience characterised by shared respect, trust, gratitude for and awareness of the other person's abilities. The same study, however, also found that conflict amongst team members which is mostly caused due to poor collaboration between them, can be a hindrance to the provision of safe patient care.

Insufficient manpower is another factor that influences the competency of nurses. As explained by the participants, insufficient manpower can lead to improper management of an aggressive patient. In this study, a female participant shared how she felt obliged to assist when not enough male staff was available to physically restrain an aggressive patient. The majority of nursing staff at MHCC are female (71%), which means that female nurses also have to work in the male wards with a bed capacity of 50. This put the already limited number of male nurses under additional

stress because they have to not only protect the patients, but also the female nurses when patients become aggressive.

Baker, Canvin, and Berzins (2019) highlighted that the availability of enough staff members to manage aggressive patients is a great concern worldwide and constant staff shortages can lead to risk-taking to provide much-needed care. Insufficient staff usually results in poor quality care to patients and can make it difficult to manage the aggressive behaviour of patients in mental health wards. The limited staff are so burdened with tasks that they cannot at times pay attention to all the needs of the patients and this can be one of the causes of aggressive outbursts. More restrictive methods are also used in poorly staffed wards leading to unnecessary physical restraints and seclusions.

According to the participants, insufficient manpower also influences the allocation of staff to the different wards and lead to the placement of female nurses in male patient wards just to provide a fair amount of staff to that specific ward. Mercer and Perkins (2018) found in a study on female staff experiences of working in forensic care with male sex offenders, that those nurses felt exposed to risky situations and open to be assaulted themselves. Moreover, female nurses working in wards with male patients mostly resort to doing tasks not related to the management of aggression, because even the male nurses consider them as weak and not able to handle aggressive patients.

In summary, the findings of this study show that external factors such as role modelling, training (CPD) and teamwork, developed the knowledge of participants and refined and polished their skills in the management of aggression. Insufficient manpower was found to be regarded by the participants as positive factors from which

they learned valuable skills. The availability or the lack of clinical supervision is another external factor that affected the opinion of the participants. When supervision was available the participants acknowledged that it influenced their competency to manage aggression, but the absence thereof led to doubt about its impact on competency development.

5.3.4. Development of competency in managing aggression

In the qualitative results, the participants shared their views on how their clinical practice experience and continuous engagement with aggressive patients influenced the development of their competencies. According to them, the experience gained from working with aggressive patients also boosted their personal attributes as part of their overall competencies. Also, in the quantitative part of this study, the participants strongly agree (57.4%) or agree (32.8%) that experience gained through constant interaction with an aggressive patient teaches beginner nurses valuable skills to manage aggression. This means that the participants were able to learn from their experiences of interacting regularly and over a prolonged period of time with aggressive patients, helping them to develop skills and knowledge on how to manage aggression. Every aggressive episode that a nurse is exposed to, is unique and teaches them different skills and refines their competency. Also, work experience assists newly graduate nurses to acquire competencies and experienced nurses to improve knowledge and skills (Khankeh, et al., 2014). Benner's Novice to Expert Theoretical Model, indicates that experience is a way of actively going through real situations such as aggressive behaviour of patients; sorting through previously collected information and modifying earlier acquired knowledge to manage the aggression.

According to Benner's Novice to Expert Theoretical Model (Benner, 1982), knowledge is accrued over time. This time has to be spent in the clinical practice such as the mental health wards and should involve active participation in clinical situations. In doing so, clinical experience is acquired through engagement with clinical situations such as aggressive episodes and that improve the knowledge of the nurse. Clinical practice experience also polished skills such as communication which further sharpened the nurses' ability to prevent aggression. The participants also shared their perceptions on how they gained their clinical skills to manage aggression through the clinical experience they accrued over the years. Prolonged engagement with the aggressive patients in the clinical wards, taught the participants not to judge the patient on the information given by others, but instead gave the patient a chance to explain. This means that they have learned to listen to the patient's side of the story and to decide only thereafter how to best assist the patient and the family.

