

UNIVERSITY OF KWAZULU- NATAL

**The Lived Experiences of Patients admitted to an Intensive Care Unit in a
Public Hospital in Ugu District**

MARCH 2015

PILISWA TSHOKOVU

202520580

**The Lived Experiences of Patients admitted to an Intensive Care Unit in a
Public Hospital in Ugu District**

By

PILISWA TSHOKOVU

202520580

Dissertation submitted

to the

School of Nursing and Public Health

University of KwaZulu-Natal

In partial fulfillment of the requirements
for course work Master's degree in Nursing

Master of Nursing (Critical Care & Trauma)

March 2015

Supervisor: Prof Petra Brysiewicz

DECLARATION

I declare that this research; “The lived experiences of patients admitted to an intensive care unit in a public hospital in Ugu district” is my own work.

It is being submitted for the Course work Master’s Degree in Critical Care and Trauma Nursing at the University of KwaZulu-Natal, Durban, South Africa. It has never been submitted for any other purpose. All sources of information that have been utilised and quoted have been acknowledged by complete reference.

Piliswa Tshokovu

Date.....

Prof Petra Brysiewicz

Date.....

DEDICATION

This dissertation is dedicated to the people of KwaZulu-Natal, with love.

ACKNOWLEDGEMENTS

Firstly, my gratitude goes to God Almighty, through whom all things are possible. The work was not easy, but He helped me endure the difficulties involved.

I sincerely thank my husband, Nicholas Ceba, and my children, Ngemihle, Yolanda and Zizo, who patiently supported me in all ways. I thank you for your love and understanding; without you I would not have come this far.

I am greatly indebted to my research supervisor, Petra Brysiewicz, for her words of encouragement and emotional support. Her advice and guidance were invaluable throughout the duration of the study. I am also indebted to the staff of the Discipline of Nursing.

To the management and staff of the hospital, thank you for allowing me to conduct my research. To the participants involved in this study, I express my endless gratitude for your cooperation.

Thank you Catherine Eberle for editing this study.

It is also with pleasure that I acknowledge the encouragement from my friends who I have not mentioned personally, but who have offered assistance in a variety of ways. THANK YOU.

Lastly I am thankful for the financial assistance of the National Research Foundation (NRF, South Africa) for having sponsored my studies.

ABSTRACT

Introduction: During their stay in the Intensive Care Unit (ICU) most patients experience a lack of privacy, sleep disturbances, noise, pain and stress. Patients need continuous close monitoring in ICU.

Purpose: The purpose of this study was to describe the lived experiences of patients admitted to an intensive care unit in a public hospital in the Ugu District.

Methodology: A phenomenological approach was used to describe the lived experiences of patients admitted to an ICU in a public hospital in Ugu District. Two unstructured interviews were conducted with each participant; an initial and a verifying interview, each lasting approximately 15-30 minutes. The researcher applied the principle of saturation and a total of 6 participants took part in this study.

Findings: The findings showed that the participants had positive and negative recollections of their stay in the ICU. The experiences indicated that they viewed the ICU as a hostile environment which was not conducive to meeting their needs while they were admitted to the ICU. Many of the participants experienced bad dreams which is common in critically ill patients admitted to an ICU. The findings showed that the various religious and cultural beliefs of the patients came into conflict with the functioning of the ICU environment and that this caused anxiety in the participants. Although the participants found certain of the procedures painful, some reported that these had been helpful in providing relief, as they were able to breathe more easily after the removal of secretions. The findings showed that, at the time of their transfer out, participants were not given much information concerning their discharge from the ICU to the ward.

Recommendations: A number of recommendations were proposed for the ICU staff, for education and for further research in an attempt to focus more on patients' experiences.

Conclusion: This study allows the voices of the patients to be heard so that ICU staff can pay special attention.

Keywords: Qualitative research, phenomenology, lived experiences, ICU patient, ICU.

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CHAPTER ONE

INTRODUCTION

1.1 Background to the study

According to Rodriguez, (2005) intensive care units (ICUs) are likely to be the most complex and stressful units in any hospital. In general, in an ICU environment, sounds of different monitors and alarms of different intensities can be heard, as well as the beeping of many different machines, flashing lights of different colours and other continuous sounds and activities. In addition, the language of the staff sounds complicated and technical. The staff working in the ICU environment consider this to be 'normal and usual', but these sounds and activities may lead to feelings of worry and stress for patients, who are often not able to rest or sleep, impacting on their protection and recovery. Overall, the ICU environment is a frightening and stressful environment for patients because they are connected to a variety of machines and tubes, due to the noise of the monitors and other equipment, the conversations of staff and the continuous bright lights and constant activity. This creates a sense of being exposed in patients because of their physical and emotional dependency, lack of information and the depersonalised care they receive which promotes suspicion and stress (Morton, Fontaine, Hudak and Gallo, 2005). Morton et al. (2005) mention that Florence Nightingale emphasised holism in nursing, that is, caring for the whole person. The term 'caring' implies conditions of faith that allow the patient being cared for to use the help that is offered to meet his/her needs, including sleep and rest. In the modern ICU environment, with such technological advancement, nurses may struggle to create a healing environment where they are able to meet the patients' physical and psychological needs.

The various patients admitted to ICUs are generally much the same worldwide. They are critically ill patients who need ventilator support, who have cardiac or respiratory problems. They may also have electrolyte imbalances which require close monitoring as these levels are being corrected, or serious infections which require specialised ICU care (California Pacific Medical Centre, 2004-2008). These patients need constant close monitoring as well as specialist nursing, and the suggested ratio is usually one nurse to one patient (Field, Prinjha and Rowan, 2008). Admissions to

ICUs often occur as a result of the complications of chronic conditions such as cardiac, diabetic and renal failure (Waiker, Liu and Chertow, 2008). In South Africa, however, the statistics of these patients differ, because many patients are admitted to ICUs as a result of trauma and the HIV/AIDS epidemic (Mathivha, 2002). These patients are either too ill to be looked after in general hospital wards, or have an illness which requires close observation, monitoring and support from specialist equipment which is only available within an ICU.

When patients are admitted to an ICU they carry their beliefs with them and these can have an effect on the functioning of the hospital environment (Gwala, 1993; Mzimkhulu and Simbayi, 2006; Davidson, Boyer, Casey, Chavez and Walden, 2008). The researcher experienced patients who refuse to have operations because they don't believe in western medication, they are used to traditional treatment which has a negative impact on their recovery. Culture includes what they think, say, do, believe and make, and is like a learned guide for living (Muecke, Lenthal, and Linderman, 2011). Culture defines how masculinity or femininity is perceived, what clothes are worn, attitudes toward the dying and the sick, mating behaviour, attitudes toward odours and how the aged and disabled are treated. Cultural norms and social rules regulate whether a person will be accepted by others or will be isolated, whether the sick are accepted by society or whether they are discriminated against (Cassell, 2004). According to Carteret (2011) and Dhingra (2008), language barriers and cultural influences can affect the way in which a person expresses pain, which can make it difficult for health care professionals to effectively evaluate the patient's pain. For some elderly Chinese patients, stoicism and fatalism can create barriers to effective pain management. Fatalism, as influenced by Buddhist and Confucian beliefs, proposes that pain should be borne, as it could show the way to spiritual growth (Carteret, 2011).

Patients' experiences are triggered by factors within the ICU environment such as noise from machinery, alarms, nurses and visitors, as well as the physiological processes of illness such as pain and their unmet needs. Patients have reported that they found the sounds of the different machines disturbing and that the noises made by hospital personnel were loud and irritating. They have also reported that they found it difficult to lie in the same position for a long time and experienced thirst and

pain. Patients having negative intensive care experiences identify their experiences as 'scary'. These greatly affect their emotional state and sleep patterns. In a study conducted in South Africa by Ehlers, Moleki and Watson (2013) on factors contributing to sleep in a multi-disciplinary intensive care unit, it was found that such patients felt they had been subjected to physical and emotional stress.

A study undertaken by Demir, Korhan and Khorshid (2013) in Turkey revealed that the use of patient monitoring and advanced technology in intensive care units (ICUs) has increased the treatment volume for patients requiring complicated care due to life-threatening diseases. Until recently, it was considered that ICUs were successful in saving the lives of such patients, but it is now widely accepted that patients hospitalised in an ICU environment are exposed to emotional stress. The physical and psychological effects of spending time in an ICU have become known by the clinical term 'intensive care syndrome' (ICS). Disturbances, orientation disorders, hallucinations and sleep disorders have been reported by patients with ICS.

Concurring with these authors, Granja, Lopes, Moreira, Dias, Costa-Pereira and Carneiro (2005) and Morton et al.'s (2005) study of patients' recollections of their experiences in an ICU in Portugal, found that some patients had negative memories of their stay in the ICU. Patients reported that they had felt nervous on waking up and becoming aware of all the equipment and machines. Seventy-five percent (75%) reported stressful experiences of tracheal tube aspiration and nasogastric tube insertion. Along the same lines, a study on patients' ICU experiences following transfer from an ICU in Northern Ireland, by Strahan and Brown, (2005) found that patients reported the feeling of being trapped and tied down by equipment.

As found by Magnus and Turkington (2006), effective communication by the patient regarding his/her condition will assist the nurse to respond accordingly, thereby meeting the patient's needs. However, as Morton et al. (2005) state, useful conversation with severely ill patients can be extremely challenging and frustrating for different reasons. The presence of endotracheal tubes prevents verbal conversation, and patients' physiological status and treatment may change their cognitive functions, making useful conversation difficult. Magnus and Turkington (2006) compared how communication was perceived from the point of view of the health-care teams as opposed to that of the patients who were on mechanical

ventilators in the ICU, and found that, while the nurses felt frustrated at the patients' inability to communicate verbally, the patients felt lonely and isolated. Magnus and Turkington (2006) concluded that using communication aids such as alphabet charts or a board, would be helpful for both groups. They pointed out, however, that patients who were unconscious could not convey their needs using such techniques and would therefore need special support.

In a study by Sifflet, Young, Nikoletti and Shaw (2007) they described the pain the patients experience during procedures. Findings showed that patients in intensive care units experience a range of complex and life-threatening conditions which are often associated with severe pain and discomfort, and that considerable pain may be experienced despite the presence of deep sedation. The causes of pain in the ICU are multi-factorial, although tissue damage from trauma and surgical incisions are the most common. In addition, anxiety, fear and uncertainty have also been found to contribute to the patients' experiences of pain.

Physical trauma and severe illness involve the entire person and his/her whole family (Bowers, 2004; Engström and Söderberg, 2007). Chaboyer (2006) explains how, when a person is severely ill, both the person and his/her family become exposed to experiences that are strange to them. The private zones and personal integrity of the patients decrease as they become too sick to take care of themselves. Most patients thus rely totally on caring healthcare employees to satisfy their basic human needs. Wallis (2005) discusses the 'lack of control' that patients and family members feel when a devastating injury or sickness has happened. Therefore, in the first phase, together with taking control of the situation, it is important that nurses create a faithful relationship in order to defend the self-respect of patients and make them feel protected and secure. However, as the patients get well, the caring nurse allows patients and their families other options and thereby more control.

A study by Engström (2008) highlights the importance of family in the ICU environment. This author found that, in cases where critically ill patients are unable to speak because of tubes in their throats, it was easier for close relatives to interpret their needs than nursing staff. Close relatives could better understand what they were trying to say and could see if they were in pain or were tired. This could then be communicated to the staff. The study found that people who had been critically ill

were aware that close relatives had been present during their illness, and that their presence had made them feel secure, but when close relatives were absent, they felt alone, that they had lost control, were trapped in their beds and could die. While critically ill, the patients had felt exposed, worn out, ill and unable to speak, and therefore needed the reassurance of close relatives to make them feel protected. They felt that their close relatives cared about them and they did not want to fail them by giving up. The presence of close relatives gave them back their will to live when they felt like giving up.

Visits by close relatives should be made easier by the nurses because such relatives generally motivate the severely ill patient to stay alive (Engström and Söderberg, 2007). Although nurses in the ICU should be knowledgeable about the technology they work with, Wikström, Cederborg, and Johanson (2007) argue that it is more important for them to get to know the patients and take care of their relatives. Söderstrom et al (2006) concur that the nurses in ICUs should arrange the care and manage critical situations. Caring in the ICU, therefore, includes the nurses' skills in terms of interactions with the patients while providing physical attention and mental support. A nurse is an important person in terms of providing faith and protection. Badly injured patients entering the crisis unit and later admitted to an ICU may be slightly, not fully conscious, and may, therefore, have only incomplete memories of the event. In this often life-threatening situation, the goal is to evaluate and to keep the patients stable with immediate effect.

A study by Chiu and Chan (2007) on the stress and coping of Chinese families in Hong Kong, pointed out that high levels of stress were experienced by females, those with lower educational achievement and those whose relatives were admitted to an ICU unexpectedly. These findings were also reflected in a review of literature by McAdam and Puntillo (2009) which reported that being a spouse, female and child significantly increased the risk of symptoms of worry, depression and post-traumatic stress disorders. Other risk factors reported were low education status, the patient's unplanned admission to the intensive care unit and incomplete information in relation to the patient's condition. The ICU can be stressful for both patients and their families. Even if discharge is a good idea in terms of physical recovery, patients may not be psychologically ready to be transferred to the general wards.

Many patients experience high anxiety during movement from ICUs to the wards. Admission to the ICU can be very stressful for the families, but the sense of security provided by an ICU is reassuring (Chaboyer, Thalib, Alcorn and Foster, 2007). The transfer of patients from an ICU to a ward is a normal event, and is an accepted part of the daily work of an ICU.

During the transfer process, patients are not normally asked, nor are they given an opportunity to air their needs which they may experience as stressful. It is the responsibility of the intensive care nurses to help with the coping process by recognising the needs of the patients and making individual discharge plans for them (Wu and Coyer, 2007). The discharge of patients from the ICU to the wards can be explained as part of the continuity of hospital care that prepares the patients for their return to the community. However, due to insufficient procedure and training, the ability of the staff to recognise and meet the needs of the patients and their families is limited (Wu and Coyer, 2007). Once transferred to the general wards, ICU patients may be the sickest patients in the ward, and may need close observation and continuous nursing care. Some patients experience physical impairments such as weakness of the muscles, difficulties in eating, swallowing, chewing, coughing, movement of the upper extremities, toileting and mobilising. Patients may experience anxiety, panic attacks, and, on some occasions, signs and symptoms of acute post-traumatic anxiety disorder. The patient-to-nurse ratio in the wards does not always accommodate the complicated emotional and physical needs of these patients. As a result, the patients may take a long time to gain the goal of self-care status in this setting, additionally complicating this initial change and affecting the next major change to the home environment (Chaboyer, James and Kendall, 2005). Some studies indicate that patients who have been discharged from an ICU and their families would opt for ICU staff to visit them in the wards for a certain period of time after discharging them (Deeny and McKinney, 2002; Straham and Brown, 2005). According to this study (Prinjha, Field and Rowan, 2009), follow-up services assist in improving transfer anxiety among patients and improving communication between the wards and the ICU. It also helps in identifying early warning signs if the condition of a patient is worsening. This current study deals with participants from a multicultural society and is a phenomenological study which allowed for an in-depth

exploration of their experiences. It is for these reasons that the researcher decided to explore the experiences of patients who are admitted to an ICU.

1.2 Problem statement

According to the researcher's experiences and observations while working in an ICU, patients are continuously exposed to nurses' conversations and noises from various sources (alarms and ventilators). The researcher also noticed that the inability to communicate creates frustration, fear and stress for the patients and thus wanted to explore this further. To provide effective nursing care one has to understand the expectations and needs of the individual patients. Patients in an ICU are nursed with very little privacy. They are in beds in rows in the unit, where they may be able to see and hear everything that is going on around them. For the patients, this can be extremely frightening, and may leave them with disturbing memories of their time in the ICU. Many studies have been done on patients' experiences while in an ICU, and a common feature of these studies was the effect of the physical environment on patients (Strahan and Brown, 2005; Morton et al., 2005; Eliassen and Hopstock, 2011; Aro, Pietila and Vehviläinen-Julkunen, 2012). Most of these studies were conducted internationally, with only a few being undertaken in the context of South Africa, which has diverse socio-cultural groups as well as resource constraints (Jordan, Van Rooyen and Strumpher 2002; Ehlers et al., 2013). Different cultural groups have different beliefs and various cultures have different coping mechanisms for illness and admissions to hospital, and need different kinds of support in times of critical illness. The act of hospitalisation itself has different psychological implications for patients from different cultural groups (Gwala, 1993; Davidson et al., 2008).

According to Kaplow and Hardin (2007), cultural awareness is described as the method by which nurses learn to identify and respect the cultural beliefs and principles of others, while, at the same time, acknowledging their own personal judgement and values. Many studies have been conducted in various countries which have looked at the experiences of different cultural groups in an ICU (Gwala, 1993; Mzimkhulu and Simbayi, 2006; Davidson et al., 2008; Carteret, 2011; Van Niekerk, 2012). The common features of experiences in these studies were related to the psychological, environmental and physiological disease processes.

In a study conducted by Mazanec and Tyler (2003) on cultural considerations in non-Western cultures, it was found that the families of critically ill patients prefer to receive the relevant medical information first, and then to explain that information to the patient, regardless of the patient's age. The reasons mentioned by family members for this include firstly, the fear that the truth will cause the patient to lose hope, and secondly, their need to protect the patient from bad news. Conflict occurs when the beliefs and wishes of family members differ from those of the patient, the team members, or both. If the patient wishes, and is capable of understanding, full exposure, his wishes should be respected and the matter discussed with family members who may have different opinions. According to the constitution of South Africa (Act no 108 of 1996) which proclaims the Patients' Rights Charter, every patient has a right to be given full and accurate information about the nature of the illness, diagnostic procedures and proposed treatment and also the cost involved. Legally, a patient's right to accurate information is included in the Patient Self-Determination Act (Mazanec and Tyler, 2003), which doesn't specifically address age. Some patients in China place value on suffering. These patients believe suffering before death is a way to answer for past sins, and that if they don't suffer while alive, they will suffer in death. Such patients may not want to take medication to relieve pain, and the arrangement of emotional support, rather than pain relief for these patients may be the respectful choice. It is important, though, to make sure that such a patient is aware of pain relief alternatives. Also, staff could call upon a spiritual counsellor familiar with the patient's religion to help find out whether the patient's expressed need to suffer is not a misinterpretation (Mazanec and Tyler, 2003).

1.3 Purpose of the study

The purpose of this study was to describe the lived experiences of patients who were admitted to an ICU in a state hospital in the Ugu district in KwaZulu-Natal, South Africa.

1.4 Research objective

The research objective of this study was to describe the lived experiences of patients who were admitted to an ICU.

1.5 Research questions

- What were the positive experiences of patients admitted to an ICU?
- What were the negative experiences of patients admitted to an ICU?
- Are there any recommendations for the future?

1.6 Significance of the study

There seems to be limited data available on the experiences of patients admitted to intensive care units (ICUs) in S.A. Most of these studies (Strahan and Brown, 2005; Rattray and Hull, 2007; McAdam and Puntillo, 2009) were conducted internationally, with a few being carried out in South Africa (Gwala, 1993; Jordan et al., 2002; Ehlers et al., 2013). This study will thus add information to the existing body of knowledge and provide a deeper understanding of patients' experiences when admitted to an ICU in the context of S.A. The study deals with a multicultural society and is a phenomenological study which allowed an in-depth exploration of experiences. It may enable health professionals to become more sensitive to the needs of critically ill patients in these unique circumstances. The findings may also help to provide recommendations to training institutions to take the experiences of patients in ICUs into account when designing their courses, in order to promote holistic care and a favourable ICU environment for patients. Nurse managers and other policy-makers may use the findings to draft policies and guidelines for the care of patients. This study may also form the baseline for other research that focuses on patients' experiences in an ICU environment.

1.7 Definition of operational terms

1.7.1 Intensive care unit (ICU)

An intensive care unit is a specialised section of a hospital designed for the continuous monitoring and management of patients with severe and life-threatening conditions from within the hospital and catchment area. These units contain resuscitative equipment and are staffed by nurses trained and experienced in life-threatening health emergencies.

1.7.2 Patient

For the purpose of this study, a patient refers to any person (18 years or older) admitted to an ICU due to various medical or surgical reasons.

1.8 Conclusion

The background to the study, as well as its significance and problem statement were presented. The purpose and objectives of this study were also discussed.

In the next chapter a discussion of the literature related to the study will be presented.

CHAPTER TWO

LITERATURE REVIEW

2.1 Overview of national and international intensive care units

The practice of critical care medicine has spread to every country in the world over the past fifty years. Some aspects of caring for critically ill patients are universal, while others are particular to a specific country (Murthy and Wunsch, 2012). Universally, the ICU beds are insufficient, especially in public hospitals and there is also considerable variation in the allocation and distribution of critical care services across the world given that 70% is rural (Naidoo, Singh, and Lalloo, 2013).

2.1.1 Profile of the patients admitted internationally and nationally

South Africa (S.A.) is a land of disparities, a situation that originates from its political history. The majority of hospitals and health care facilities serve a wide range of communities, treating patients from wealthy environments as well as those living in poverty in shacks. Regardless of having an advanced healthcare structure, the disease patterns in S.A. reflect those of a less developed country (Mathivha, 2002). According to a study by de Beer, Brysiewicz and Bhengu, (2011) in South Africa, patients admitted to ICUs are normally males (65%), and trauma (motor vehicle collisions, gunshots and stabbings) accounts for 53% of admissions. Other reasons for admission are medical (e.g. sepsis, metabolic, overdose - 30%), infectious diseases (8%), gynaecological (5%) and post-surgical (4%). The predicted death rate for patients in ICUs in S.A. is 30%, while the real death rate is 31.5% and the process of dying can take minutes or weeks. HIV/AIDS also exerts a negative impact on ICUs in SA. Out of the world's 40 million HIV-infected people, 5 million live in South Africa (10% of the country's population). These patients often need long stays in ICUs, increasing the strain on the services and further impacting on the already limited resources. In addition to this problem, a national study of 222 health care facilities showed that 16% of health care workers are HIV positive themselves (de Beer et al., 2011).

According to Marik, Pastores, Annane, Meduri, Sprung and Arlt (2008), more than 5 million patients are admitted yearly to ICUs in the United States. The five primary ICU admission diagnoses are, in decreasing order: Respiratory insufficiency/failure,

postoperative management, ischemic heart disorder, sepsis and heart failure. Since 1991, treatment of many serious conditions has become more common, including gastrointestinal haemorrhage, hemodynamic abnormalities, multiple organ system failure, respiratory insufficiency or failure, sepsis and shock. This can be related in part to the aging US population, whereby age is increasing and the number of individuals aged 65 years and older is rising, primarily due to the baby boom generation. Also evident is the dramatic rise in patients 85 years and older, from 4.1% in 1991 to 6.9% in 2004. Between 2000 and 2020, the population younger than 65 years is expected to grow by about 10%, while the number of individuals 65 years and older is projected to rise by approximately 50% (Marik et al., 2008). In European countries, sepsis accounts for 10% of ICU admissions and in Switzerland, for 64% of admissions (Murthy and Wunsch, 2012).

2.1.2 Structure of the ICUs

In S.A. the Critical Care Society set out guidelines for the establishment of intensive care units (ICUs) for the care of the critically ill. The design of the facilities was mostly styled like those in Australia, USA and Europe. In South Africa, ICUs are designed and graded from level I to level IV, as stated in the 1993 National Institute of Health Consensus Development Conference. The level I units are found in university-affiliated tertiary referral hospitals and are run on a closed-unit standard. These units tend to have highly advanced equipment and can treat a wide spectrum of critical diseases such as myocardial infarction, pneumonia, respiratory failure and renal failure. These units have a committed Medical Director and 24-hourly committed staff coverage (specialists, residents and medical officers) (Mathivha, 2002). Some units have a nurse/patient ratio of 1:1, but in some, this ratio is 1:2. Level I ICUs are placed in both public and private sectors, but those in the private health care sector are profit-driven. The care delivered in most level I units is as good as that in any developed country. Level II - level IV ICUs are staffed by non-intensivists. Level II ICUs are coronary care or neuro-units. Level III ICUs are found in community hospitals and are high dependency units with limited invasive monitoring. The private units provide for a small number of patients with medical aids and insurance schemes. The "ICUs worldwide" arrangement is designed in

partnership with the World Federation of Societies of Intensive and Critical Care Medicine (WFSICCM) (Mathivha, 2002).

In Colombia, more than 90% of all ICUs attested to the presence of a full-time Medical Director: 64% were internists and 27% were anaesthesiologists, while 5% reported specialised training/certification in intensive care. The hospitals reported that there are 12,987 hospital beds and 460 ICU (3.5%) beds. If it is taken for granted that 5% (ideally it would be 10%) of available beds would be available for critical care services, there would be a shortfall of 320 ICU beds (1997 survey data) with the required staffing and technological support absorbing more funding (Celis, 2002).

2.1.3 Staffing and resources

In 1992, South African academic ICUs were formally accredited to train medical specialists as intensivists. These professionals could have background specialities in internal medicine, paediatrics, surgery and anaesthesiology and would train in a qualified unit (fellowship) for a period of two years, and, on completion, could register as critical care sub-specialists with the Health Professions Council of South Africa. In 1999, a Faculty of Critical Care Medicine was established in the College of Medicine of South Africa (Mathivha, 2002). In South Africa, critical care training is presently offered by ten universities, and all of these institutions concentrate on postgraduate research. However, even though a significant amount of critical care research is undertaken in South Africa there is a limited profile of research on the lived experiences of patients who have been admitted to ICUs in South Africa as only a minimal number of nurses have presented their research at congress or published their results (Schribante and Bhagwanjee, 2006).

Of all acute care beds in South Africa, ICU beds account for 1 - 2%. As a result, there is a direct shortfall of beds in ICUs. Although enough critical care nurses and doctors have been trained in South Africa, there is currently a shortfall of both in the public sector. This shortfall is mostly due to the private sector and developed countries aggressively recruiting these professionals and offering them better salary packages. In South Africa, the delivery of critical care faces major challenges. The country has limited resources that must be used rationally and

distributed widely. Most South African people were disadvantaged in many respects in the past, including services such as health care delivery. There is now an agreed upon attempt to redirect resources to primary health care to benefit the majority of the South African population. This means there will be fewer resources available for high-tech medicines, including ICUs. Since the 1994 democratic elections, the South African borders have opened up, and citizens of neighbouring countries have come to this country, searching, among other things, for better health care (de Beer et al., 2011). This adds to the increasing number of patients burdening a system that is already battling to cater for its own people. Superimposed on this, is the persistent HIV epidemic that has hit sub-Saharan Africa. In addition, skilled professionals have immigrated to developed countries for different reasons, such as career insecurity, the change in the government, the high levels of crime and a better salary. All of these factors force major challenges on health care facilities in S.A. in general, but also on critical care medicine specifically (Mathivha, 2002; de Beer et al., 2011).

In the rest of the world, in ICUs, there is a shortage of over 85% of ICU beds in both the private and public sectors, and the shortage of nurses was four times more common, the cause being that the public hospitals refused to admit patients. Only 25% of the nurses stated that they had received some degree of critical care training. A lack of formal training was more commonly seen in physicians and nursing staff working in the public sector. Two out of four ICUs with high death rates did not have invasive monitoring technology. There seems to be a clear interaction between the lack of specialists and trained nursing personnel and the poor results that public ICUs present (Cellis, 2002).

2.1.4 Patient admission criteria

In most countries, admissions to ICUs are often as a result of the complications of chronic conditions such as cardiac, diabetic and renal failure (Waiker et al., 2008). Patients are generally those who need specialist care and continuous close monitoring to keep them alive, usually with one nurse being dedicated to the care of one patient (Field et al., 2008). Patients can remain in a critical condition for various lengths of time and may need several types of life support, such as ventilation, or cardiovascular

or renal support. Patients also receive various types of sedation and analgesics to ensure compliance with ventilation (Granja et al., 2005). As a result of the severe shortages of ICU beds in S.A., especially in the public sector, ICU doctors are required to outline strict admission/exclusion criteria for their sections, to be able to offer this form of expensive medication to those patients who would derive the most benefit from it. Examples of exclusion criteria include AIDS, neurological destruction, end-stage cardiac or renal disease and severe head injury with a Glasgow Coma Score <8 in an adult patient (Mathivha, 2002; de Beer et al., 2011). Selecting the most suitable patients is a stressful triage exercise that the ICU doctors in S.A. have to deal with every day. S.A. has moved towards non-discriminatory criteria for ICU admissions, and, regardless of the shortage of ICU beds, HIV-infected patients have relatively greater access to this level of care than in other developing countries in Africa, such as Botswana (Naidoo et al., 2013).

In the rest of the world there is no comprehensive legislation to address HIV/AIDS nor criteria for ICU admission. Naidoo et al. (2013) states that the number of ICU beds available is surprisingly low in the private and public hospitals, and there is also considerable variation in the allocation and distribution of critical care services across the country, given that 70% of the country is rural. India has few regulatory mechanisms to ensure ICU care for critically ill patients including HIV-infected persons. In Brazil, some ICUs have no admission criteria, and the decision rests only on the availability and the knowledge of the most experienced ICU specialist at the institution.

2.2 The ICU environment

In a study by Pang and Suen (2008) on stressors in the ICU, patients' fear of death was reported as the highest stressor. This was related to the environmental stressors in the units which trigger the flight and fight response. The other stressors that were rated highly were being pressurised to agree to medication, being in pain, and not knowing how long they would stay in ICU. These stressors negatively affect patients' experiences of their stay in ICU.

Noise is an environmental hazard that creates distress in a patient. Patients' complaints include listening to banging doors, water sounds, such as water drainage,

and doors opening and closing (Morton et al., 2005). Noise may simply be explained as unwanted sound, or as any sound that may create an unwanted physiological or psychological effect in an individual or group (Pugh, Jones and Griffiths, 2007). According to Morton et al., (2005) the ICU beds are encircled by noisy machines and equipment that seems threatening to patients, creating an irritation to them. The factors associated with lack of sleep in the intensive care unit include patient-ventilator dyscromy, medication, patient care, interaction and environmental noise and light. ICUs have machines and equipment, such as ventilators, monitoring systems, intravenous lines, chest insertion bottles and tubes and other essential equipment which frighten the patients (Granja et al., 2005). Several studies have confirmed that patients remember some of the noises that they found disturbing during their stay in the ICU (Morton et al., 2005; Strahan and Brown, 2005; Granja et al., 2005; Johansson, Bergbom, Wayne, Ryherd, and Lindalh, 2012; Ehlers et al., 2013) Similar findings were highlighted in a study conducted by Hweidi (2007) which mentioned that patients found the noise of buzzers and alarms from the machines particularly stressful, and studies conducted by Johansson and Fjellman-Wiklund (2005), Granja et al. (2005) and Jones and Griffiths (2006) which found that patients felt restless when they woke up and became aware of all the sounds of the machines and alarms.

In studies by Johansson and Fjellman-Wiklund (2005); Jones and Griffiths (2006), patients reported difficulties in communicating during ventilator treatment or having had a tracheostomy tube, as well as problems of moving, controlling their arms, writing or communicating with gestures. One of them explained that he had felt trapped because he was unable to communicate with ICU staff. They expressed feelings of being restrained physically and psychologically by all the equipment that was attached to their bodies in the form of lines and tubes to machines, drips and medicines.

ICUs were developed to care for critically ill patients and the spacing between the beds may be considered as insufficient to ensure privacy. Morton et al. (2005) stated that the ill patients are cared for close to the area where the nurses' station is located and also close to each other, where the environmental effects of noise, lights and common disturbances are a frequent and usual occurrence, implying that the ill

patients undergo the most sleep disturbances. Most commonly, an ICU design fulfils the idea of close monitoring and speedy intervention. Morton et al. (2005) stated how often, ICU beds are so close to each other that patients can hear everything that is going on with the patient in the next bed. The lack of privacy and fears related to overhearing ICU procedures and communication cause nervousness and could worsen sleep problems. To use a bedpan in an area close to other patients may be embarrassing and uncomfortable, and the noises of other patients close by may encourage nervousness. Smells may be disturbing and upsetting. During visiting hours, patients may feel that the lack of privacy makes them unable to communicate with their visitors. Smeltzer and Bare (2004) state that "people are likely to regard the space in their area as an extension of themselves". Patients may be frustrated if 'strict bed rest' is prescribed. The beds in hospital become uncomfortable; normal bodily functions become difficult, monitor leads get caught up with the intravenous lines resulting in upset, very worried, frustrated, unhappy patients who are unable to sleep. Aro et al. (2012), who conducted a similar study on the needs of adult patients in intensive care units of an Estonian hospital, reported that, although 76.7% of the patients agreed that their privacy was ensured during all procedures performed, they stressed that the need for privacy was important to them. They also found that the need for privacy was not important to others, as they assumed that there was no privacy in an ICU.

According to Morton et al. (2005), the harsh type of light created, if unshaded, is known to lead to visual tiredness and headaches. Night time lighting levels in an ICU may change, with higher lighting levels more likely to affect the human circadian rhythms than lower lighting levels. One may also imagine that harsh bright lights make the environment feel somewhat unnatural. When the light is reflected off environmental surfaces such as glass or other shiny surfaces, it may cause a glare which is unpleasant (Morton et al., 2005).

According to Ramful, (2005) patients mentioned that bright lights from the nurses' station, lights that were not dimmed and were switched on at night were very disturbing to their sleep which causes psychological disturbances in the ICU. Nurses forget to dim the lights, or there may be sick patients who need medical or surgical interventions, or there may have been an emergency admission. Similar findings

conducted by Morton et al. (2005) explain that normal physiological processes can be disrupted by light-dark patterns, but that continuous lighting and high-intensity light lead to complete disruption of the normal melatonin concentration rhythm. This has important implications in the critical care setting because melatonin facilitates sleep and regulates corticosteroids and thyroid hormone levels. This has been supported by Kamdar, Needham and Collop (2012), who state that critically ill patients commonly experience poor sleep, which is characterised by common disruptions and loss of circadian rhythms.

Eliassen and Hopstock (2011) mention that sleep deprivation is common amongst patients in the ICU and can lead to physiological and psychological dysfunctions that affect the healing process and increase morbidity and loss of life in the ICU. According to Hofhuis, Spronk, Van Stel, Schrijvers, Rommes, and Bakker (2008), 11% of patients have psychological problems such as sleeplessness, concentration difficulties, depression and hallucinations, after being critically ill in an ICU. Patients reported nightmares and delusions in the ICU when they were asked about their stay (Pugh et al., 2007).

According to Ramful (2005), if patients are denied sleep they will have difficulty concentrating and may experience nightmares. Nightmares are sensations that are not real but can involve any one of the five senses. A person can see, hear, taste smell or feel something that is not there. Seeing something that is not real can be frightening for the person experiencing this and for those near to them. According to Granja et al. (2005), Jones and Griffiths (2006) reported that, in an ICU, patients have terrifying nightmares, hallucinations and delusions and precursors to these experiences may be the patients' illnesses, together with the use of sedatives, drugs, withdrawal from these and the strange environment of the ICU. These influence memory and behaviour and have the potential to predispose the ICU patient to experiences such as nightmares (Rattray and Hull, 2007).

Similar studies (Green, 1996; Arthur and Wong, 2000; Ramful, 2005) have shown that patients suffer from the residual effects of the ICU environment in the form of sleep disturbances and nightmares. Such frightening experiences in the ICU, whether associated with the disease itself or with the ICU environment, have an important

impact on recovery and reform. Patients have recounted psychological disturbances in the form of disturbing dreams and hallucinations, like experiencing an earthquake moving through a desert, as well as nightmares associated with the feeling that they were dying, were scared or were going mad.

2.3 The ICU patient

An ICU patient is an adult or a child who is receiving care or medical treatment in an ICU. ICU patients are those with critical illnesses who are suffering from failure of one or more of their systems, such as the heart, lung or kidneys. Waiker et al. (2008) found that a heart attack, stroke, poisoning, pneumonia, surgical complications, major trauma as a result of a road traffic accident, a fall, burns, an industrial accident or violence are all examples of critical illnesses. Patients recovering from a major operation are also admitted to intensive care units (ICUs).