Benner's Novice to Expert Theoretical Model (Benner, 1982) further assert that nurses expand their knowledge through active participation in the on-going clinical activities and this enables them to move to the next level of skills acquisition. Continuous involvement with mentally ill patients also fosters a privilege nurse-patient relationship in which a nurse comes to know and understand the patient better. In a study on the skills and competencies of hospital managers, Barati, Sadeghi, Khammarnia, Siavashi, and Oskrochi (2016) found that years of experience in the same specialization field such as mental health, polished and improved their competencies in the management of aggression. Nurses with more years of clinical experience also have attained extensive knowledge and gained greater competency in managing aggressive patients.

Clinical practice experience can have both positive and negative effects. Adverse experiences such as physical assaults in the workplace can bring negative feelings in nurses which make it difficult for them to learn from the experience, contrary to the findings of this study (Oshondi, et al., 2019). According to Benner's Novice to Expert Theoretical Model (Benner, 1982), the transition of nurses from the novice to the expert level can only take place if the learning experiences were internalized by the nurse and applied regularly. If not, the nurse will remain on the same level of skill acquisition, which can lead to job dissatisfaction and eventually burnout.

In summary, the findings of this study show that the participants were able to learn from their clinical practice experience and continuous involvement with an aggressive patient. These factors helped them to grow and developed from novice nurses to experts in the management of aggression in line with Benner's Novice to Expert Theoretical Model (Benner, 1982).

5.4. CONCLUSIONS

The objectives of the study was to identify and describe the factors that influence the competency of the nursing staff at the Mental Health Care Centre (MHCC) in managing aggressive behaviour in mentally ill patient as well as to explore and describe the perceptions of the nursing staff regarding their competencies in managing aggressive behaviour in mentally ill patients.

5.4.1. Conclusions on objective one of the study

Objective one of the study was to identify and describe the factors that influence the competency of the nursing staff at MHCC in managing aggressive behaviour in a mentally ill patient. The conclusions on the findings of this study for objective one proved that personal and external factors influenced the competency of the nursing staff at the MHCC. It is ascertained that the registered and enrolled nurses at the MHCC has generally good theoretical knowledge of aggression and good communication skills. This study's findings confirmed what was found by Bekelepi (2015) that nurses have sufficient knowledge about aggression.

The attitude of the nursing staff is proven to be neither positive nor negative with regards to the management of aggression, as the registered and enrolled nurses show notable differences pertaining to patient-centred care activities. It has been concluded that the registered and enrolled nurses' attitudes were positive towards the provision of ward activities and the establishment of therapeutic relationships with the aggressive mentally ill patient. With regards to becoming easily angry when previously assaulted; giving attention to an agitated patient may worsen aggression, not leaving aggressive patients to beat others and not intervening until they calm down by themselves, their attitudes were neither positive nor negative. On this basis, the conclusion was reached that the attitudes of the registered and enrolled nurses are the primary concern and whether they have all other factors in place, with negative attitudes, competency is compromised. This study's findings confirmed what Zieber and Sedgewick, (2018) found that positive attitudes of nurses assist them in gaining knowledge and improve their skills, whereas negative attitudes limit their professional growth.

However this study attested that not enough nursing staff in relation to the number of staff employed at the MHCC, were trained in the management of aggression and also identified some shortcomings in the training of the nursing staff especially concerning the phases of aggression, medication administration and proper application of physical restraint techniques. The majority of registered and enrolled nurses had been physically assaulted and it was concluded that it is because they have never been trained or insufficiently trained in the management of aggression and therefore lacked skills to negotiate with patients and handle aggressive situations. The study's findings also proved that an inadequate number of the registered and enrolled nurses were trained in physically restraining or holding down an aggressive patient. All nursing staff at the MHCC have to be competent in physical restraint because it is primarily used when a patient refuses oral medication, which is common in psychotic patients, who then have to be injected.

The researcher believes that the objective of the study which was to identify and describe the factors that influence the competency of the nursing staff at MHCC in managing aggressive behaviour in a mentally ill patient, has been achieved, and this is evident in the discussion on the personal and external factors.

5.4.2. Conclusions on objective two of the study

Objective two of the study was to explore and describe the perceptions of the nursing staff regarding their competencies in managing aggressive behaviour in mentally ill patients.

Conclusions for this study on objective two proved that external factors such as role modeling and factors such as clinical practice experience and continuous involvement with patients displaying aggression, developed the nursing staff's competency.

The nursing staff in this study progressed and evolved from being novices, when they started to work at the MHCC to experts in the management of aggression in line with Benner's Novice to Expert Theoretical Model. This study's findings uniquely show that the nursing staff went through a process of growth over the years while working in the mental health wards, learning from others unique ways on how to manage aggression. They developed skills such as communication and de-escalation techniques and sharpened and refined it to the point where they are now competent in the management of aggression and can also teach others. The objective of the study which was to explore and describe the perceptions of the nursing staff regarding their competencies in managing aggressive behaviour in mentally ill patients, was reached, because it provide information, which was not known, with regards to the competency of the registered and enrolled nurses at MHCC.

5.5. RECOMMENDATIONS

Recommendations will be made regarding the possible improvement in nursing practice and nursing research.

5.5.1. Recommendations for nursing practice

It is recommended that on-going training on the management of aggression should be provided. This should be done in the form of in-service training and should include

practical sessions during which the nursing staff can refine their skills. This training should specifically focus on communication skills such as verbal negotiation, appropriate physical restraint techniques and incident reporting, amongst others. All interdisciplinary team members should be involved in the training activities to ensure uniformity in the manner in which the aggression is managed.

Guidelines should be reviewed and be up to date with current developments in the management of aggression. A compulsory induction and orientation program which includes aggression management should be implemented and attended by all new staff members.

It is further recommended that continuous professional development should not only be the responsibility of nurses but management should also contribute by sending nurses for short courses and refresher courses to keep them up to date with the latest techniques of aggression management. This will be in line with Casey, et al., (2017) who asserted that nurses should get on-going refresher courses to keep them abreast of new developments in the management of aggression.

Debriefing sessions for nurses are also recommended because the nursing staff work in challenging environments with difficult mentally ill patients. The participants in this study reported experiences of being assaulted (63.9%) by aggressive mentally ill patients and physical injuries (28.0%) that manifested after assaults. Such debriefing sessions may assist the nurses to discuss their feelings with a professional therapist who would be able to identify sources of stress that can lead to burnout and provide remedial actions. That would make the nurses feel that they are listened to and appreciated more (Sobekwa & Arunachallam, 2015).

5.5.2. Recommendations for nursing research

It is recommended that future research be conducted on:

- The type of aggression most prevalent in acute mental health wards and its impact on nurses. Since violence is encountered or experienced daily and the participants also reported that they had been physically assaulted, research should also be done on the perceptions of nurses and patients on safety in the mental health wards.

- The psychological effect of years of exposure to patient aggression on the nursing staff. Participants in this study worked for as long as 27 years continuously in MHCC.

- The effect of burnout on the attitude of nursing staff dealing with aggressive mentally ill patients. The findings of this study show that participants vary in their agreements concerning the rendering of care to an agitated patient, because of beliefs that it can worsen aggression and put nurses at risk.

5.6. LIMITATIONS OF THE STUDY

The research took place only in the Mental Health Care Centre located in Windhoek and is limited to nurses assigned to that unit. Therefore, the findings of the study cannot be generalised to other mental health wards in the country. Countrywide research is needed; therefore, the researcher will share the results of this study with the

management of WCH to motivate for a bigger study. The study sample comprised of nurses that worked closely together and are familiar with each other, which may have discouraged some participants from expressing their views and opinions openly. Social desirability bias might have influenced the study because the respondents might have presented a good impression of themselves in the manner in which they completed the questionnaire and how they responded during the focus group discussions. To limit social bias, this study employed a combined method in which quantitative was anonymous while qualitative was more personal.

5.7. SUMMARY

This chapter presented a discussion on the findings of the research, conclusions, recommendations and limitations. The researcher believes that the objectives of the study have been achieved, and this is evident in the discussion on the conclusions.

This study aimed at identifying and describing the factors that influence the competency of nursing staff at MHCC in managing aggressive behaviour in mentally ill patients; as well as exploring and describing the perceptions of the nursing staff regarding their competency in managing aggressive behaviour in mentally ill patients. The study provided valuable insight into the factors influencing the competencies of the nursing staff as well as their perceptions regarding their competency in managing aggressive behaviour in mentally ill patients. There was a need for research in this regard, therefore it is expected that this research will contribute to the body of knowledge.