Im, Lee, Liu, Lim, Guevara and Chee (2010) indicated that some Asians and Hispanics felt that cancer was related to death. Since death was unacceptable, the more pain they felt meant that their cancer was getting worse; talking about pain was not right, so they minimised the amount of pain they had (Im et al., 2010). Not allowing oneself to experience pain or severe pain results in obstacles to active pain management. In most cultures, religious or spiritual belief in fate and karma (God's will) explains that when an individual has developed a life-threatening illness, pain is seen as a test of one's faith, spiritual beliefs, as a means of achieving higher religious status, or even as a punishment for a sin (Yee, 2007; Shavers, Bakos, and Sheppard, 2010; Carteret, 2011). If these beliefs were observed, patients might not ask for pain medication or expect pain relief. Some studies of African-Americans consider the role of religion and spirituality as a positive pain-coping plan, which could result in lowering pain scores, more positive attitudes to pain and indicators of pain and greater acceptance of pain medication (Shavers et al., 2010).

2.4 Pain and anxiety

According to De Jong, Molinari, Lattre, Gniadek, Carr and Conseil (2013), pain is a frequent event for patients in an ICU as they commonly experience incidents of moderate to severe pain during their ICU stay. These authors reported that some of the most painful nursing procedures for ICU patients were moving and turning

procedures (bathing, massage of the back and pressure parts and changing the patient's position). Similar results were highlighted in a study conducted by Sifflet et al. (2007) and Puntillo (2009) also explained that patients in intensive care units experience a range of complex and life-threatening conditions which are often associated with considerable pain and discomfort, and that pain may be experienced regardless of the presence of deep sedation. The causes of pain in the ICU are multi-factorial, although tissue damage from trauma and surgical incisions are the most common. In addition, anxiety, fear and uncertainty have also been found to contribute to the patients' experiences of pain. Pedersen, Rosendahl-Nielsen, Hjerminde and Egerod (2009) mention that intubated patients may be unable to cough up enough secretions. Endotracheal suctioning is therefore important in order to reduce the risk of consolidation and atelectasis that may lead to insufficient ventilation. The suction procedure is associated with complications and risks including bleeding, infection, telecasts, lack of oxygen delivered in body tissues, cardiovascular instability and elevated intracranial pressure.

Magarey and McCutcheon (2005) describe how patients in pain, who were also disturbed and did not know that they were critically ill, battled to understand the reason why they had pain and its meaning, and therefore depended on the health care workers to explain to them what was happening. People also experience discomfort and pain due to the endotracheal tube, having to maintain an uncomfortable position in bed, a reduction in sensory input, sleep disturbance and feelings of isolation, and they struggle to regain control over their bodies. ICU patients still frequently experience pain even if there is an ability to control pain with medication. Ferns (2007) noted that, in addition to pain and annoyance, seriously ill patients experience feelings of being exposed, difficulty in expression and communication, terrifying physical experiences and an inability to sleep. Patients reported that they had a feeling of "just needing to sleep" since they were unable to control the environment. Pain and anxiety worsens sleep deprivation which makes it more difficult to sleep. Morton et al. (2005) state that a speedy recovery may occur and minimal pain medication will be required, only when careful attention is given to providing a restful environment. According to Perrie (2005), there are many factors which cause anxiety in critically ill patients. These include the patient's underlying disease, diagnostic or therapeutic procedures and physical isolation from loved ones, unfamiliar surroundings, noise,

sleep deprivation and life-sustaining therapies such as mechanical ventilation or electronic pacing. Furthermore, extreme anxiety, delirium, adverse drug effects or pain can lead to agitation, which occurred at least once in 71% of patients in a medical-surgical ICU. Patients aware of unpleasant or frightening memories of their stay may also experience post-traumatic stress disorder. When interpersonal needs like security or freedom are not met within a person, anxiety or tension occurs. According to Morton et al. (2005), any stress that threatens one's sense of wholeness, containment, security and control causes anxiety.

Fleischer, Berg, Neubert, Koller, Behrens and Becker (2009) state that an ICU stay is often associated with negative experiences for the individual patient. Many patients are disabled, and their communication is restricted during the ICU stay. Specific information on procedures, sensations and coping behaviour are thought to reduce anxiety in the ICU. Information programs to reduce anxiety are usually delivered preoperatively, which completely neglects the informational needs of non-elective ICU patients. Taylor (2013) explained that many patients must be prescribed sedating medication to manage the anxiety and promote breathing in time with the ventilator.

2.5 Inability to communicate

Taylor (2013) mentions that the drugs which are administered in an ICU can have serious side-effects, including low blood pressure and a low heart rate, as well as contributing to confusion and frustration about not being able to communicate.

In a study by Johansson and Fjellman-Wiklund (2005), patients reported difficulty communicating during ventilator treatment or with a tracheostomy tube, as well as problems with moving, controlling their arms and writing or communicating with gestures. They expressed feelings of being restrained physically and psychologically by all the equipment that was attached to their bodies in the form of lines and tubes to machines, drips and medicines. They concluded that failure in communication due to the inability to communicate verbally resulted in feelings of frustration and powerlessness and stressed that staff skills were a key factor for successful communication. Similar studies done by Jordan et al. (2002) explained that patients' inability to express themselves verbally makes them find other ways of communicating in order to make their needs known. It was noted that losing hope and experiencing frustration often forced patients to use non-verbal modes of

communication, which included gestures and incomprehensive sounds to attract attention, and expression through writing (Jordan et al., 2002).

Antai-Otong (2007) and Meriläinen, Kyngäs, and Ala-Kokko (2012), define communication as talking at the same time and/or indicating non-verbally, listening and/or observing non-verbal actions, thinking, interacting, planning and responding. It also includes understanding things from another person's ideas, and interpreting and responding to actions based on the person's experiences. Spoken or oral communication is an important part of communication, and with more consistency between verbal and non-verbal communication, the messages will be interpreted or understood clearly. In the ICU, verbal communication plays a smaller part than its usual role related to non-verbal signs in conveying messages, as the majority of patients in ICUs have compromised ability to communicate. Patients are unable to communicate verbally, and cannot clearly express their thoughts, feelings and wishes. Verbal communication can help patients retain a sense of self and restores confidence, which, in turn, can improve their well-being. On the other hand, when patients in ICUs cannot respond to verbal communication, staff members generally underestimate the importance of talking to them (Travaline, 2002; Alasad and Ahmad, 2005).

Grossbach, Stranberg and Chlan (2011) state that critical care staff who manage intubated patients often experience difficulties with one of the most basic human functions, communication. Patients with endotracheal or tracheostomy tubes are unable to communicate verbally because of the placement of the tube and inflation of the tube's cuff, which prevents passage of air across the vocal cords. Even though these patients are unable to speak, they can communicate effectively via other methods. Intubated patients can communicate with nurses, other clinicians and family members primarily through gestures, head nods, mouthing of words and writing. Other communication methods include letter/picture boards, lists of common words or phrases tailored to meet individual needs and other high-tech communication devices.

2.6 Cultural support

Many studies have been undertaken in various countries on different cultural groups considering their experiences as patients in the ICU (Gwala, 1993; Mzimkhulu and

Simbayi, 2006; Davidson et al., 2008; Van Niekerk, 2012). The common features of experiences in these studies are related to the psychological, environmental and physiological disease processes. When patients are admitted to an ICU, they carry their beliefs with them and these can have a negative impact psychologically. Patients of African culture may be conflicted between using Western medicine and traditional medicine, and this stress besides their inability to completely trust the Western medical techniques may be disadvantageous to their health. Van Niekerk (2012) mentions that in South Africa, traditional healers are often the first to be called for help when illness strikes, as the majority of South African communities have faith in their ability to cure their conditions.

According to Coolen (2012), the use of modern medicine is generally acceptable by many ethnically different patients in the care of severe illness, although acceptance depends on a number of factors, which include how assimilated the individual is with Western (American) culture (Le and Le, 2005). Western medicine, as patients may view it, may be used together with other methods by the patient which may negate the efficacy of the medicine. As a result of the disease and dying process, signs commonly experienced involve pain, nausea and vomiting, breathing difficulties, skin wounds, bowel and bladder problems, anxiety and sadness and sleep interruptions. Patients may look to the care of spiritual healers and the use of other methods in order to address these symptoms, such as herbal remedies. Filipinos, for example, may consider medicine for healing which uses *halaman* (herbs) and a *herbolaryo* (*traditional healer*) if they believe that evil spirits entering the body caused the illness (Le and Le, 2005).

Cultural norms, for example, influence the perception of health among the Jordanians, as women feel it is disgraceful to be examined by a male medical doctor (Omran and Al-Hassan, 2006). Religion can also affect the way in which women perceive their bodies. Muslim women in many Western countries consider the *hijab* as part of their Muslim identity (Ruby, 2006). In a study done by Zeilani (2008), it was reported that cultural norms and Islamic religious beliefs relate to the way in which Muslim women perceive the care they receive in the ICU. The findings of this author used the concept of 'the cultural body' to describe the different effects of cultural norms and Islamic religious beliefs on the women's experiences. Covering the body forms part of the

Jordanian women's cultural norms, and therefore, wearing a long dress and scarf is part of their identity. They thus feel exposed when having to wear the ICU gowns. They lose their cultural norms, and, accordingly, their cultural body. Furthermore, the women wish to be cared for by female nurses, as, according to their Islamic religious beliefs, a strange male, such as the ICU male nurse, is not allowed to touch their bodies or provide bodily care. The patients used phrases such as 'no honour' and '*haram*' to express their anger and dissatisfaction. Support from family and relatives is also part of Jordanian cultural norms, and, for most Jordanian Muslims, illness is a family issue and all family members become involved in providing help and support to the ill person. The family-social relationships become stronger when any of the family members are admitted to hospital or are affected by a critical illness (Zeilani, 2008).

Carteret (2011) and Dhingra (2008) argue that different language barriers can be a concern, as the way a person verbalises pain can make it difficult for health professionals to effectively assess their pain due to cultural influences. For some elderly Chinese patients, stoicism and fatalism can create obstacles to effective management of pain. Confucian and Buddhist beliefs, influenced by Fatalism, suggest that pain should be borne as it can lead to spiritual growth (Carteret, 2011). Calm patients may be less likely to openly show their pain verbally and non-verbally, and may choose to be left alone in order to experience their pain and suffering. Being calm and lying about one's pain may influence requests for pain medication or result in the non-reporting of pain. Studies have indicated that calm pain behaviour was more generally found among Mexican Americans, American Indians and Asian Americans (Narayan, 2010; Shavers et al., 2010; Carteret, 2011). Health care professionals may believe that if the patient does not indicate that there is pain it means that there is no pain, which results in under-treatment. Alternatively, patients from Middle Eastern or Mediterranean cultures may be more indicative in their communication and more likely to openly show their concerns about their pain. Openly indicating that there is pain does not necessarily mean their pain is severe, but may indicate the need to assuage their suffering (Shavers et al., 2010; Im et al., 2010; Carteret, 2011).

Davidson et al. (2008) mention that blood transfusions are unacceptable to people who belong to the Jehovah's Witness religion, and that this can be a very difficult situation when patients have lost blood and are anaemic and in need of a blood transfusion for survival. In a study on resident physicians' provision of cross-cultural care, Weissman, Betancourt, Campbell, Park, Kim and Clarrige (2005) mentioned that patients whose religious beliefs affect treatment result in patient non-compliance and delays in obtaining consent forms.

2.7 The relationship between patients, nurses and doctors

Findings of a study conducted by Cutler, Hayter and Ryan (2013) showed that participants' comments regarding the ICU staff were positive, which indicated that the participants had developed a strong relationship with the staff. Care, communication and relationships with health care professionals were a strong and prevalent theme within the literature. Similarly, another study found that patients express their happiness that nurses talked to them, not over them, and spoke the truth (Green 1996). Samuelson (2011) mentions that patients perceived competence and caring as positive attributes of health care professionals.

A study conducted by Meriläinen et al. (2013) on patients' memories of their time in an intensive care unit emphasised the importance of communication, whether by talking or other forms of non-verbal communication. In a recent study that compares the health care teams' views of communication with the views of the patients who were on a mechanical ventilator in the ICU, Magnus and Turkington (2006) agreed that using communication aids, such as alphabet charts or a board, would be helpful for both groups. A person will be more likely to share additional feelings about strange experiences when s/he feels that his/her feelings are recognised and understood. It seems to be important to create a faithful patient-nurse relationship to support patients' own natural joy in life and their will to fight for survival (Wahlin and Idvall, 2006). Patients' relationships with staff can be complicated and depend on a number of factors, not least on open communication. Good relationships with staff are characterised by confidence and trust. This confidence extends not only to those who are seen as competent and skilled with procedures, but also to the manner and sensitivity with which they perform them. While Magnus and Turkington (2006) discuss the impact of this within the ICU, this understanding also extends beyond the

critical areas where there is an expectation that staff will provide a quality of care that is at least comparable to specialist areas.

2.8 Being transferred to a ward

In respect of transfers from the ICU to a ward, Chaboyer et al. (2007) and Denny and McKinney (2002) explained that some patients were pleased to return to the ward, while others were not pleased. According to Wong and Arthur (2000), 52% were pleased because they thought that it was a step closer to being discharged and going home. While a few studies focussed on the discharge and recovery phase, most focussed on the severely ill patients (Denny and McKinney, 2002; Strahan and Brown, 2005; Field et al., 2008). To leave an ICU means getting better to some people and was therefore linked to positive feelings. Nevertheless, these feelings were indicated after discharge from an ICU as a retrospective reflection. Another patient felt, however, that the decision to transfer him/her was made by the health care professionals, thus taking it out of his/her hands (Cutler et al., 2013). Similar findings were highlighted in a study conducted by Forsberg, Lindgren and Engström (2011) who found that patients felt that it was important to prepare for the transfer and to know what was going to happen. Researchers Denny and McKinney (2002), Strahan and Brown (2005) mention that overall, there was a positive evaluation of the care received. Patients felt that the care they received was exceptional.

2.9 Conclusion

The literature has shown that patients suffered from a residual effect of the ICU environment and routines mostly in the form of sleep disturbances and nightmares. The frightening experiences in the ICU, whether related to their disease itself or to the ICU environment, have an important impact on recovery and on rehabilitation. These studies highlight the need for ICU health care providers to understand, be aware of and try to minimise the adverse effects of the ICU environment and to help patients recover from the experience. This explains the importance of carrying out research in that field.

In the following chapter the research approach, setting, selection of participants and data collection processes will be discussed. This is followed by details of the ethical

considerations observed in this study and evidence of the trustworthiness of this research. The method of analysis used in this study will also be presented.

CHAPTER THREE

METHODOLOGY

3.1 Research approach

The research approach in this study will take the form of qualitative research using a phenomenological approach. Qualitative research is an efficient, interactive and also subjective approach used to explain the experiences of life and give meaning to them. The purpose of qualitative research is to understand a detailed social situation, event, group or interaction (Burns and Grove, 1997). According to Burns, Grove and Gray (2011), phenomena are a world of experience and take place only when a person experiences them. An experience is considered unique to an individual. The research problem was not explained in terms of a conceptual framework, as this study was based on phenomenological methodology. Brink (2002; p.31), Burns, Grove and Gray (2011) mention that in “purely qualitative research, the problem may not be explained in terms of theoretical or conceptual framework”. The descriptive phenomenology is used to gain real meanings by means of engaging in-depth with reality (Laverty, 2003; Lopez and Willis, 2004). The participants who took part in this study were encouraged to relate in-depth their experiences of being admitted to an ICU.

Descriptive phenomenology was created by Husserl and interpretive-hermeneutic phenomenology was created by Heidegger. The descriptive type of phenomenology that will be used in this study was developed by Husserl (1962), who was primarily interested in the question of what we know as a person. His philosophy was to create descriptions of the meaning of human experiences. A phenomenological approach will be used because it studies human experiences through the descriptions that are provided by people, although overlapping between both approaches is expected (Fochtman, 2008). Husserl highly regarded the experience of phenomena as recognised by the human consciousness which should be an object of scientific study (Lopez and Willis, 2004). The important presupposition of Husserlian phenomenology is bracketing, in which the researcher discloses personal biases, presuppositions and puts them aside (Gearing, 2004). The purpose of this is to maintain what is already known about the description of the phenomenon separately

from the participants' descriptions. On the collection of data or the structure of the data, the researchers should prevent any imposing of his/her presuppositions (Ahern, 1999; Gearing, 2004; Streubert-Speziale and Carpenter, 2007). As a result, bracketing is a way of confirming the validity of data collection and findings, and maintaining the objectivity of the phenomenon (Ahern, 1999; Streubert-Speziale and Carpenter, 2007). Husserl believed that bracketing helps to gain understanding of the common features of any lived experience. Husserl referred to these features as common essences and considered them to represent the real nature of the phenomenon under investigation (Lopez and Willis, 2004; Wojnar and Swanson, 2007). Thereafter, Heidegger (a student of Husserl) changed the work of Husserl and introduced some presuppositions that may result in meaningful investigation. Heidegger's views involve the interpretive or hermeneutic research tradition. To study human experience, hermeneutics includes, not only the description of the main ideas and essences, but also looks for meanings rooted in common life practices. These meanings are not deep, so they can be elicited from the narratives generated by people (Lopez and Willis, 2004; Wojnar and Swanson, 2007). Heidegger imagined that the relationship between an individual and his or her world should be the focus of phenomenological investigation.

A phenomenological approach will be used because it studies human experiences through the descriptions that are provided by people. Brink (2002) mentions that phenomenological studies examine human experiences through descriptions that are provided by the people involved. In this research, the commitment and interest of the researcher is related to the study of the lived experiences perceived by patients in the ICU. In order to get a full explanation and understanding of the patients' world while they were in an ICU, the researcher decided to use unstructured interviews, as she considered this to be the most useful way of gaining an understanding of people's experiences.

3.2 Research setting

The study was conducted in one public hospital in the Ugu Municipality district. This hospital was chosen as the site for this study as it is the only the referral hospital in Ugu Municipal district, and is a local hospital accessible to many community

members providing 24-hour services. The hospital is situated on the Hibiscus Coast, approximately 100 kilometres south of Durban. It is a regional hospital with a bed capacity of 350 and accepts referrals from 7 clinics and 3 district hospitals in the vicinity. The hospital caters for general, medical, surgical and paediatric critically ill patients of all ages, sexes and socio-economic backgrounds. The services offered by the hospital are the same as those of other national hospitals, although this hospital caters for a big catchment area populated by various segments of a multi-cultural society. The hospital has approximately 1000 admissions a month, 100 of whom are admitted to the ICU, with an average of 5 surgical discharges and 3 medical discharges to the relevant ward per week. The type of patients admitted to the ICU are Whites, Asians and Blacks and include adults of all ages, from paediatric patients of two years of age and above. Both males and females who were critically ill and needed mechanical ventilation for at least 48 hours were admitted. During data collection, only adults admitted to the ICU were included. The ICU has eight (8) beds, with three (3) ICU trained nurses and twelve (12) experienced nurses, thus a ratio of 1:1.

3.3 Research participants

It was proposed that this study would consist of approximately 6-8 participants (depending on when data saturation was reached) all of whom had been patients in an ICU. The researcher included all those patients who were willing and able to communicate their experiences by using a non-probability purposive sampling method. The inclusion criteria comprised patients, 18 years and over, who had been cared for in the ICU and had been connected to a mechanical ventilator for at least 48 hours and then discharged from the ICU to a general ward. When the participants' condition was stable, as established by the doctor responsible for their care and they were no longer under the care of ICU staff, they were interviewed in the wards. This took place approximately 3 to 5 days after they had been discharged from the ICU and a day before they were discharged from the hospital so that their memories of the ICU were fresh. The second verifying interview took place approximately 3 to 7 days after the participants had been discharged from hospital and this was done via the telephone. The researcher interviewed participants after explaining the purpose of the research to them and attaining their written consent to participate in the study. The

participants were able to choose to communicate in either Zulu or English, and were therefore able to understand the questions and respond to them.

3.4 Data collection process

After obtaining ethical clearance from the University and permission from the research site to conduct the research, the researcher, as an ICU nurse, made an appointment to meet the nursing service manager of the hospital, the sister in charge of the general ward, the sister in charge of the ICU, and the doctors who were responsible for the patients. The researcher explained the purpose of the study to them and arranged a suitable time and venue for data collection. It was agreed that data would be collected from the patients the day before they were discharged from the hospital. The researcher sought guidance from the unit manager and sister in charge of the ward regarding the daily routine in the wards, and together they agreed on an appropriate time to interview the patients. The researcher made appointments with the doctors responsible for the patients to ensure that they were well enough to cope with the interviews. She also informed the family members regarding the research study and the interview. The family members were present during the interviews if the participants wished it so.

On the day of the data collection, the researcher interviewed the participants after explaining the purpose of the study, process, benefits, risks and rights and attaining their written consent to participate in the study. Participants were assured that they were not under any pressure to participate and that they were able to withdraw from the study at any time. The participants were interviewed in a consultation room attached to the general ward to ensure privacy. The interviews took almost 30 minutes and took place when patients' conditions were deemed stable by their doctors.

The researcher used an unstructured interview guide and began with the following question: Can you describe any experience you remember regarding your stay in ICU? This was followed by general probing questions such as: “Can you tell me more about this? How did this make you feel”? (Refer to interview guide, Annexure A and B). The participants permitted the researcher to use an audiotape recorder to tape interviews, and the recording was then translated word for word. During the data collection process, the researcher used a personal journal and field notes to

record her own feelings, reactions and observations. The second verifying interview took place approximately 3 to 7 days after the participants had been discharged from hospital and was conducted via the telephone. The researcher informed the participants about the second interview during the initial interview and obtained their contact details as well as arranging a suitable time to call them to ensure that the participants would be at home. Patients who were Zulu speaking were interviewed in isiZulu. These interviews were transcribed by the researcher into isiZulu first, then translated into English. The English transcript was then sent to an isiZulu and an English language expert for validation (school language teachers). The researcher continued to collect data until saturation was reached.

3.5 Data analysis

Data analysis (of both the 1st initial interview and the 2nd verification interview) was done in accordance with the phenomenological analytic method developed by Colaizzi (1978) using thematic analysis. This process involved seven steps:

3.5.1 Acquiring a sense of each transcript

After interviewing participants and transcribing the data, the researcher repeatedly read the transcripts and descriptions and listened to the tapes to become familiar with participants' words. The researcher looked for themes and sub-themes which combined the data.

3.5.2 Removing important statements

Colaizzi (1978) recommended that the researcher should remove important groups of words and statements from the notes that together formed the whole meaning of what was, in this case, the experience of patients in the ICU. The researcher therefore returned to the participants' descriptions and focused on the aspects that were seen as being the most important for the phenomenon under study.

3.5.3 Formulation of meanings

At this stage of the findings, Colaizzi (1978) suggested that the researcher try to develop more general restatements or meanings for each important statement clarified from the words.

3.5.4 Arranging formulated meanings into clusters of themes

To arrange developed meanings into clusters of themes, the researcher repeated each interview (Colaizzi, 1978).

3.5.5 Detailed description of the investigated phenomenon

In the fifth stage of analysis, Colaizzi (1978) advised that the researcher should combine all the results of ideas into a detailed description of the phenomenon. The description of the participants' feelings and views were contained in the themes using their own words where possible.

3.5.6 Describing the essential structure of the phenomenon

Given the length of the detailed description, Colaizzi advised that this should be reduced to an essential structure. He described this as an absolute structure of the phenomenon.

3.5.7 Returning to the participants

Colaizzi (1978) suggested that the last confirmation stage of data findings should include coming back to the participants for another interview to obtain their ideas on the essential structure of the phenomenon to ensure that it did represent their experience. Holloway and Wheeler (2002), however, encouraged the researcher to take the detailed description back to the participants, instead of the essential structure, because it would be more identifiable for them to comment upon, which would confirm rigor. After the participants had been discharged from hospital approximately 3 to 7 days after discharge, while they were at home, the second validation interview took place and this was done via telephone.

3.6 Trustworthiness

Trustworthiness, as described by Lincoln & Guba (1985), was used to attempt to ensure the rigor of the study. This was based on the identification of four aspects of trustworthiness namely; confirmability, credibility, transferability and dependability. According to Husserl (1960) and Colaizzi (1978), bracketing is essential, since it is only once this has been accomplished that more special investigation into the understanding of the data can begin.(Refer to Annexure I for bracketing)

3.6.1 Credibility

Each person approached was given the opportunity to refuse to participate in the study, so as to ensure that the data collection sessions only involved those who were genuinely willing to take part and were prepared to offer data freely. The researcher aimed to establish a rapport from the outset of each session by indicating that there were no right answers to the questions that were asked, and by encouraging participants to be frank. It was made clear to participants that they had the right to withdraw from the study at any point without having to disclose an explanation to the researcher (Lincoln and Guba, 1985; Emanuel, Wendler, Killen and Grady, 2004).

At each interview, the researcher confirmed the findings from the previous interview with the participants, in order to ensure that the results were in fact a true reflection of the participants' experiences (Colaizzi, 1978, Brink, 1993). The researcher tried to give the reader a sense of being there and of truly experiencing the research by giving an in-depth description of events. A thick description of the research process was provided in an attempt to demonstrate that the knowledge acquired may be relevant to a similar situation or participants. The researcher collected the data until no new information could be attained (Polit and Beck, 2008). Frequent debriefing sessions were held between the researcher and her supervisor to discuss the proposed plan of action for the study and to make changes where necessary. These meetings also allowed for the discussion and validation of the findings.

3.6.2 Transferability

Transferability refers to the generalisability of the data, which is the extent to which the findings of the study can be applied to other settings or groups (Shenton, 2004). According to Lincoln and Guba (1985), it is the responsibility of the researcher to provide sufficient thick descriptions of the study to ensure that readers can evaluate the applicability of the data to another context. The researcher provided sufficient thick descriptions by providing detailed descriptions of the research settings, participants, data collection methods and interviews.

3.6.3 Dependability

Dependability concerns the strength of the data and was confirmed by the long time period over which the data collection took place. Data were collected from 25th

November 2012 to 25th April 2013. The researcher tried to explain, in detail, the decision-making process of the research study, in addition to the background of the study (Lincoln and Guba, 1985; Holloway and Wheeler, 2002; Shenton, 2004). In these interviews the research participants reviewed, validated and verified the researcher's interpretations and conclusions of their interviews.

3.6.4 Confirmability

Confirmability refers to the stages at which the data ensures the findings. A rich description of the research was provided by the researcher to give the reader a sense of being there, so that the reader would be able to follow the route the researcher had taken. Documentation was kept regarding personal reflections during the study, reflections regarding data findings, and any changes in the methodology of the study (Lincoln and Guba, 1985; Holloway and Wheeler, 2002; Shenton, 2004).

3.7 Ethical considerations

The researcher obtained ethical clearance from the Ethics Committee of the University of KwaZulu-Natal and ethical approval from the KwaZulu-Natal Department of Health Research Unit and the public hospital under study. This study complies with the ethical standards described by Emanuel et al. (2004). Refer to Annexure C-H.

3.7.1 Community participation

The study involved patients admitted to the ICU of the hospital who were asked to describe their own experiences of being cared for in an ICU.

3.7.2 Social value

The study will produce a deep understanding of patients' experiences when admitted to an ICU which will add to the body of existing information. It could enable health professionals to become more sensitive to the needs of critically ill patients. This study might also form the baseline for other research that focuses on patients' experiences in ICU environments.

3.7.3 Scientific validity and integrity

The objectives of the study were to describe the lived experiences of patients who were admitted to an ICU. The researcher analysed the data to ensure confidentiality. The taped interviews were destroyed after they had been transcribed. Hard copies of the interview transcripts will be kept under lock and key with the researcher's supervisor for a period of five years and then incinerated thereafter.

3.7.4 Selection of participants

The researcher included all those patients who were willing and able to communicate their experiences by using a non-probability purposive sampling method. All the participants (patients) who met the inclusion criteria were asked to participate, but they had the opportunity to refuse to take part if they did not wish to do so.

3.7.5 Informed consent

Written informed consent was obtained from each patient. The purpose of the study was explained to them, as well as the fact that the participation was voluntary, and that they could decide to participate or withdraw from the study at any time. These details were also given to them as information sheets (see Annexure E-F). Their privacy and confidentiality were maintained throughout the study. The participants were requested to select a pseudonym so that the data attained could not be traced back to individuals. The participants were given the choice of having the interview in either English or isiZulu, according to their preference.

3.7.6 Protecting vulnerable participants

The researcher made every effort to protect the participants from discomfort and emotional, social and physical harm. In order to do this, the researcher ensured that she only approached the participants once they had been found to be physically and emotionally stable, after consultation with their doctor, and on the day prior to their discharge from hospital. The researcher, as an experienced ICU and mental health nurse, was aware of the possibility of psychological distress, and therefore monitored the participants for any signs of emotional disturbances during the interviews. Should any such distress have been noted, the interview would have been terminated immediately. The researcher undertook to inform the doctor, so that any traumatised

patients could be referred to the psychologist or social workers who were available in the hospital.

3.7.7 Risk-benefit ratio

There were minor psychological risks inherent in respect of the study. Participants' names and identifying data were not disclosed. It was not anticipated that there would be any cost to those who participated in the research, nor would the researcher need to arrange meetings with participants, as it was envisaged that the research would be conducted using an unstructured interview guide. Ethical approval was obtained from the hospital.

3.7.8 Independent Ethics review

The constitution of South Africa (Act no. 108 of 1996) was essential to any ethical considerations in this interview, and the human rights of the participants were protected by this Act. An independent ethics review was obtained from the Research Ethics Committee of the University of KwaZulu-Natal.

3.8 Data management and storage

Hard copies of the interview transcripts will be kept under lock and key with the researcher's supervisor for a period of five years and incinerated thereafter.

3.9 Dissemination of findings

The findings will be disseminated in the form of a hard copy thesis to the University of KwaZulu-Natal and three copies will be sent to the University library for public use. The findings will further be published in academic journals and presented at a national critical care conference. Names of participants and the institution will be protected.

3.10 Conclusion

The research approach setting, selection of participants and data collection was discussed. This was followed by the details of the ethical consideration taken in this study and evidence of attempts to ensure trustworthiness. The method of data analysis used in the study was presented. The following chapter discusses the findings of the

interviews and discussion.

CHAPTER FOUR

FINDINGS AND DISCUSSION

4.1 Data collection process

Contact was first established with the Nursing Service Manager of the hospital and permission was sought to interview patients who had been admitted to the ICU (see Annexure C for information). The researcher introduced herself to the Nursing Service Manager of the hospital and presented the objectives, purpose and significance of the study, as well as explaining the ethical considerations were explained to her. The researcher sought guidance from the unit manager and the sister in charge of the ward regarding the daily routine in the wards, and together with them agreed on an appropriate time to interview the patients. The researcher made appointments with the doctors responsible for the patients to ensure that they were well enough to cope with the interviews.

One of the participants, Don (pseudonym) was initially scared of the idea of being recorded and was concerned that the hospital or nurses would learn of the information he had given, but the researcher convinced him that he had nothing to worry about and, during the interview, he was relaxed and spoke freely. None of the other participants appeared to be concerned about the recording of their interviews. When the researcher transcribed the interviews, she made comments in the text like this: **[SILENCE]**, **[SMILING]**, **[FROWNING]**, **[RED CHEEKS]**. One participant was frowning when s/he talked about noise and one had red cheeks when she talked about the lack of privacy. One participant smiled when she talked about prayer. During the interviews, the researcher showed support to the participants by using therapeutic touch as a gesture to acknowledge their experiences. The interviews were conducted in a consultation room attached to the general ward when the condition of the participants was stable. For the first contact the researcher always introduced herself and the following interview was organised between the researcher and the participant. Each participant was interviewed twice with the second interview being used to confirm the findings. The second verifying interview was done via the telephone after the participants had been discharged from the hospital. A total of six patients were interviewed. The research followed the principle of theoretical saturation. The

interviews were audio-taped and were not documented during the process. The interviews were conducted in isiZulu or English as preferred by the participant and then later translated and transcribed into English.

4.2 Description of the setting

The first hospital in Port Shepstone was a Sanatorium and was built by the Catholic Church with the help of the Chamber of Commerce and the Government. The interviews took place in one public hospital as this was the most convenient place for the researcher and the participants. This was a Regional hospital. The participants who were involved in this research were all from around the hospital area and all of the participants had been admitted to the ICU. The research was conducted in a general ward after ICU discharge. The types of patients interviewed were both medical and surgical patients.

4.3 Description of the participants

The six participants who agreed to participate in this study included both males and females from different cultural backgrounds. The participants chose to use pseudonyms. A description of these participants can be found in Table 4.1 below:

Table 4.1 Description of the participants

Pseudonym	Ages	No. of days in ICU	Comments	
LUCY	20s	2	Surgical	This was the first time she had been admitted to hospital. She has strong religious beliefs.
SHAUN	30s	3	Medical	She had never been admitted to hospital before and heard everything that was happening around her.
DON	40s	2	Medical	He missed his family.
MZULU	40s	3	Surgical	He strongly believed in traditional healing.
MENZI	40s	2	Surgical	He was happy that he was transferred to the ward and was satisfied about the care he had received in ICU.
LIZZIE	40s	3	Surgical	She complained of insufficient sleep.

All the participants who were contacted agreed to participate in the study. The participants of this study were happy to discover that people were interested in hearing about their experiences during their time in the ICU. The participants believed that, by publishing their experiences, their pain, fear and lack of knowledge would be acknowledged and recognised.

When their condition was stable, free of sedation and they were well orientated and they were no longer under the care of ICU staff, the six participants were interviewed. The researcher interviewed each participant after explaining the process and attaining their written consent to participate in the study. The participants were interviewed the day before they were discharged. Apart from one interview that was conducted in isiZulu, the participants were interviewed in English and the interviews took between 15-35 minutes. A week later the researcher contacted the participants telephonically to hold a confirmation interview with them.

4.4 The interview process

The interview which was conducted by the researcher took place in the consultation room which was close to the general ward in hospital in order to ensure privacy and to avoid being disturbed. The second interviews (verification interviews) were carried out via telephone. The fact that the interviews would be translated by the researcher and another person was explained to the participants, but this did not make the participants reluctant to participate in the study. The researcher created a therapeutic environment to facilitate the establishment of a good relationship with the participants.

Before starting the interviews, each participant was informed of the research being undertaken and that participation in this study was voluntary. The interviews were taped, with the knowledge and consent of the participants. Three patients were interviewed in the morning and three in the evening, as they were busy during the day. These interviews took almost 15-35 minutes. Some patients had been in the ICU for surgical reasons and others for medical reasons. The researcher made notes after the interviews concerning her thoughts regarding the interviews and the non-verbal cues that had been noted from the participants during the interviews.

A written consent was obtained from the six participants. Participants accepted that notes would be taken during the interviews. The interviews were conducted in isiZulu and English, which were the languages used by the participants. The researcher used an interview guide to avoid losing focus of the purpose of the study (refer to Annexure A and B). She also made use of probing questions to prompt descriptions of participants' experiences during their stay in the ICU. Some participants were accompanied by their family members for support.

4.5 Discussion of the findings

This discussion will be followed by a discussion of the experiences of patients admitted to the ICU. The themes and sub-themes used in the presentation of the data gathered in the research are presented in Table 4.2.

Table 4.2 Themes and sub-themes

Theme	Sub-theme
Living in a hostile environment	Lack of privacy
	Interpretation of noise
	Poor quality of sleep
	Lightning
	Separation from family
	Felt threatened
“Between reality and the unreal”	
The effect of culture and religion	
Experiences of painful routine procedures	
Experiences of caring and providing and security	Assurance
	Explanation
	Communication with nurses
	Communication with doctors
Transferring out	
Participants’ recommendations	Privacy
	Noise and Sleep
	Family visits
	Culture
	Need for information

4.5.1 Living in a hostile environment

When asked to give their thoughts about the ICU environment, all of the participants said it was a difficult, hostile environment, and they commented on the screens between the patients' beds, saying that they could still see and hear what was happening around them and could hear patients shouting.