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ANNEXURES

ANNEXURE 1: ETHICAL CLEARANCE CERTIFICATE: UNAM

UNAM
UNIVERSITY OF NAMIBIA

ETHICAL CLEARANCE CERTIFICATE

Ethical Clearance Reference Number: SON /524/2019 **Date: 13 November, 2019**

This Ethical Clearance Certificate is issued by the University of Namibia Research Ethics Committee (UREC) in accordance with the University of Namibia's Research Ethics Policy and Guidelines. Ethical approval is given in respect of undertakings contained in the Research Project outlined below. This Certificate is issued on the recommendations of the ethical evaluation done by the Faculty/Centre/Campus Research & Publications Committee sitting with the Postgraduate Studies Committee.

Title of Project: Factors That Influence The Competency Of Nursing Staff In Managing Aggressive Behaviour In Mentally Ill Patients At Windhoek Mental Health Care Centre, Khomas Region

Researcher: KATRINA BEUKES

Student Number: 8602417

Supervisor(s): *Dr. W. Wilkinson (Main) Ms. A. Shilunga (Co)*

Faculty: School of Nursing
Take note of the following:

(a) Any significant changes in the conditions or undertakings outlined in the approved Proposal must be communicated to the UREC. An application to make amendments may be necessary.
(b) Any breaches of ethical undertakings or practices that have an impact on ethical conduct of the research must be reported to the UREC.
(c) The Principal Researcher must report issues of ethical compliance to the UREC (through the Chairperson of the Faculty/Centre/Campus Research & Publications Committee) at the end of the Project or as may be requested by UREC.
(d) The UREC retains the right to:
(i) Withdraw or amend this Ethical Clearance if any unethical practices (as outlined in the Research Ethics Policy) have been detected or suspected,
(ii) Request for an ethical compliance report at any point during the course of the research.

UREC wishes you the best in your research.

Dr. J.E. de Villiers: Chairperson

Ms. P. Claassen: Secretary

ANNEXURE 2: RESEARCH PERMISSION LETTER: UNAM

CENTRE FOR POSTGRADUATE STUDIES

University of Namibia, Private Bag 13301, Windhoek, Namibia
340 Mandume Ndemufayo Avenue, Pioneers Park
☎ +264 61 206 3275/4562; Fax +264 61 206 3290; URL: http://www.unam.edu.na

UNAM
UNIVERSITY OF NAMIBIA

RESEARCH PERMISSION LETTER

Student Name: Katrina Beukes

Student number: 8602417

Programme: Masters in Nursing Science

Approved research title: Factors that influence the competency of nursing staff in managing aggressive behavior in mentally ill patients at Windhoek Mental Health Centre in Khomas region, Namibia

TO WHOM IT MAY CONCERN

I hereby confirm that the above mentioned student is registered at the University of Namibia for the programme indicated. The proposed study met all the requirements as stipulated in the University guidelines and has been approved by the relevant committees.

The proposal adheres to ethical principles as per attached Ethical Clearance Certificate. Permission is hereby granted to carry out the research as described in the approved proposal.

Best Regards

23/06/17

Name: Dr Marius Hedimbi **Date**
Director: Centre for Postgraduate Studies
Tel: +264 61 2063275
E-mail: directorpgs@unam.na

Centre for Postgraduate Studies
Office of the Director
2017 -06- 23
University of Namibia
UNAM

ANNEXURE 3: PERMISSION LETTER FROM PERMANENT SECRETARY

REPUBLIC OF NAMIBIA

Ministry of Health and Social Services

Private Bag 13198 Windhoek Namibia	Ministerial Building Harvey Street Windhoek	Tel: 061 – 2032150 Fax: 061 – 222558 Email: shimenghipangelwa71@gmail.com

OFFICE OF THE PERMANENT SECRETARY

Ref: 17/3/3 **KB**
Enquiries: Mr. J. Nghipangelwa

Date: 06 November 2017

Ms. Katrina Beukes
University of Namibia
Windhoek

Dear Ms. Beukes

Re: Factors influencing the competence of nursing staff in managing aggressive behaviour in mentally ill patients at Windhoek Mental Health Care Centre, Khomas Region

1. Reference is made to your application to conduct the above-mentioned study.
2. The proposal has been evaluated and found to have merit.
3. **Kindly be informed that permission to conduct the study has been granted under the following conditions:**

3.1 The data to be collected must only be used for academic purposes;
3.2 No other data should be collected other than the data stated in the proposal;
3.3 Stipulated ethical considerations in the protocol related to the protection of Human Subjects should be observed and adhered to, any violation thereof will lead to termination of the study at any stage;
3.4 A quarterly report to be submitted to the Ministry's Research Unit;
3.5 Preliminary findings to be submitted upon completion of the study;

3.6 Final report to be submitted upon completion of the study;

3.7 Separate permission should be sought from the Ministry of Health and Social Services for the publication of the findings.