4.5.1.1. Lack of privacy

One of the main comments from the participants related to the lack of privacy.

Lizzy claimed that she felt extremely uncomfortable and requested that the nurses be excused from the scene:

I was very embarrassed when my clothes were stripped off, and when the doctors, especially the male doctors, examined me in front of the nurses during the ward round. I was not comfortable at all... I asked the nurse to give me a minute.

Mzulu explained further:

I was embarrassed at first, but felt guilty when small girls lifted me from the bed and I was shy during the bed bath when they washed my genitalia.

The participant's embarrassment was indicated by red cheeks when he spoke about the lack of privacy.

Menzi explained:

I felt terrible embarrassment, especially when stripped while other patients had full view of what was happening. There was no space to push in the screen... The nurses offered me little privacy because of the space problem... when the doctor examined me in front of the nurses I felt like sinking into my bed and being covered completely. I was not at all comfortable during nursing procedures because of the insufficiency of privacy. [PARTICIPANT HAD BRIGHT RED CHEEKS]

Shaun expressed her complex feelings:

I was embarrassed at having my clothes stripped off, but, at the same time, I felt [nurses] were helping me because I could not dress myself... when doctors examined me I felt very bad because I thought there was something which they had noticed which indicated that I would soon die. I was very frightened because it was the first time I had been bathed and admitted to hospital, and the insertion of the tubes was strange, especially as they were

interfering with my private parts. I could see and hear what was happening around me. Patients were shouting.

She added:

Having my clothes removed made me feel humiliated and I was very embarrassed when I was examined in front of all the people and felt shy as I did not expect to be exposed to all the doctors and nurses.

One participant felt that the nurses worked fast and never exposed her unnecessarily.

Lucy said:

I was not embarrassed by the exposure to the doctors and nurses. I took it as a routine... the nurses worked fast and never exposed me unnecessarily.

Most of the participants confirmed that they could see and hear other patients and what was going on around them. In a study carried out on the needs of adult patients in ICUs in an Estonian hospital, Aro et al. (2012) mentioned participants' concerns about privacy. These authors highlighted the need for privacy, even though 76.7% of the participants agreed that their privacy had been ensured during all the procedures, and that they were not too worried about privacy as they had assumed that there would be no privacy in the ICU. This is in line with the study in which Morton et al. (2005) stated that a lack of privacy and fears related to overhearing the ICU routine and discussions caused anxiety and could worsen sleep problems.

4.5.1.2 Interpretation of noise

One participant explained to the researcher that she didn't expect noise; she had thought it would be quiet in hospital and that she could hear the sounds of the ventilators, telephones, pedal bins and nurses' voices in the unit. Participants frowned as they described the noises in the ICU, and, when they spoke of machines that sounded like frogs, it was evident to the researcher that they had found the noises disturbing and irritating.

Lucy said:

Although I was sick I was irritated by the noise from the machines... They sounded like frogs in the river, and it was worse if the nurses were very busy and couldn't attend to it, but if they were not busy, the nurses attended to this. Alarms of machines for running fluids... too much noise, especially if the line was blocked and it was very painful if the nurses squeezed it to unblock it. Oh no! How can I forget the noise the nurses made? Chatting, mumbling, phones ringing for 24 hours... didn't know if it was day or night. I did not expect noise. I thought it would be quiet in hospital. Nobody told me what to expect [FROWNING].

Some participants found the noise of the ventilators disturbing because they sounded like a man snoring. Participants mentioned that there was a telephone near to the patients in the ICU and that they were constantly awakened by the noise of it ringing, particularly at night. They also mentioned the sound of shoes.

Don explained:

I was irritated by the noise and lights. I heard sounds of shoes: Qwa, bang; the bang of pedal bins and the dropping of objects... Immediately I woke up and heard the ringing of a telephone near me.

Mzulu mentioned that:

Church people came and sang over me as they prayed for the sick people. I found it noisy, but I couldn't do anything as it is important to pray. The machines were making a noise as if there was a snoring man near me and there was a ringing of phones.

Most participants had been disturbed and were sometimes fearful of the noise.

Lizzy said:

Hmm... beeping of alarms; bang, bang of pedal bins, dropping of objects... nurses always laughing and mumbling. But I can't express the sounds of the machines... it was scary and irritating. Although people who were singing and praying made a noise, this was better because it was important.

Many patients complained of the noise in the ICU. The findings of this study were supported by Ramful (2005) who conducted a study on the psychological disorders caused by sleep denial in ICUs. This author mentioned that the noise in an ICU environment involved ringing phones, talking, beepers and equipment sounds from infusion devices; alarms from cardiac monitors, while pulse oximetry and ventilators added to the noise pollution. Conversation between health professionals was also a common cause of too much noise in the clinical environment.

Similar findings were highlighted in a study conducted by Hweidi (2007), who found that some of the most important stressors in patients were the noises from buzzers and the alarms from various processes of technology and machines. Johansson et al. (2012) support this, saying that most patients remembered some sounds from their stay in the ICU, but that, while many were aware of the sounds, they had not found them disturbing. Morton et al. (2005) state that the noises of patients in close proximity to each other could be worrying.

4.5.1.3 Poor quality of sleep

Patients often complained about the poor quality of sleep in hospitals. This would be worsened by their awareness of unfamiliar and irritating noises. In this study, participants felt that their sleep had been interrupted. Some participants said that such interrupted sleep caused them to feel anxious. They felt that nurses should be more sensitive to their sleep needs. Shaun mentioned:

I couldn't sleep, phones were ringing. I heard the other nurse shouting "Help". And they left me alone. I slept for only five minutes then I woke up. Lights were on, I couldn't see the time; nurses were rushing around doing their jobs. I heard the sounds of shoes: Qwa, Qwa Qwa, Qwa and immediately I woke up. Nurses must be aware that I need to sleep.

Don explained that:

There are not so many sick people in this ward. In the ICU it was different because they were always busy and noisy... that is why I could not sleep and stayed awake most of the time and didn't know the time of day.

Lizzy confirmed:

No, because of the bright lights where the nurses stayed during the night. Lights were switched on at night and disturbed me. The tubes disturbed me. When I turned I couldn't sleep at all. Sometimes doctors woke me up taking bloods and nurses gave me injections so that I couldn't feel pain. Noise of nurses, the bang of pedal bins caused me to be unable to sleep. I wish nurses could be more aware of noise. Anyway I understand that nurses are busy.

This showed the feeling of never getting sufficient sleep. Some of the participants told the researcher that there was no difference between day and night due to the noise, and that it was important that patients in the ICU should have enough sleep. Participants thought that nurses should be more aware of their sleep needs.

This is in line with Kamdar et al. (2012) who stated that severely ill patients commonly experience an inability to sleep characterised commonly by disruptions and the loss of circadian rhythms. Patient-ventilator dysynchrony, medication, patient care, interaction and environmental noise and light are factors that are associated with disruption of sleep in the ICU. Eliassen and Hopstock (2011) mentioned that sleep deprivation is common amongst patients in intensive care units (ICUs) and can lead to physiological and psychological dysfunctions that affect the healing process and increase morbidity and mortality.

4.5.1.4 Lighting

The participants reported that continuous bright lighting, especially during the night, disturbed them and affected their sleep.

Don told the researcher:

The bright light was on for 24 hours and I couldn't sleep, even when I took sleeping tablets. Instead, the sleeping tablets confused me. And I slept for a while and then woke up. I was tired all the time. I couldn't differentiate between day and night and felt disorientated in terms of time.

Mzulu reported:

No, can't tell you. In ICU you couldn't even see the view. All you saw was the wall, bed, machines. The lights were on 24 hours a day. Nurses were busy.

The participants were not happy about the lights that were on all night and all day as this resulted in participants not having enough sleep.

Lizzy told the researcher:

How could I see if it was day or night? To me it was the same. I only saw walls, no windows, I could not see if it was night because those lights were always on.

Menzi commented:

That I cannot tell you, all I saw was the walls, the light were bright for 24 hours a day and nurses were very busy. I kept on asking the nurses for the time.

This finding is similar to that of Ramful's, (2005) namely that patients who also mentioned the bright lights from the nurses' station; lights that were not dimmed and which were switched on at night were very disturbing to the patients' sleep which caused psychological disturbances in the ICU. Nurses forgot to dim the lights, or there were sick patients who needed medical or surgical interventions, or there had been an emergency admission.

4.5.1.5 Separation from family

The results of the study showed that visitors played a very important role for the participants. All the participants had been allowed visitors during visiting hours, but they all wished that the visiting time had been longer. There were 2 hours visiting times per day, from 11h00 to 12h00 in the mornings and 18h00 to 19h00 in the evenings. However, visitors were not allowed in the unit during these times if the doctors were doing their rounds or were busy with procedures and this caused complaints as some visitors had come from far away. However, the participants explained that the nurses ensured that visitors were able to spend one hour with their relatives once the doctors had finished. One of the participants said she had desired to be with her children, some worried about the long distance their families had to travel,

hours. The participants explained that they missed their spouses and children and found this stressful. This showed that the participants felt distanced from families while they were in the ICU and were anxious about them having to travel long distances.

This was confirmed by Menzi, who said to the researcher:

Firstly my family comes from far away. They stayed only for one or two hours and it was not enough. We couldn't discuss our concerns because time was short. It would be better if they could shift me to a local hospital so that they could see me every day. But nurses make sure that we spend the restricted minutes with our families.

Lucy made the following statement:

Oh I miss my parents, especially my mum. I only spent two hours per day with her. I wished she could sleep with me. I didn't have enough time to talk with her. The time was too short. I wished I could extend time. Did not have anybody to talk to except for reading my Bible and books.

Shaun was not happy to be in hospital because she was from far away and wanted to see her family every day.

She said:

It would be better if they could shift me to another hospital so that I could see them every day. I miss my family. I wish they could give us enough time. I could not talk to other patients, as they were too sick to talk with me.

She explained that she had felt isolated because the other patients in the unit were too sick to talk and she needed to have somebody to talk to. She felt she hadn't been given enough time to talk to her family.

It was clear that, although participants were sick, they didn't want to be far away from their families and it showed that participants were close to their families.

This showed that participants felt distanced from their families while they were in the ICU and were anxious about them having to travel long distances.

This was confirmed by Don when he said:

I needed to go home to my wife and kids as soon as possible... I could not wait to go home, I missed them a lot.

This study has similar findings to those of Strahan & Brown (2005) on experiences of patients following a transfer from an ICU. All the participants needed to be discharged, and it was clear to the researcher how important it was for them to see their relatives. Visits from close relatives should be made easier by the nurses because these generally encourage the severely sick patient to stay alive (Engström & Söderberg 2007). Engström (2008) also explained that nurses have difficulty in communicating with critically ill patients who are unable to speak, and that close relatives who know them well can better assess whether they are tired or in pain, which can then be communicated to the staff. People who have been critically ill were aware when close relatives were present during their illness, and their presence made the patients feel more secure. When close relatives were absent, critically ill patients felt alone, as if they were lost and trapped in their beds and could die. They felt vulnerable, worn out, ill and unable to speak. They wanted close relatives to visit them and stay with them as long as possible so that they might feel safe.

This finding was confirmed by Alpers, Helseth and Bergbom (2011) who stated that staying in hospital, especially during treatments that confine patients to bed, may lead to feelings of being excluded and isolated from ordinary society and social life, and may result in feelings of loss of identity. Cutler et al. (2013) found that family visits reminded critically ill patients of their life outside hospital, and that family visit times made patients think about their families at home and life outside the hospital. Therefore, patients often became upset when family members left after a visit. Aro et al. (2012) added that this was compounded by the fact that visiting times are restricted in ICU areas. The participants were not happy when discussing this aspect during the interviews, which was evident from their facial expressions.

4.5.1.6 Felt threatened

The participants reported that they found having lines and tubes in their bodies stressful. One of the participants told the researcher that she was scared of the

machines that were attached to her, since it was the first time that she had been admitted to hospital and didn't know what intensive care involved.

Menzi said:

I was scared. I thought I was going to die, leaving my kids alone. I was restless, trying to take out the tube and I had never slept in a hospital in my life before. I was scare of the lines and tubes that were attached to me.

Lucy told how nurses had threatened to restrain her:

Then I remember fighting with them telling no, or trying to say no and I remember them saying 'we have to keep these in or we'll have to tie you down'. I was scared because of the lines and tubes that were inserted in me.

Engström, Nyström, Sudenlin and Rattray (2013) mention that being dependent for survival on other people and technical medical equipment creates a sense of being vulnerable, which leads to feelings of anxiety and uncertainty about one's own capacity to breathe. The study of Langley, Schomllgruber and Egan (2011) found that, although the use of mechanical restraints is a controversial practice internationally, it is common in South African ICUs. In their study of the use of restraints in ICUs at an academic public hospital in Johannesburg, South Africa, these authors found that 48.8% of the patients were restrained and sedated to ensure their safety.

In their study on patients' recollections of their stay in ICUs, Ballard, Robley Barret, Fraser and Mendoza (2006) reported that many of the patients had talked about losing their sense of control over the situation, and attempting to regain control at one time or another during their experience by fighting, especially when being restrained or being told that restraints might be necessary. They also felt threatened at the possibility of having to be tied down. According to Morton et al. (2005) any stress that threatens ones' sense of wholeness, containment, security and control causes anxiety.

4.5.2. "Between reality and the unreal"

This topic deals with participants' recollections of dreams that they had experienced while they were in the ICU, and the difficulty they experienced in separating what

was real from what was not real. All six participants who were interviewed had experienced dreams during their stay in the ICU.

The researcher speaks IsiXhosa and is aware of different cultures and, while working in critical care units, became aware that disturbing dreams were commonly experienced by patients in these units. She was therefore anxious to explore patients' experiences more fully during the interviews.

Menzi told the researcher:

The only thing that I can say, to dream is usually normal, especially for me as a Shembe. If I did not dream there must be something wrong. If I dream I have to go to church leaders (but not always) to describe the meaning of the dream I have. If there is a problem they can solve it by praying through Shembe as is my way to God.

This participant was very happy to discuss this topic. According to him, it is normal for people to have dreams and they can therefore expect to have them in hospital. The participant went further and explained the importance of dreams to the researcher:

Um, according to my culture, dreaming is normal, and if you don't dream that means there is a problem. My dream was scary because my ancestors were angry. I told myself that it was because of that that my dream was like this. I was surrounded by elderly tribal people who were held in high esteem... they have some spiritual connections. I was very confused but not aggressive, I did not know what went on around me ... perfume bath. I know that there was more but can't remember much. [Menzi and Mzulu]

Lucy associated her bad dreams with an evil spirit and woke up so restless, tearful and frustrated that she asked the nurses to call her mother so that she could bring a priest to pray for her.

Lucy described her dream:

I was in an elevator... but I stood... besides I was abusing the nurse who was trying to kill me. I was mad and it was scary. I woke up and I called the nurse to call my mum so that she could come with the priest because I was so restless and I cried.

Shaun explained her dreams:

Mmh... I remember I was in my country. I left the hospital and I could not come back and it was terrible. I was not feeling good. I was on the street. I could not find the hospital and the nurse woke me up, gave me medication. I felt something was inside and it was not a good experience at all. This lasted only two days.

Don also described his dream:

[SILENCE] *I saw an earthquake. I was travelling through a desert on a train. I was so scared. I don't want to be scared during the night. The dream lasted for one week.*

Some participants recalled having dreams that they were dying, causing them to feel frightened or to believe that they were going mad.

Lizzy and Menzi told the researcher that they had even had bad dreams in the ward.

There was a time I felt like I was in a cartoon world. I felt I was going mad, I didn't realise until I came back to the ward that I was too sick... that I had almost died. I thought people had attacked me and that they would come back again. [MENZI]

Lizzy and Menzi associated their dreams with the experiences they had gone through when they had been shot. They explained that each time they thought about the incidents they were sure of having a dream that the same people were still attacking them.

These findings are supported by Green (1996), who highlighted that patients had psychological disorders in the form of distressing dreams and hallucinations, such as experiencing an earthquake, moving through a wilderness, and nightmares that were associated with the feeling that they were dying, frightened or going mad. Such feelings were acknowledged by Ramful (2005), who reported that if patients are denied sleep, they will have difficulty in concentrating and can experience nightmares. Nightmares are sensations that are not true, but can involve any one of the five senses. A person can look, listen, taste smell or feel something that is not there. Seeing something that is not true can be frightening for the person experiencing this, and for those close to them. In a study conducted by Griffiths and Jones (2008),

patients reported nightmares and delusions and the author explained that these might be related to the sickness, the use of sedative drugs and the strange atmosphere of the ICU with its lack of a proper day and night and continuous sounds.

4.5.3 The effect of culture and religion

This theme deals with how the culture and religion of the participants affected their stay in the ICU.

Some of the participants appeared to have strong religious and cultural beliefs and these were evident during the interviews. Some of the participants stated during the interviews how they had prayed when they feared they were dying, or when they had had frightening dreams.

LUCY stated that:

I was saved at an early age. I know the word of God. I believe in him. I am in the hospital, but with God's grace, soon I'll be out of hospital. [SMILE] My pastor and spiritual counsellors visit and pray for me and also my friends.

The religious belief helped her to live without any fear because spiritual counsellors and her pastor visited and prayed for her.

Shaun mentioned how she had needed a blood transfusion, but that she had told them that she could not receive blood because she is a Jehovah Witness. She said that the doctors and nurses had asked her to sign a consent form, which, according to her religious beliefs, she is not allowed to do it. This caused her stress. Shaun also said that the hospital had not catered for various other religious aspects.

Shaun explained:

If you are a Jehovah witness, you have to live according to God's commands. Taking blood from somebody is wrong. I agree to accept treatment in all the aspects apart from those involving the like of blood or blood in components, or food containing it. In all, I refused to be given somebody's blood because of a shortage of blood in my body. I did not sign the consent form when doctors and nurses asked me to sign. I was irritable.

On Saturdays I have to eat cold food, bath with cold water, but they did not understand and some forgot to cater for me.

Shaun stressed the importance of religion:

I used Vaseline that had been prayed over to make me feel better. And I always prayed when I saw people dying and I was always scared .

During his interview, Mzulu mentioned that he had not told the nurses that he was in pain because he wanted to consult his traditional healer. His ancestors were angry because he had not slaughtered a goat when he had bought a car and that was the reason he had been admitted to hospital.

He said:

I did not believe in English medicine. I came here to the hospital just for a drip because I was dry. I wanted to be discharged early so that I could see my traditional healer. Last month I did not slaughter a goat for my ancestors and they were angry after I bought a car. I couldn't bring my traditional medicine here because the nurses always opened the drawers.

Menzi also strongly believed in his cultural traditions and emphasised the importance of his traditional bracelet called an *isiphanga*.

Menzi elaborated:

I was not allowed to expose isiphanga in the hospital because of the infection. According to my culture, this is not allowed. The nurses said I had to cover it.

Lizzy explained the importance of her religion:

Life revolves around my religion. In all aspects of life I try to follow religious practices that put God first. All other activities are secondary.it would be better if the nurse who was looking after me was female not a male. According to my culture I am not allowed to wear short gowns and in the hospital there are no long gowns.

It is unacceptable for people who belong to the Jehovah Witness religion to receive any form of blood input into their bodies, such as packed red cells, plasma and

platelets (Davidson et al., 2008). This causes a very difficult situation when patients have lost blood and are anaemic and in need of a blood transfusion for survival. The findings of this study relating to traditional healers were supported by Van Niekerk (2012), who stated that many communities in South Africa have faith in traditional healers and call on them first for help when they are sick. The findings of the current study were supported by Zeilani (2008) in a study on how cultural norms and Islamic religious beliefs affected the way in which Muslim women perceived the care they received in the ICU. The concept of 'the cultural body' was used to describe the effect of cultural norms and Islamic religious beliefs on their experiences. The women preferred to be cared for by female nurses. Some women indicated that this was because they tended to spend most of their time with other women in their everyday lives. In addition, some Jordanian women felt it was disgraceful to be examined by a male medical doctor (Omran and Al- Hassan, 2006).

4.5.4 Experiences of painful routine procedures

All of the participants in this study complained about the pain they had experienced in the ICU.

Don explained:

I felt pain when they pricked me with needles. Some nurses said to me, 'I'll take the drainage out but I'll give you an injection', but when the nurse took it out it was painful. Also, drips were painful, mmh it was a little painful but I was a bit scared.

Menzi said:

The pain was minimal, I managed to tolerate it. Nurses gave me injections for pain. The insertion of tubes in the nose, ribs, it was not good, that's where I felt it.

Although some of the participants reported that certain procedures had been helpful and provided relief, after removal of secretions their breathing was easier, it is clear that they did experience a certain amount of pain.

Lucy told the researcher:

When they suctioned me, I felt pain and discomfort, and when they inserted drips and put the tube in my nose. I felt pain when they were taking sputum from my throat although, after that, I breathed easily. I was mad feeling more pain.

Lizzy said:

I was always in pain, all the time, and was not comfortable when the nurses turned me, and I felt pain when they pricked me, taking bloods and giving me injections.

De Jong et al. (2013) emphasised that, for patients in ICUs, pain is a frequent event, where incidents of moderate to severe pain are experienced during the ICU stay. Their findings showed that the nursing procedures in the ICU which were most commonly found to be painful were those which involved moving and turning, such as bathing, massage of the back and pressure parts and change of position. Pedersen et al. (2009) explained that intubated patients may be unable to adequately cough up secretions. Endotracheal suctioning is therefore important in order to reduce the risk of consolidation and atelectasis that may lead to inadequate ventilation. The suction procedure is associated with complications and risks including bleeding, infection, atelectasis, hypoxemia, cardiovascular instability and elevated intracranial pressure.

4.5.5 Experiences of caring and providing security

This theme deals with the safety of participants and whether they had received reassurance from the nurses and doctors when they felt frightened by procedures or the ICU environment.

4.5.5.1 Assurance

Most of the participants in this study were happy about the care they had received in the ICU and it was evident that they had found the nurses supportive and caring.

Menzi explained that the nurses had been kind:

I chewed the tubing; the machine was alarming. Nurses talked to me and said, 'Breathe easily don't stress yourself'. Nurses told me that they were going to suction me. Shame, they were kind.

Menzi smiled when he talked about the care he had received, especially when the nurses told him to breathe easily.

This was supported by Lizzy:

Nurses always offered me yoghurt and told me that I was going to be fine. I was worried that the people who had attacked me at the machines might come back again. The nurses told me that only two visitors were allowed in this unit, 'We all here and the doctors are always around. The security guard is always outside the ICU'. [PARTICIPANT SMILED]

The results of a study done by Aro et al. (2012) highlighted that the Estonians placed importance on physical comfort and feeling safe. The majority of the needs regarding reassurance relate to interactions with staff. Designers of ICUs therefore need to provide opportunities for interactions at the bedside. Chaboyer et al. (2007) revealed that admission to the ICU can be very traumatic for the families, but the sense of protection given by the ICU provides reassurance.

According to Wikström et al. (2007), nurses in the ICU not only need to know how to operate the hi-tech machinery, but also need to get to know the patient and take care of relatives while carrying out their duties. Söderström et al. (2006) added that nurses in the ICU need to prioritise care and to control serious conditions. Lastly, in the ICU, caring also involves the nurses' skills in terms of conversation with the patient while giving physical care and mental support.

4.5.5.2 Explanation

The participants told the researcher that, although the nurses had been very kind and explained most things to them, there were some instances when they felt they had not received the explanations they would have liked.

Shaun said:

Nurses were very kind to me, they explained some things, but some things were not explained, for instance, I was admitted to the ICU, but they did not tell me why I was here. If I needed help they always came to me. They were always next to my bedsides. If the nurse was leaving she would say,

'M'am I'm going for lunch, I'll be back, don't worry, there are other nurses who will take care of you'.

Lizzy had been worried about the sounds of the alarms on the machines and felt that the nurses had not reassured her by explaining why they were there. She said:

Because of the blood I had lost, the wires showed the functions of my heart which was their explanation. The nurses did not explain this in a way that I could easily understand, and I did not know how these things worked and I thought the alarming machines showed that I was going to die, especially when the doctors were discussing me.

Mzulu told the researcher:

Nurses did not tell me why I was here, but I didn't mind because I was sweating, sick, depressed, with no one to talk to.

Don explained that the nurses had tried to explain things to him, but that he hadn't understood. He seemed very comfortable when I interviewed him on this topic:

Nurses were trying to explain, but not everything, and not in a way that I could easily understand.

In a study done by Aro et al. (2012) in Estonia, these authors maintained that information and explanations should be given to patients in the presence of their family. However, Ballard et al. (2006) suggested that nurses use a therapeutic touch by giving information and providing reassurance so that each patient knows that he or she is being cared for. Meriläinen, et al. (2013) observed instances where patients did not receive the necessary information, such as when staff members informed the patient what they were about to do, while they were, in fact, already carrying out that task, or when nursing duties were disturbed and the patient was sleeping, and, when the duties resumed, the staff member did not tell the patient what tasks they had been busy with.

4.5.5.3 Communication with the nurses

The findings showed that participants communicated mostly with the nurses. There were always approximately 8 nurses on day duty and 9 nurses on night duty. While the enrolled nurses performed many of the nursing activities, each shift had more than

2 registered nurses. The participants understood that the nurses were always busy and acknowledged that, while they did communicate with them, it was mostly about medical or physical topics and not about their concerns. The participants indicated that they had expected the nurses to let them discuss their social, physiological and spiritual needs with them.

Menzi explained:

I tried to talk but it was difficult and the nurses were always available. They gave me a letter board to write on, but I was unable to hold the pen and a nurse helped me to hold the pen. It was very nice what they did, but it will be better if nurses can talk to me about my concerns not only about my health.

Don said that the nurses had helped him a lot. He explained:

Nurses were very kind to me, they explained before and after examination, nurses reassured me when they changed my position. They were always asking me if I was comfortable and telling me I would be fine.
[PARTICIPANT SMILED]

If I couldn't talk, the nurse said I must blink an eye. Nurses must talk to me about my spiritual needs.

The findings showed that, although the participants were very sick, communication was very important to them. Their inability to express themselves verbally made them find other methods of communication in order to meet their needs. It was recognised that they used non-verbal forms of communication, which included gestures and expression through writing.

These findings were supported by Meriläinen et al. (2013), who conducted a similar study on patients' memories of the ICU. According to these authors, communication means talking at the same time and/or indicating non-verbally, listening and/or observing non-verbal actions, thinking, interacting, planning and responding. It also involves understanding things from another individual's view, and interpreting and responding to actions found in individual experiences. In a study done by Johansson and Fjellman-Wiklund (2005), findings showed that patients reported difficulties in communicating during ventilator treatment, or if they had a tracheostomy tube, as

they had problems moving and controlling their arms, writing or communicating with gestures. They expressed feelings of being both physically and psychologically restrained by all the equipment that was attached to their bodies in the form of lines and tubes to machines, drips and medicine. Some found that the lines and tubes prevented them from moving in bed. They concluded that being unable to speak resulted in feelings of frustration and powerlessness, and highlighted the importance of staff skills in promoting other methods of communication.

However, as Morton et al. (2005) state, effective communication with seriously ill patients is generally challenging and depressing for different reasons. The insertion of endotracheal tubes prevents oral communication, and patients' physiological status and treatment may alter their cognitive functions, making effective communication difficult.

4.5.5.4 Communication with doctors

The findings showed that the majority of the participants felt that the doctors had communicated with them in a professional way. They said that every morning while they were in the critical care unit, doctors greeted each patient and asked them how they felt and participants believed that the doctors were good. During the rounds and physical examinations they would ask questions which the participants were able to answer. If the participant did not understand the question, the nurses were available to explain what the doctor was asking.

Shaun explained:

Mmm... doctors were there to explain and said, 'I will prescribe tablets that will relieve your pain'. They introduced themselves and asked about my progress. 'I am a doctor, a specialist. I will examine you and I'll close the screens'. Doctors were so gentle. They talked to me for a very long time discussing and discussing my condition.

It became evident that participants had positive memories of doctors' rounds and their discussions regarding their progress and treatment.

Lizzy said:

The doctors were very kind and asked me about my progress and listened well to me and showed great interest. They talked to me for a very long time discussing my condition.

Mzulu told the researcher:

Mmm... I'm always afraid of white doctors, especially when they said to me, 'Good morning, how are you? I am a doctor so I'll examine you'.

Lucy said:

Okay, the doctors came early in the morning to greet me then asked me how I felt on examination, asked me questions that I could answer and I was satisfied about the amount of time they spent with me, and even in the ward they came and visited me... Mmm, doctors were there to explain and said to me, 'I will prescribe tablets that will relieve your pain' and I told them I didn't understand and I told them and I was happy.

The participants were pleased that the doctors had introduced themselves and had made an effort to interact with them. This study showed that the relationship between participants and the doctors was good.

Most patients said they were happy with the way medical information had been explained to them by the doctors and felt it had been given honestly and clearly. According to Antai-Otong (2007), communication includes accepting things from another individual's view, and translating and replying to behaviour found in individual experiences.

4.5.6 Transferring out

There were different responses from the participants when asked about their experiences of moving from the ICU to the ward. They indicated that it was very important that patients should be provided with information about being transferred from an intensive care unit to the ward as they need to be emotionally prepared for such a move.

Lizzy told the researcher:

It was hard. You do not know where are you going to, what is going to happen, although I was fine. I tried to do my things alone in the ward. The noise, especially the ones with higher levels speak loudly. When they took blood pressure, they just tied your arm before you knew where you were, but anyway, it is their job. The ward was so hot, no fans. In ICU, one nurse looked after me, here though it is totally different. Nurses in the ward, they just strap your arm before you know where you are.

Lucy explained:

Mmh, it was a bit of a shock. They did not tell me that I was out of the ICU. I was more settled in the ICU. When I came up to the ward it was funny to me, but more about the funny... No, the nurses will kill me [laughs]. I could bath myself then and that meant I would be better and go home as soon as possible.

Although the participants found the move to the ward unsettling, they settled down quickly in the new environment.

Don explained:

Moving from the ICU was a way of getting to stand up on my own. I was encouraged to get out of bed and walk whilst in the ICU. I was wired to something in the ICU. In the wards they helped me, but they were not as fast as in the ICU.

The participants mentioned that it was hard for them to be moved out of the ICU without being told where they were going. Some of them also mentioned that the nurses in the wards were not as fast as the ICU nurses and took much longer to attend to them when they needed help.

Mzulu made the following statement:

Okay! It was convenient, but it was disappointing and I was not happy, but I adjusted myself again. It was not difficult, because I was happy with my way of lying down. I knew that I would be discharged soon. Doctors visited me, but this ward was very hot,

no fans like in the ICU. I was ringing the bell for a long time because the nurses were too busy to attend and came late.

To leave the ICU meant getting better to some patients and was therefore linked to positive feelings. Nevertheless, these feelings were voiced after discharge from the ICU as a retrospective reflection. Another patient thought that, since the decision to transfer them was made by the health care professionals, it was not the patients' choice (Cutler et al., 2013). Similar findings were highlighted in a study conducted by Forsberg, Lindgren and Engström (2011) who found that patients felt that it was important to be prepared for the transfer and to know what was going to happen. Some participants had felt more secure in the ICU, while others appreciated leaving the stressful environment of the ICU for a more peaceful ward. Patients felt worried and exposed during the transfers and felt that it would have been helpful if the staff involved had been made known to them.

Strahan and Brown (2005) found that participants need an explanation when moving from the ICU to the ward, and nurses should give such information to the patients and their relatives. This was supported by Chaboyer et al. (2005) who found that the transition process from the ICU to the general wards involves patients, relatives and staff. Field et al. (2008) found that many patients were not prepared for the busy environment of a general ward, and found that they were nervous and felt unsafe due to the noise from other patients and their visitors. Chaboyer et al. (2007) mentioned that, although transferring patients from the ICU to the wards is a common event and part of the routine, patients are generally not consulted about the process, nor are they given the chance to voice their demands, which aspect might be experienced as traumatic by them.

4.5.7 Participants' recommendations

The participants suggested a number of recommendations for future patients in ICU.

4.5.7.1 Privacy

The participants felt embarrassed at having their clothes stripped off, particularly when doctors examined them in front of nurses during procedures.

Shaun said:

Having my clothes removed made me feel humiliated and I was very embarrassed when I was examined in front of other people and felt shy as I did not expect to be exposed to all the doctors and nurses.

Lizzy said:

I was not comfortable at all...I asked the nurses to give me a minute.

This is in line with the study in which Morton et al. (2005) stated that a lack of privacy and fears related to overhearing the ICU routine were reported by their participants. However, a study conducted by Aro et al. (2012), found that 69% of the participants agreed that they were ensured privacy by being curtained from other patients, while only 17.7% did not.

4.5.7.2 Noise and sleep

The participants told the researcher that nurses should be more sensitive to patients' needs to sleep and thus reduce the level of noise in the unit.

Lucy said:

I did not expect noise. I thought it would be quiet in hospital. Nobody told me what to expect [FROWNING].

Shaun mentioned:

I heard the sounds of shoes: Qwa, Qwa Qwa, Qwa and immediately I woke up. Nurses must be aware that I need to sleep.

Lizzy confirmed:

I wish nurses could be more aware of noise. Anyway I understand that nurses are busy.

This is in line with Kamdar et al. (2012) who stated that severely ill patients commonly experience an inability to sleep characterised commonly by disruptions and the loss of circadian rhythms. Patient-ventilator dysynchrony, medication, patient care, interaction and environmental noise and light are

factors that are associated with disruption of sleep in the ICU. Johansson et al. (2012) explain that most patients remembered some sounds from their stay in ICU and while many were aware of the sounds, they did not find them disturbing.

4.5.7.3 Family visits

Some participants suggested that the visiting times need to be extended since their families came from far away.

Menzi said:

Firstly my family comes from far away. They stayed only for 1 or 2 hours and it was not enough.

Shaun said:

The time was too short. I wished I could extend time.

This is supported by Aro et al. (2012) who added that this was compounded by the fact that visiting times are restricted in ICU areas. This was supported by Cutler et al. (2013) who found that family visiting times made patients think about their family at home and life outside the hospital.

4.5.7.4 Culture

They also recommended that allowances should be made for the different cultures.

Shaun explained:

On Saturdays I have to eat cold food, bath with cold water, but they did not understand and some forgot to cater for me.

Don explained:

Nurses were trying to explain, but not everything, and in a way that I could easily understand. Nurses must talk to me about my spiritual Beliefs.

The findings of the current study were supported by a study by Zeilani (2008) on how cultural norms and Islamic religious beliefs affected the way in which Muslim women perceived the care they received in the ICU. This is supported by Kaplow and Hardin (2007), when they defined cultural awareness as the process through which nurses learn to recognise and respect the cultural beliefs and values of others, while at the same time acknowledging their own personal judgement and values.

4.5.7.5 Need for information

The participants highlighted that it was hard to be moved out of the ICU without being told where they were going.

Lizzy told the researcher:

It was hard. You do not know where you are going to, what is going to happen, although I was fine.

Lucy explained:

Mmm, it was a bit of a shock. They did not tell me that I was out of the ICU. I was more settled in the ICU. I did not know how these things worked; I thought the machines showed I was going to die.

Strahan and Brown (2005) found that providing information to the patients is a fundamental priority. Information regarding a transfer from the ICU to the ward was something about which patients might receive no emotional preparation or information. Similar findings were highlighted in a study conducted by Forsberg, Lindgren and Engström (2011) who found that patients felt that it was important to be prepared for the transfer and to know what was going to happen.

4.6 Conclusion

All for the participants in this study remembered at least some of what happened while they were in the ICU. According to what the participants said in the interviews they were worried about the environment and these feelings were solved by nursing intervention. They were tired and could not sleep well which they related to careless

noise in the ICU. Participants highlighted the change in the level of care in the wards, and the need for information. They showed that religious beliefs played an important part in their lives. They liked flexible visiting hours. A summary of the findings in this discussion as well as the limitations, recommendations and conclusions are presented in the following chapter.