Yours sincerely,

PERMANENT SECRETARY
MINISTRY OF HEALTH & SOCIAL SERVICES

Andreas Mwoombola (Dr.)
Permanent Secretary

"Your Health Our Concern"

ANNEXURE 4: INFORMATIONAL LEAFLET AND WRITTEN INFORMED CONSENT FORM

PARTICIPANT INFORMATION LEAFLET AND INFORMED CONSENT FORM

Title of the Study:
Factors that influence the competency of nursing staff in managing aggressive behaviour in mentally ill patients at Windhoek Mental Health Care Centre, Khomas Region, Namibia.

Study Researcher: Katrina Beukes **Contact number:** + 264 81

Dear Participant
You are invited to take part in the research project as you meet the criteria for study inclusion. Kindly take some time to read through the information presented here which will explain the details of this project. Feel free to ask the researcher any questions about any part of this project that you do not fully understand.
Thank you for agreeing to participate in this research study. Your opinion will be a valuable asset in this research project.

What is this study all about?
This research study forms part of my Masters Research Project entitled: **Factors that influence the competency of nursing staff in managing aggressive behaviour in mentally ill patients at Windhoek Mental Health Care Centre, Khomas Region, Namibia.** The purpose of this study is to determine the factors that influence the competence of nursing staff in managing aggressive behaviour in mentally ill patients at Windhoek Mental Health Care Centre.

What will be expected from you to do?
Each participant will be required to complete the supplied questionnaire by answering **ALL** questions. It will take you approximately 15 – 20 minutes to complete the questionnaire. After completion put the questionnaire in the questionnaire box placed at Room 5 Outpatients Department.

What are the benefits of this research?
There is no direct benefits attached to participating in this research study. However the results will create awareness of what factors have an impact on the proficiency of nursing staff in managing aggressive behaviour in mentally ill patients and will also assist in future planning of formal education and in-service training.

What are the risk of this research?

There are no known risks associated with participating in this research project. However all information will be treated with confidentiality, anonymity and privacy and will be safely stored at the University of Namibia.

Will you be able to stop participating at any time?

You are under no obligation to participate in this research study and your participation is entirely voluntary. You have the right to withdraw at any stage and your decision will not disadvantage you in anyway. If you decide not to participate, your decision will not in any way affect you negatively.

If you have a question:

If you need more information about the research study or any matter that are directly or indirectly associated with it, please contact me: **Study researcher:** Mrs K. Beukes (Cell No: 0812342713).

Should you have any concerns regarding this research and your rights as a research participant or if you wish to report any problem you experienced related to the study, please contact:

Research supervisors: Dr W. Wilkinson (UNAM)
Tel. No.: 061 – 206 3825

DECLARATION BY PARTICIPANT AND WRITTEN INFORMED CONSENT FORM

By signing below, I hereby agree to participate in a research study titled: **Factors that influence the competency of nursing staff in managing aggressive behaviour in mentally ill patients at Windhoek Mental Health Care Centre, Khomas Region, Namibia.**

I declare that:

- I have read this information and consent form and it is written in a language with which I am fluent and comfortable.
- I have had a chance to ask questions and all my questions have been adequately answered.
- I understand that taking part in this study is **voluntary** and I have not been forced in any way to take part.
- I may choose to leave the study at any time and will not be penalized or prejudiced in any way.
- I understand that this research projects' purpose is not necessarily to benefit me personally.
- I understand that this consent form will not be linked to the questionnaire and that my responses and answers will remain confidential.

Signed at (*place*) ..... on (date) .....

Signature of Participant: .....

DECLARATION BY STUDY RESEARCHER

I Katrina Beukes declare that:

- I explained the information to the participant before signing the consent form and the participant understand and agreed to participate.
- I encourage him/her to ask questions and took adequate time to answer the queries.
- I am satisfied that he/she understands all aspects of the research as discussed above.

ANNEXURE 5: QUESTIONNAIRE

Title: Factors that influence the competency of nursing staff in managing aggressive behaviour in mentally ill patients at the Windhoek Mental Health Care Centre.