CHAPTER FIVE

SUMMARY OF FINDINGS, LIMITATIONS OF THE STUDY, RECOMMENDATIONS AND CONCLUSION

5.1 Summary of the findings

This study was conducted with the aim of describing the lived experiences of patients admitted to the ICU of a hospital in the uGu district of KwaZulu-Natal. The data was drawn from individual interviews conducted with six participants. This summary of findings is based on the research questions, to describe the lived experiences of patients who were admitted to an ICU.

5.1.1 Positive experiences in the ICU

There were a number of positive experiences described by the participants stating that nurses in the ICU worked fast during procedures and never exposed the participants unnecessarily. The current study discovered that although the participants reported noise related to singing and praying, this did not worry them because prayer was important to them. Although there was a lot of noise in the ICU, participants acknowledged the fact that the nurses and doctors were working throughout the night.

One participant reported that, with God's grace, she would be out of hospital and that she had been saved at an early age and believed in God. The findings showed that religious beliefs played a big role in the participants' experiences during their stay in the ICU. Some of the participants in this study described themselves as Christians. Their belief in God, a sense of meaning, prayer, Bible reading and the support of religious friends were described as the most valuable tools in coping with the nightmares.

The literature shows that religious beliefs seem to have a powerful effect on the lives of people. A study by the Mental Health Foundation in the United Kingdom showed that religious beliefs played a part in the lives of over 50% of those who were coping with mental illness or the illness of their loved ones (Fosket,1999). In the present study, the role played by religious beliefs in dealing with daily difficulties was emphasised.

The findings showed that, although the participants complained about pains, they reported that some of the painful procedures had been helpful and had provided relief. For example, suctioning had made their breathing easier after removal of secretions. Intubated patients might be unable to cough up enough secretions. Suctioning is important in order to reduce the risk of consolidation and atelectasis that may lead to inadequate ventilation. The suction procedure is associated with complications and risks, however, which include bleeding, infection, atelectasis, insufficient oxygen carried in body tissues, cardiovascular imbalance and elevated intracranial pressure (Pedersen et al., 2009).

Participants also said that, although it was painful at the time, they were more comfortable when the nurses massaged their backs and changed their position. Participants found the staff helpful and patient. One participant reported that he felt safe in the ICU because doctors and nurses were around him and there was security outside the ICU. Most patients said they were happy with the way they had received information from the doctors and felt that it had been given honestly, clearly and compassionately.

The findings showed that good communication was an important factor, and that the nurses had done their best to explain the various procedures, but that the patients had not always understood what they had meant. The participants said that the nurses had helped them to communicate when they could not speak by giving them a letter board to write on, or by telling them to blink an eye. One of the participants reported that he had not minded that he hadn't been given any explanations because he had been sweating, depressed and too sick to care.

This study showed that there was a mutual understanding between the doctors and the participants who told the researcher that the doctors had greeted them each morning and asked them how they were feeling. One of the participants said that he had been scared of white doctors, but had found them to be gentle.

The majority of the participants felt that the doctors communicated with them in a kind and appropriate manner. The participants described the doctors as being very professional and said that their interactions with them had been good. They said that the doctors had introduced themselves and had explained the treatment they were

providing and possible side-effects. Antai-Otong (2007) highlighted the need for good communication which involves interpreting and responding to signals and understanding things from another person's point of view. Most patients said they were happy with the way medical information had been explained to them by doctors and felt it had been conveyed honestly, clearly and compassionately.

One of the participants revealed that the nurses in the ICU were fast compared to those in the ward, and that she had had one nurse looking after her in the ICU. Participants said that they were able to move their hands and arms freely, not tied down by tubes as in the wards and could do certain things on their own, like bathing themselves. Leaving the ICU was associated with positive feelings because it meant that they were getting better. This participant reported that, while in the ICU, she had experienced a bad dream of nurses who wanted to kill her, but in the wards, she experienced no such dreams.

5.1.2 Negative experiences in the ICU

There were a number of negative experiences described by the participants, stating that they found the lack of privacy distressing. They felt embarrassed at having their clothes stripped off, particularly when doctors examined them in front of nurses during procedures. Three participants reported that they had felt embarrassed when they were stripped while other patients had a full view of what was happening. The researcher found that participants had been afraid of the machines that were attached to them since it was their first experience of an ICU. Most of them complained that they had been disturbed by the noise and the sounds of the various machines. One of the participants had found the noise of the ventilators irritating, saying that they sounded like frogs in the river, and had also complained of the banging of pedal bins and dropping of objects. One participant reported the noise of machines that sounded like a snoring man. Another reported hearing the sounds of shoes. They complained of noise from the staff who were chatting and mumbling, and the ringing of telephones near to the nursing station. They told the researcher that they found the sound of the machines frightening and irritating. One participant complained that the religious group who came to pray and sing for the sick were very noisy. The participants of this study described their experiences of noise in the ICU and most of their responses were negative. This was supported by the findings of a study

conducted by Granja et al. (2005) which produced similar results in relation to the noise of alarms, noise from conversation of the staff and noise from ventilators.

The participants complained about a lack of sleep which had made them feel anxious. They identified various factors that contributed to their difficulty in sleeping. They said they found the unfamiliar and irritating noises disturbing. While they were aware that the nurses and doctors were working around the clock, they found that the continuous bright light, especially during the night, affected their sleep and made it difficult for them to differentiate between day and night. They reported that sleeping tablets hadn't helped and had confused them. They wished that the nurses could be made more aware of the noise. One participant reported that nurses should be aware that she needed to sleep.

Eliassen & Hopstock (2011) mentioned that lack of sleep is common amongst patients in ICU and can lead to physiological and psychological dysfunctions that affect the healing process and increase morbidity and loss of life in the ICU. It is thus noteworthy that the patients in the ICU should have enough sleep.

The participants described themselves as isolated, saying that they felt separated from their families. They missed their children, spouses and mothers and found this stressful. It was clear that, although they were sick, they didn't want to be separated from their families, and this showed that their families played an important role in their lives. The researcher found that the visitors played a very important role in the lives of participants. The majority of the participants expressed the sentiment that the visiting times needed to be extended as they could not discuss their concerns in such a short period of time. All of the participants wanted to go back home, and it was clear to the researcher how important it was for patients in the ICU to see their relatives. One participant told the researcher that she had nobody to talk to and could only read the Bible and books. One participant reported that it would be better if she could shift to another hospital so that she could see her family every day. This finding is consistent with the views of Alpers et al. (2011) who maintained that, staying in hospital, especially during treatment that confined patients to bed, might lead to feelings of being excluded and separated from ordinary community and social life and a feeling of loss of identity. Patients also felt confined as they were tied down in beds. This was the first time that any of the participants had been admitted to an ICU and

they described feelings of being threatened. The researcher found that participants became distressed at the thought of being tied down, and were scared of the machines that they were attached to. These findings are in accordance with Engström et al. (2013), who stated that being dependent on other people and technical medical equipment for survival created a fearful situation and a feeling of doubt about one's own ability to breathe.

Most of the participants said that they had experienced bad dreams while they had been in the ICU which could be associated with a lack of sleep or their medication. They reported that, because they were disorientated in terms of time, they had difficulty in separating their dreams from reality. Two of the participants referred to the constant nightmares they had had about being shot. One participant reported that she was scared in her dream and she associated this with an evil spirit. One participant reported that the dream had lasted for two days. Two participants reported that to dream was normal for them. All of the participants had experienced bad dreams and found it difficult to separate their dreams from reality. It was found that all participants associated their dreams with something. One participant associated his dreams with his ancestors who were angry because he hadn't slaughtered a goat when he had bought a car, which he felt was the reason why he had been admitted to hospital. Other participants recalled having nightmares associated with dying, causing them to feel frightened or to believe they were going mad. One of the participants said that his bad dreams were associated with the shooting he had experienced and that each time he thought about the incident, he experienced nightmares about it.

Various religious and cultural traditions of the participants became an issue for them when these were challenged during their stay in the ICU. The findings showed that one participant refused to have a blood transfusion as this was not permitted by her religion. Another reported that he had to cover the traditional bracelet he wore because of the risk of infection and, according to his culture, this was not allowed, while yet another was not given the opportunity to follow his/her tradition of eating cold food on Saturdays and bathing with cold water. One participant reported that he could not have his traditional medicine in the ICU because the nurses always opened his drawers.

These findings are also supported by the literature. Davidson et al. (2008) explains that blood transfusions are unacceptable to patients who belong to the Jehovah's Witness religion which makes it very difficult to assist patients belonging to this religion when they have lost a lot of blood and are in need of a blood transfusion for survival. Van Niekerk (2012) explains that many communities in South Africa, especially sick people, believe in the ability of traditional healers to heal and the important role that they play.

All participants complained about the pain they had experienced during their time in the ICU. Some of the participants reported that they had felt pain and discomfort during the various procedures such as suctioning, giving of injections and taking of blood and on being turned. They were restricted by lines and tubes and it was painful when they moved. They said that the pain persisted, even when they were given pain injections. This finding is in accordance with De Jong et al. (2013), who emphasised that pain is a common event for patients in an ICU, saying that there would be incidents of reasonable to severe pain during the ICU stay. These authors identified nursing procedures involving moving and turning, such as bathing, massage of back and pressure parts and change of position as some of the common procedures in the ICU that cause pain. One participant reported that the pain was minimal.

Some of the participants told the researcher that, although the nurses had been kind and had explained some things, they had not explained everything, as that patient had been given medication without being told what it was for. One participant reported that the nurses had tried to explain certain things to him, but not in a way that he could easily understand. A participant reported that she thought that the alarming machines showed that she was going to die, especially when the doctors were discussing her. Some participants said that they had not been concerned about explanations because they were very sick. Ballard et al. (2006) suggested that nurses can add a remedial touch by giving information and providing reassurance so that each patient knows that he or she is being cared for.

The participants were not given enough information in regard to their transfer from the ICU to the ward. The participants reported that they did not know where they were going. One participant told the researcher that it was a shock that they did not tell her that she was going out of the ICU. Most of the participants reported a difference in the

level of nursing in the ward, saying that the nurses had seemed too busy to explain what they were doing. They also said that the nurses took much longer to respond to their needs. Strahan and Brown (2005) found that participants need information when moving from the ICU care to the ward and that nurses should give such information to the patients and their relatives.

5.1.3 Participants' recommendations for their care in ICU

The participants suggested a number of recommendations and were very concerned about the need for privacy, proposing that the staff ensure that patients were not exposed in front of others. Patients who were not adequately prepared for the ICU environment often became anxious. The ICU should be designed to limit the visual contact of patients to the suffering around them. Sufficient rest is essential and the nurse, therefore, performs most functions for them. This will reduce the feeling of helplessness and dependency. Spiritual care and guidance are often difficult to render in the ICU due to factors like the inability to maintain an effective communication system, noise, lack of privacy and the disease process. The participants told the researcher that nurses should be more sensitive to patients' need to sleep and should therefore make an effort to keep the use of lights during the night to a minimum and to reduce the noise. Some participants suggested that visiting hours should be extended since their families came from far away. They also recommended that cultural and religious beliefs should be catered for in the ICU. Better information and patients' involvement concerning the transfer from ICUs to general wards as suggested as a means of improving nursing care. Adequate explanations regarding the use of equipment and machinery should be given in the case of an emergency intubation, as this would reduce the feelings of anxiety and panic in the patient.

The ICU nurse should, however, strive at all times to understand the experiences of patients and the meaning that illness and hospitalisation holds for them. She should support the patients unconditionally, and show respect for their religious preferences and practices.

5.2. Limitations of the study

All the data for this study was collected through interviews, and it can be argued that interviewing the participants while they were still in hospital could be seen as a

limitation, as this might have affected the participants' responses about their experiences in the hospital. In other words, the results are limited to what the participants were willing to voice based on their experiences. Furthermore, the fact that the interviews were recorded may have caused the participants to be less spontaneous. A further limitation of this study was the very small sample size due to the chosen methodology, thus the researcher is unable to generalise these results beyond the context of this study.

Translation could also be a limitation, as some words might lose the original meaning that was intended. In order to minimise the negative effect of translation, the transcripts were checked by an expert translator. The presence of the researcher could have influenced the participants' responses, as all were aware that the researcher was from the ICU, and could possibly have given the answers that they thought the researcher would like to hear.

5.3 Recommendations

5.3.1 Recommendations for practice

It was discovered during the course of this study that there were no written guidelines in the ICU of the selected hospital which addressed the issue of dealing with the experiences of patients admitted to the ICU. An awareness of the experiences of patients in the ICU needs to be created among staff. Protocols and policies concerning noise, lighting, painful procedures and transferring patients out of the ICU to general wards should be made available to guide staff, as this could possibly improve service delivery in the ICU. When designing new ICUs, sufficient space between beds should be planned, windows should enable patients to see the sun and thus remain oriented to time. The nurses should explain to the patients that the suctioning process is aimed at reducing discomfort. ICU nurses should be more aware of sleep disturbances and should implement the following actions to promote sleep: prevention of excessive light and noise from alarms and limiting of staff conversations, evaluation of the need for nursing care interruptions and allowing of an opportunity for uninterrupted sleep times during night and day, explanation of environmental sounds and provision of other information to reduce patient anxiety, provision of adequate pain relief and hypnotics and evaluation of continuous analgesia to promote effective sleep. The ICU nurses should discuss their transfers

with individuals during the pre-transfer period and provide information about the changes the patient can expect.

5.3.2 Recommendation for education

It became apparent during this study that there is a need for ICU staff to be aware of the experiences of patients in order to improve the care these patients receive. ICU nurses should be given training in communication and counselling skills. An in-service education is needed to examine the importance of sleep and ways to minimise noise levels. An education programme could also be developed for ward nurses, outlining the psychological as well as the physical needs of post-critical-care patients. It is recommended that the experiences of patients in the context of the ICU should be introduced into the undergraduate and postgraduate training of nurses to make them aware of the specific needs of these patients. The formulated guidelines can be integrated into the in-service education programmes, which will assist the registered nurse to be more sensitive to the needs of patients admitted to the ICU.

5.3.3 Recommendation for further research

There is a need for further research with regard to the experiences of patients admitted in ICUs in KwaZulu-Natal. There is a need for the public interest to be described, particularly in relation to the cultural diversity and religious beliefs that exist in this province. There is a need for more research in the field of the ICU and a need for research which focuses more on patients' experiences. As the sample size in this research study was very small, a quantitative research study in this area would be of great interest to describe the views of more ICU patients.

5.4 Conclusion

The researcher believes that the staff in the ICU will take cognisance of the findings of this study relating to the patients' experiences in the ICU. This study allows the patients' voices to be heard so that we, as nurses, can pay special attention. The researcher recommends that more research be conducted so that nurses working in all countries and cultures can become more aware of patients' experiences in their specific locality, so that they can implement strategies to respond to their patients' cultural needs and thus improve the quality of care they provide.

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ANNEXURE A

Interview guide in English

The following information was requested from the participant at the start of the interview.

1 Demographic information

1.1 What is your age in years?

1.2 Cultural or religious affiliations?

1.3 Length of stay in the ICU?

1.4 When were you in the ICU?

1.5 When were you discharged from the ICU?

2.1 Please can you describe the experiences you remember of your admission to the ICU?

2.2 Please can you tell me about any positive experiences you had during your stay in the ICU?

2.3 Please can you tell me about any unpleasant experiences you had during your stay in the ICU?

2.4 Do you have any suggestions as to how the patient's experience of the ICU can be improved?

ANNEXURE B

Interview guide in isiZulu

Nhlolokhono

Ulwazi oluzofuneka kulowo muntu ozobe ebuzwa imibuzo ngaye.

Imininingwane

1.1 Uneminyaka emingaki?

1.2 Inkolo yakho iyiphi / ukholelwa kweyiphi inkolo?

1.3 Wahlala isikhathi esingakanani egumbinilabagula kakhulu?

1.4 Kwakunini?

1.5 Waphuma nini egujini labagula kakhulu?

2.1 Akusho osakukhumbula okwakusenzeka kuwena ngesikhathi uyongena egujini

labagula kakhulu

2.2 Ake usho izinto ezinhle osazikhumbula ezazenzeka ngesikhathi usegujini labagula kakhulu.

2.3 Ake usho izinto ezimbi osazikhumbula ezenzeka ngesikhathi usegujini labagula kakhulu.

2.4 Ikhona imibono onayo ongakhuphula izinga lokuphathwa kweziguli egujini labagula kakhulu.

ANNEXURE C

Participant information sheet 1

DESCRIBING THE LIVED EXPERIENCES OF PATIENTS ADMITTED TO AN INTENSIVE CARE UNIT IN A PUBLIC HOSPITAL IN UGU DISTRICT

Dear Sir / Madam

Request for participation in the above research

I am a student at the University of KwaZulu-Natal, involved in describing the experiences of patients admitted to an intensive care unit in a public hospital. I am conducting a research project as part of the requirements for Nursing in Critical Care and Trauma (Master's Degree) and your participation is requested as a representative of the population under study.

The purpose of this study is to describe the experiences of patients who have been admitted to an ICU in a public hospital. It is believed that the information gained from this study will be useful. Your involvement in this research will require you to answer questions which will take you about 30-40 minutes to complete and a follow-up telephonic interview. The data obtained from the answered questions will be analysed and interpreted by the researcher. Please note that your identity and information will be treated as confidential, and the researcher will ensure anonymity in the reporting of any information you provide by ensuring that your name is not used for any documents produced. The risk will be minimal. Participation is voluntary, as you are free to participate or to refuse participation at any stage during the study without any penalty. On completion of the study, the findings will be made available to you if you want them. Please feel free to ask any questions you may have so that you are clear about what is expected of you.

Your contribution to this research will be highly appreciated.

I thank you for your participation.