Instructions: Thank you for participating in this study. Kindly read the following instructions and answer all questions. There is no right and wrong answers to this questionnaire. Please do not leave any questions unanswered. On completion of the questionnaire, please drop it in the provided box marked *questionnaire box* placed in Room 5 Outpatient Department (OPD).
Unique ID No.: .....

SECTION A: Demographic and Work-related Data:

Instructions: Please read the questions carefully, before answering. Tick (√) only one most appropriate answer for each question.

1. Gender: 1.1 Male: ☐ 1.2 Female: ☐

2. Age: .....

3. Current rank: 3.1 Senior Registered Nurse: ☐ 3. 2 Registered Nurse : ☐
   3.3 Enrolled Nurses: ☐

4. Highest education: 4.1 Post Graduate Diploma: ☐ 4.2 Degree: ☐
   4.3 Diploma: ☐ 4.4 Certificate: ☐

5. Duration of period employed at the Mental Health Care Centre:
   5.1 Years: ..... 5.2 Months: .....

6. How often do you encounter or experience violence at your workplace:

   6.1 Daily: ☐ 6.2 Weekly: ☐ 6.3 Monthly: ☐ 6.4 Rarely: ☐

   6.5 Never: ☐

7. Were you previously assaulted by a patient: 7.1 Yes: ☐ 7.2 No: ☐

8. If yes did you sustain any physical injuries: 8.1 Yes: ☐ 8.2 No: ☐

9. Can you physically restrain or hold down an aggressive patient: 9.1 Yes: ☐
   9.2 No: ☐

10. Were you trained in the management of an aggressive patient: 10.1 Yes: ☐
    10.2 No: ☐

SECTION B: Personal factors that influence competency in the management of aggression

1. Theoretical Knowledge of Aggression

1.2 Description and Phases of Aggression:

Circle the best answer for each of the following questions:

1.2.1 A fist fight erupted between two patients without any provocation and caused serious injury. This type of behaviour can be classified as:

1. Anger
2. Verbal aggression
3. Physical aggression
4. None of the above

1.2.2 A patient was brought into the ward while shouting and swearing at his relatives who accompanied him. This type of behaviour can be classified as:

1. Acting out
2. Instrumental aggression
3. Verbal aggression

1.2.3 A client is pacing in the corridor with clenched fists and an upset face. He is yelling and swearing. Which phase of the aggression cycle is he in?

1. Anger
2. Triggering
3. Escalation
4. Crisis

1.2.4 The face-down restraint technique means that the patient is:

1. Hold down on the floor with the face looking forward away from the nurse and the patient is laying on his/her chest and stomach.
2. Hold down with the face looking upwards at the nurse and is laying on his/her back.
3. Kneels on the floor looking away from the nurse with the arms pinned behind the back.

1.3 Signs of Aggression:

Mark with a cross (×) all that apply to indicate when a patient shows clear signs of aggression:

1.2.1 ☐-----patient maintains good eye contact.

1.2.2 ☐-----Has an angry facial expression.

1.2.3 ☐-----He/she is easily irritated and argumentative

1.2.4 ☐-----Restless.

1.2.5 ☐----Tense body posture and tightened jaw

1.2.6 ☐---Talks with a loud and harsh voice

1.4 Causes of aggression:

Please mark with a cross (×) on the number (indicated as 5 most likely, 4 likely, 3 uncertain, 2 unlikely, 1 least unlikely) displayed on the scale, to indicate how likely you consider a patient to be aggressive and be involved in fights with others:

1.3.1. Patients who hears voices commanding them to hurt others.

(Mostly) o---------o---------o--------o---------o (Least)
5 4 3 2 1

1.3.2. Patients known with previous history of violence.

(Mostly) o---------o---------o--------o---------o (Least)
5 4 3 2 1

1.3.3. Patients who are place in a ward where locked doors limit their movements.

(Mostly) o---------o---------o--------o---------o (Least)
5 4 3 2 1

1.3.4. Patients who were admitted as involuntary.

(Mostly) o---------o---------o--------o---------o (Least)
5 4 3 2 1

1.3.5. When requests such as demands to be discharged or to smoke are refused.

(Mostly) o---------o---------o--------o---------o (Least)
5 4 3 2 1

1.3.6. Patients with substance intoxication.

(Mostly) o---------o---------o--------o---------o (Least)
5 4 3 2 1

2. Clinical Skills in the management of an aggressive patient:

2.1 Skills in Prevention of Aggression:

Please tick (√) one box for each of the statements below to indicate the degree to which you consider the statements listed below to be important for the prevention of aggression:

Statements	Very important	Important	Neutral	Low importance	Not important at all
	5	4	3	2	1
2.1.1. Find out what helped the patient to calm down when he/she was previously aggressive.					
2.1.2. If possible remove the aggressive patient from other patients and bystanders.					
2.1.3. Speak to the patient in a calm and controlled voice to avoid escalation (increase) of aggression.					
2.1.4. Listen attentively to what patient has to say to prevent escalation of aggressive behaviour.					
2.1.5. Assist patient with his/her current problem to show concern and to manage aggressive behaviour.					
2.1.6. Aggression may be prevented if					

Statements	Very important	Important	Neutral	Low importance	Not important at all
	5	4	3	2	1
the nurse does not argue with or threaten the patient with seclusion.					

2.2 Medication Administration Skills:

Please tick (√) one box for each of the statements below to indicate the degree to which you consider the statements listed below to be important to manage an aggressive patient:

Statements	Strongly agree	Agree	Uncertain	Disagree	Strongly disagree
	5	4	3	2	1
2.2.1. Medication is an effective approach in managing an aggressive patient.					
2.2.2. When the patient become aggressive, he/she may be given the option to take oral medication to calm down.					
2.2.3. Sedation of an aggressive patient has held no risk for the health of the patient.					

2.3 Physical Restraint and Seclusion Practices:

Please tick (√) one box for each of the statements below to indicate the degree to which you consider the statements listed below to be important when managing an aggressive patient who is secluded:

Statements	Very important	Important	Neutral	Low importance	Not important at all
	5	4	3	2	1
2.3.1. The use of force is the most effective method to restrain an aggressive patient.					
2.3.2. Working together as a team, is required when physically restraining an aggressive patient to be able to sedate him/her.					
2.3.3. An effective way to deal with an aggressive patient is to put him/her in the seclusion room.					
2.3.4. Before an aggressive patient is secluded, a body search for hazardous objects should be done.					

3. Attitudes towards the management of aggression

Please tick (√) one box for each of the statements below to show how much you agree or disagree:

Statements	Strongly agree	Agree	Uncertain	Disagree	Strongly disagree
	5	4	3	2	1
3.1. I believe that various meaningful					

Statements	Strongly agree	Agree	Uncertain	Disagree	Strongly disagree
	5	4	3	2	1
ward activities can be used to reduce agitation and potential aggression.					
3.2. I believe that nurses should only intervene when the patient beats up other patients.					
3.3. I believe nurses become easily angry with an aggressive patient if they had been assaulted previously.					
3.4. I believe that nurses who keep on giving attention to an agitated patient may worsen aggression and put other nurses at risk.					
3.5. I believe that nurses do not need to intervene with an aggressive patient because he/she will calm down by themselves.					
3.6. I believe that a therapeutic one-to-one relationship between the nurse and the patient can reduce the incidence of patient aggression.					

SECTION C: External Factors that influence the competency of nursing staff: Please tick (√) one box for each of the statements below to show how much you agree or disagree:

Statements	Strongly agree	Agree	Uncertain	Disagree	Strongly disagree
	5	4	3	2	1
1. Role modelling in handling aggressive patients by a senior nurse may enable a junior nurse to promptly intervene when a patient become aggressive.					
2. Clinical supervision may assist the nurse to manage aggressive patients with greater efficiency.					
3. Guidelines on the management of patient aggressive behaviour may assist the nurse in gaining crucial skills needed to deal with aggression.					
4. Mentoring may prepares the inexperienced nurse to handle aggressive episodes of patients more effectively.					
5. Staff training on the prevention and management of aggression results					

Statements	Strongly agree	Agree	Uncertain	Disagree	Strongly disagree
	5	4	3	2	1
in effective management of patient aggressive behaviour.					
6. Experience gained through continuous involvement with an aggressive patient, teaches the junior nurse valuable skills to manage aggression and reduces fear.					

Thank you very much for your time. Your cooperation is highly appreciated!

ANNEXURE 6: CONSENT FORM: FOCUS GROUP DISCUSSIONS

INFORMED CONSENT INFORMATION SHEET

Dear Participant
Thank you for agreeing to participate in this research study. Your opinion will be a valuable asset in this research project. This research study forms part of my Masters Research Project entitled:

Factors that influence the competency of nursing staff in managing aggressive behaviour in mentally ill patients at Windhoek Mental Health Care Centre in Khomas Region

Please be advised that you are under no obligation to participate in this research study and your participation is voluntary. You have the right to withdraw at any stage and your decision will not disadvantage you in anyway.

Your participation in this research study will be through participation in a focus group discussion. This will be arranged to bring the least interruption in your daily activities. There is no direct benefits attached to participating in this research study. The information obtained and also the tape recordings will be treated as confidential and will be safely stored at the University of Namibia.

Your information and responses shared during the research will be kept anonymous during the focus group discussions. The focus group discussions will be audio-recorded with your consent to ensure that no comments and opinions are missed.
No information identifying the respondents is required to ensure that the respondents' identities are protected.

If you need more information about the research study or any matter that are directly or indirectly associated with it, please contact me or my research supervisors:
Study researcher: Mrs K. Beukes (Cell no: 0812342713)
Research supervisors: Dr W. Wilkinson at UNAM: Tel. No. 061 – 206 3825.

WRITTEN INFORMED CONSENT FORM

I hereby agree to participate in research regarding the factors that influence the competence of nursing staff in managing aggressive behaviour in mentally ill patients at Windhoek Mental Health Care Centre in Khomas region.

I understand that I am participating freely and without being forced in any way to do so. I also understand that I can stop this focus group discussions at any point should I not want to continue and that this decision will not disadvantage me in any way.
I understand that this research projects' purpose is not necessarily to benefit me personally.

I have received the telephone number of a contact person, should I need to speak about any issues which may arise in the focus group discussions.

Participant No: _____ Group No: _____

Signature of Participant: _____ Date: _____

I hereby agree to the tape recording of my participation in the study.

Signature of Participant: _____ Date: _____

ANNEXURE 7: FOCUS GROUP DISCUSSION GUIDE

Introductory question

I am just going to give you a couple of minutes to think about your perception regarding the management of aggressive behaviour in mentally ill patients.

Guiding Questions: Let's start the discussion.

Competency	
Principle Questions	Examples of Probes
1. What do you understand under the concept competency?	**Listen for and probe:** 1. Explanations and meanings of competency.
2. How will you describe a nurse who is competent in handling an aggressive patient?	**Listen for and probe:** 1. Knows patient well (history and symptoms) to intervene early to prevent aggression. 2. Able to identify patient triggers and early warning signs. 3. Ability to assess physical environment correctly. 4. Good communication techniques e.g. calm and low tone of voice, active listening. 5. Interpersonal skills e.g. calm and friendly manner, showing interest, being open. 6. Attitude e.g. non-judgmental (pleasant and approachable), open and friendly body posture, non-threatening approach. 7. Ability to recognize when to swiftly intervene and efficiently physically handle patient (restraint, sedation and seclusion).
Own Competency	
Principle Questions	Examples of Probes
3. How do you perceive your own ability to manage aggressive patients?	**Listen for and probe:** 1. Specific skills learnt and acquired through clinical experience, to handle an aggressive patient.
4. How do you think your own competency has developed?	**Listen for and probe:** 1. Practical experience and continuous involvement with aggressive patients.

2. Role modelling by experienced nurses in the unit.
3. Knowledge about aggression e.g. sharing knowledge with nurses and other professionals, enlarging knowledge continuously through self-development and training.
4. Interpersonal skills e.g. active involvement in team discussions.
5. Management skills e.g. coordinating the team while physically handling the patient, assertiveness skills.

Concluding question

- Of all the things we've discussed today, what would you say are the most important issues you would like to express regarding the management of aggressive behaviour in mentally ill patients.

Conclusion

- Thank you for participating and sharing your thoughts and opinions with me. This has been a very successful discussion.
- Your opinions will be a valuable asset to this study.
- We hope you have found the discussion interesting.
- If there is anything you are unhappy with or wish to complain about, please speak to me.
- I would like to remind you that any comments featuring in this report will be anonymous.
- Before you leave, please hand in your completed personal details questionnaire.