Piliswa Tshokovu
E-mail bantu1@telkomsa.net

Research Supervisor: Prof P. Brysiewicz
E-mail Brysiewicz@ukzn.ac.za

Name of Research Student : Piliswa Tshokovu

Tel : 0733526116

Email : bantu1@telkomsa.net

Name of supervisor : Prof Petra Brysiewicz

Tel : 031-2601281

Email : Brysiewicz@ukzn.ac.za

University of KwaZulu-Natal Faculty of Health Science Biomedical Research Ethics
Committee:

Name : Marie

: Tel: 031-2604769

: Email:BREC@ukzn.ac.za

ANNEXURE D

Participant information sheet in isiZulu

Ulwazi olufunekayo kwabayingxenywe sesibili

UKUCHAZA INDLELA IZIGULI EZIHLELI NGAYO MANA ZINGENISWE EGUNJINI LABAGULA KAKHULU KWISIBHEDLELE SONOBA WUBANI KWISIFUNDA SOGU.

Nduna nomaNkosikazi

Isicelo sobayingxenywe kulolucwaningo lungenhla

Ngingumfundi waseNyuvesi yakwaZulu-Natali ngixhumene ekuchazeni indlela iziguli ezamkelwe ngayo egunjini labagula kakhulu kwisibhedlele somphakathi. Ngenza ucwaningo njengenywe yezidingo ukuhlenga kwaba bucyi nokukhahlamezeka buyacelwa ubayingxenywe kwakho njengelunga lomphakathi kulesisifundo.

Inhloso yalesisifundo kukuchaza indlela iziguli ezamkelwe ngayo egunjini labagula kakhulu kwisibhedlele somphakathi. Kuyakhokakala ukuthi ulwazi olutholakele kulesisifundo kuyobawusizo. Ukubakhona kwakho kolucwaningo kuyakufuna ukuthi uphendule imibuzo eyakuthatha amaminethi awuteti noma awufoti. Ulwazi olufumaneke ekuphenduleni imibuzo iyakuchubungulwa bese itolikwe ngumcwaningi. Siza qinisekisa ukuthi imininingwane yakho nolwazi lobayimfihlo noba wubani onike olulwazi namagamakho akasetshenziswa noma yiphi ingqilikithi ethe yakhishwa. Akuzubakhona bungozi ngobayingxenywe kwakho kulesisifundo. Ukubayingxenywe kukuzinikela, njengoba kukhululekile ubayingxenywe noma ungafuni ubayingxenywe nangasiphi sikhathi kulesisifundo akunasijeziso. Umangisiqedile isifundo, okufunyenwe uyakufumana uba uyakufuna. Ukhululekile ukuza imibuzo ukuze uacelwe okufuneka kuwe.

Ukuba yingxenywe kwakho kulolucwaningo kuyoncomeka.

Ngiyakubonga ubayingxenywe kwakho.

Piliswa Tshokovu.

Isikhahlamezi bantu1@telkomsa.net

Igama lenduna: Njingalwazi P. Brysiewicz

Isikhahlamezi Brysiewicz@ukzn.ac.za

Igama lomfundi ofuna ulwazi : Piliswa Tshokovu

Umakhalekhukwini : 0733526116

Isikhahlamezi : bantu1@telkomsa.net

Igama lenduna : Njingalwazi Petra Brysiewicz

Ucingo : 031-2601281

Isikhahlamezi : Brysiewicz@ukzn.ac.za

Inyuvesi yakwaZulu-Natal Kwicandelo leZempilo no Sayenisi
iomedicalResearchEthicsCommittee:

Igama : Marie

: Ucingo : 031-2604769

: Isikhahlamezi : BREC@ukzn.ac.za

ANNEXURE E

Informed Consent Form

I.....freely and voluntarily consent to participate in the study entitled: **DESCRIBING THE LIVED EXPERIENCE OF PATIENTS ADMITTED TO AN INTENSIVE CARE UNIT IN A PUBLIC HOSPITAL.**

I understand that I am free to participate or to refuse participation at any stage during the research project without any penalty to me. I have been informed that there will be no risk attached to my participation. I have been given the right to ask questions related to the research project.

I have read the contents of this document with understanding and sign knowingly and consciously.

Signature of Participant.....Date.....

Witness.....

ANNEXURE F

Consent form in isiZulu

Ifomu lokuzibophezela

Mina.....ngokukhululeka
nokuzinikela ngiyazibophelela ukuba yingxenyeye yale sisifundo esihloko: **CHAZA
INDLELA IZIGULI EZINGENISWA NGAYO EGUNJINI LABAGULA
KAKHULU ESIBHEDLELA SIKAHULUMENI.**

Ngiyavuma ukuthi ngikhululekile ukuba ngibe yingxenyeye noma ngingabi yingxenyeye ngoqhubeka kwesikhathi kule sisifundo ngaphandle kokuhlawuliswa. Ngitsheliwe ukuthi ngeke kube nabungozi ngokuba yingxenyeye. Nginikiwe ilungelo lokubuza imibuzo ngerisetshi.

Ngiyifundile ingqikithi yalomqulu ngazi ngayo ngaqinisekisa

Isiqinisekiso soba

yingxenyeye.....Usuku.....

Ufakazi.....

ANNEXURE G

Permission to undertake research

Piliswa Tshokovu
University of KwaZulu- Natal
School of Nursing
Durban 4041, South Africa The

Nursing Manager
Port Shepstone Regional Hospital
Port Shepstone

Dear Miss B.C. Ndlovu

Request permission to involve patients in research study

I am Piliswa Tshokovu, a professional nurse working in the ICU currently involved in conducting a research study entitled: **THE LIVED EXPERIENCES OF PATIENTS ADMITTED TO AN INTENSIVE CARE UNIT IN A PUBLIC HOSPITAL IN UGU**. It is hoped that this research study will add information and provide a deeper understanding of patients' experiences when admitted to an ICU. It may enable health professionals to become more sensitive to the needs of critically ill patients. Please see attached the research proposal.

I would like to interview patients who have been in the ICU for at least 24 hours prior to their discharge from the hospital. The patients will be informed of their right to refuse to participate or to withdraw from the study at any time. Confidentiality will be maintained at all times. I will ensure that I will only approach the participants once they are physically and emotionally stable after having consulted with their doctors and prior to their discharge. I will monitor them for any signs of physical or psychological distress during interviews. If any such distress is noted, the interview will be terminated immediately. I will also inform the doctor and ask that any traumatised patients be referred to the psychologist or social workers who are available in the hospital.

Please find enclosed herewith with a copy of the proposal for the project and the letter of permission from the University of KwaZulu-Natal/School of Nursing

Thank you very much and please contact me should you require any further details. My contact details are 0733526116, e-mail bantu1@telkomsa.net. My supervisor email Brysiewiczp@ukzn.ac.za

Yours sincerely

Piliswa Tshokovu

ANNEXURE H

Letter of Support

The Consultant
Anaesthetic Team
Port Shepstone Hospital
Port Shepstone

Dear Dr A Moses

Request for a letter of support for my research study

I am Piliswa Tshokovu, a professional nurse working in the ICU and am currently involved in conducting a research study entitled: **THE LIVED EXPERIENCES OF PATIENTS ADMITTED TO AN INTENSIVE CARE UNIT IN A PUBLIC HOSPITAL IN UGU**. I would like to request your support for my research study as I found that the needs of patients differ and these needs resulted in more complaints regarding the ICU environment, besides which, the act of hospitalisation has different psychological implications for patients from different cultural groups. I found it difficult to relate to patients who could not speak or who were on mechanical ventilators and were unconsciousness. Most patients complained of noise and of not sleeping. Patients recovering from critical illnesses frequently have little or no recall of their period in the ICU or remember nightmares, hallucinations or paranoid delusions and unexplained feelings of panic after discharge from the ICU, and this raised the question about how those patients felt about the care in the ICU and how I could meet their needs. In the ICU we admit both female and male patients while there are only curtains separating their beds. This led to some patients attempting to pull the curtains around their beds most of the time as they said it made them more comfortable, and the lack of privacy led to them seeing or hear what was happening around them. I also noticed that some patients refused to be transferred to general wards. Some patients performed rituals in the ICU that caused infections.

It is hoped that this research study will add information and provide a deeper understanding of patients' experience when admitted to an ICU. It may enable health professionals to become more sensitive to the needs of critically ill patients.

Thank you very much and please contact me should you require any further details. My contact details are 0733526116, e-mail bantu1@telkomsa.net

Yours sincerely

Piliswa Tshokovu
e-mail bantu1@telkomsa.net

Research Supervisor
e-mail Brysiewiczp@ukzn.ac.za



health

Department:
Health
PROVINCE OF KWAZULU-NATAL

PORT SHEPSTONE REGIONAL HOSPITAL
Private Bag X5706, PORT SHEPSTONE 4240
11 Bazley Street, PORT SHEPSTONE 4240
TEL: 039 688 6111
FAX: 039 682 1514
bawinile.ndlovu@kznhealth.gov.za
www.kznhealth.gov.za

Reference :

Enquiries : Ms BC Ndlovu
Telephone : (039) 688 6117

24 April 2012

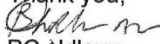
Ms P Tshokovu
Port Shepstone Regional
PORT SHEPSTONE

Dear Ms Tshokovu,

**RE: REQUEST FOR RESEARCH STUDY ON THE LIVE EXPERIENCES OF PATIENTS
ADMITTED IN INTENSIVE CARE UNIT IN PUBLIC HOSPITAL IN UGU**

With reference to your request to conduct research study at Port Shepstone Regional Hospital ICU, the study appears to be valid and relevant to the health care service. I believe that it will assist us in gaining more insight on patients' perspective on our services and improvements needed

Therefore the request is fully supported. Once I receive the research proposal, I will present it to senior management for recommendations and forward it to Head Office Ethics Committee Chairperson for approval

Thank you,

BC Ndlovu
Deputy Manager Nursing
Port Shepstone Regional Hospital



uMnyango Wezempilo . Departement van Gesondheid

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health

Department:
Health
PROVINCE OF KWAZULU-NATAL

PORT SHEPSTONE REGIONAL HOSPITAL
Private Bag X5706, PORT SHEPSTONE 4240
11 Bazley Street, PORT SHEPSTONE 4240
TEL: 039 688 6208
FAX: 039 682 1514
melinda.cranzi@kznhealth.gov.za
www.kznhealth.gov.za

Reference: 2/7
Enquiries: Mr. GBC Khawula
Telephone: (039) 688 6208

18th August 2012

Chairperson: Research Committee
KZN Department of Health
Private Bag 9051
PIETERMARITZBURG
3200

RE: PERMISSION FOR RESEARCH TITLED: STUDY ON THE LIVE EXPERIENCES OF PATIENTS ADMITTED IN INTENSIVE CARE UNIT IN PUBLIC HOSPITAL IN UGU

OBJECT

To grant permission for Ms Tshokovu to do research on the live experiences of patients admitted in Intensive Care Unit in Public Hospital in UGU.

SUPPORTING DOCUMENTS

Appended hereto is documentation received from the University of Kwa-Zulu Natal.

OFFER OF SUPPORT

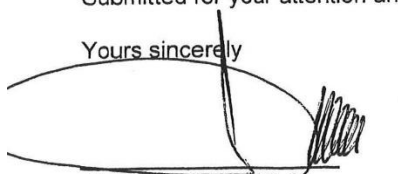
This office wishes to inform that the proposed research to be conducted by Ms Tshokovu is wholly supported. There are no financial implications.

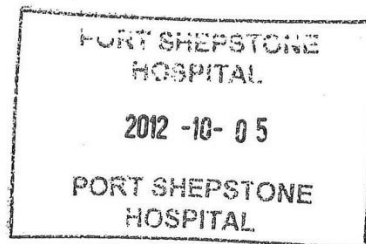
RECOMMEDATION

In view of Ms P Tshokovu request I recommend the necessary authority be granted by the Research Committee for Ms Tshokovu to continue with her research.

Submitted for your attention and further action.

Yours sincerely


MR GBC KHAWULA
CHIEF EXECUTIVE OFFICER



uMnyango Wezempilo . Departement van Gesondheid

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DEPARTMENT OF HEALTH

PROVINCE OF KWAZULU-NATAL

REGIONAL HOSPITAL PORT SHEPSTONE
DEPARTMENT OF INTERNAL MEDICINE

Bazley Street Port Shepstone
Private Bag X5706, Port Shepstone 4240
Tel.: 039 688 6000, Fax: 039 682 6678
Dr M. Panajatovic, Clinical Manager Cell: 083 26 22 55 9

Att: Ms P. Tshokovu
Regional Hospital Port Shepstone

30 April 2012

Dear Ms Tshokovu

Re: Research Study: The Lived Experiences of Patients Admitted in an Intensive Care Unit

I hereby give my full support to the above research study in hope of improving understanding on this very relevant topic.

Regards

Dr Miljenko Panajatovic
Clinical Manager (Internal Medicine)





DEPARTMENT OF HEALTH

PROVINCE OF KWAZULU-NATAL

PORT SHEPSTONE REGIONAL HOSPITAL

Cnr Bazley and Colley Street
Private Bag X5706, Port Shepstone, 4240
Tel.: 039 6886000, Fax.: 039 6825404

Ms P Tshokovu
Port Shepstone Regional Hospital

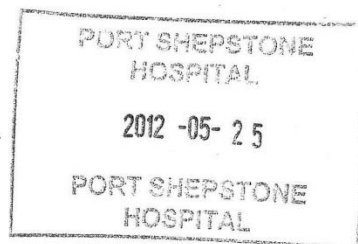
Dear Ms Tshokovu

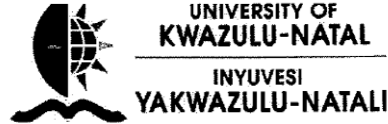
Letter of Support for Research Study

I hereby give my full support to your research study into The Lived Experiences of Patients Admitted in an Intensive Care Unit. This area of healthcare seems to be less well studied and hopefully you will shed more understanding on this very relevant topic. May your diligence be rewarded and your studies be successful.

Sincerely

V L Moses
Consultant Anaesthetist, Theatre/Intensive Care
Port Shepstone Regional Hospital
Ext. 6171





RESEARCH OFFICE
Biomedical Research Ethics Administration
Westville Campus, Govan Mbeki Building
Private Bag X 54001
Durban
4000
KwaZulu-Natal, SOUTH AFRICA
Tel: 27 31 2604769 - Fax: 27 31 2604609
Email: BREC@ukzn.ac.za

Website: <http://research.ukzn.ac.za/ResearchEthics/BiomedicalResearchEthics.aspx>

25 June 2012

Prof P Brysiewicz
C/o Health Sciences
University of KwaZulu-Natal
e-mail bantu1@telkomsa.net

Dear Prof Brysiewicz

PROTOCOL: Lived experiences of ICU patients after discharge: REF:BE049/12

PROVISIONAL APPROVAL

I wish to advise that your application received on 27 February 2012 has been noted by a sub-committee of the Biomedical Research Ethics Committee.

The study is given **PROVISIONAL APPROVAL** pending receipt of:

1. Site permissions
2. Copy of questionnaire to be submitted to BREC for approval and relevant consent forms.

Please refer to attached document "Permission to Conduct a Research Study/Trial". This must be completed and submitted to the Hospital Manager for signature. For King Edward VIII Hospital (KEH) and Inkosi Albert Luthuli Central Hospital (IALCH) studies please submit the document **together with items 1 to 5 as outlined on the form.**

Once the document has been signed it should be returned to this office.


Only when full ethical approval is given, may the study begin. **Full ethics approval has not been given at this stage.**

PLEASE NOTE: Provisional approval is valid for 6 months only - should we not hear from you during this time - the study will be closed and reapplication will need to be made.

Your acceptance of this provisional approval denotes your compliance with South African National Research Ethics Guidelines (2004), South African National Good Clinical Practice Guidelines (2006) (if applicable) and with UKZN BREC ethics requirements as contained in the UKZN BREC Terms of Reference and Standard Operating Procedures, all available at <http://research.ukzn.ac.za/ResearchEthics11415.aspx>.

BREC is registered with the South African National Health Research Ethics Council (REC-290408-009). BREC has US Office for Human Research Protections (OHRP) Federal-wide Assurance (FWA 678).

Yours sincerely

A handwritten signature in black ink, appearing to read 'Ms A Marimuthu', written in a cursive style.

Ms A Marimuthu
Senior Admin Officer: Biomedical Research Ethics Committee

PERMISSION TO CONDUCT A RESEARCH STUDY/TRIAL

This must be completed and submitted to the Medical Superintendent/s / Hospital Manager/s for signature.

For King Edward VIII Hospital (KEH) and Inkosi Albert Luthuli Central Hospital (IALCH) studies please submit the document together with the following:

1. Research proposal and protocol.
2. Letter giving provisional ethical approval.
3. Details of other research presently being performed by yourself if in the employ of KEH, (individually or as a collaborator).
4. Declaration of all funding applications / grants, please supply substantiating documentation.
5. Complete the attached KEH Form - "Research Details"

Once the document has been signed it should be returned to Mrs Patricia Ngwenya: Biomedical Research Ethics Administrator, Room N40, Govan Mbeki Building, Westville Campus, University of KwaZulu-Natal.

To: Chief Medical Superintendent / Hospital Manager

Permission is requested to conduct the above research study at the hospital/s indicated below:

Site 1 address:

Port Shepstone Regional Hospital
P1 Bag 5706 Port Shepstone
Cnr Connor & Barley Street
PORT SHEPSTONE 4240

Investigator/s:

Principal: _____

Co-investigator: _____

Co-Investigator: _____

Signature of Chief Medical Superintendent/Hospital Manager:

[Signature]

Date: 05/10/12

G.B.C. KHUMULA
HOSPITAL MANAGER
PORT SHEPSTONE HOSPITAL

Site 2 address:

Investigator/s

Principal: _____

Co-investigator: _____

Co-Investigator: _____

Signature of Chief Medical Superintendent / Hospital Manager:

Date: _____

NB: Medical Superintendent/s / Hospital Manager/s to send a copy of this document to Natalia



health

Department:
Health
PROVINCE OF KWAZULU-NATAL

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

Reference : HRKM116 /12
Enquiries: Mrs G Khumalo
Telephone : 033 – 395 2805

22 August 2012

Dear Ms P Tshokovu

Subject: Approval of a Research Proposal

1. The research proposal titled '**Describing the lived experiences of patients admitted in an intensive care unit in a public hospital in Ugu District**' was reviewed by the KwaZulu-Natal Department of Health.

The proposal is hereby **approved** for research to be undertaken at Port Shepstone Hospital.

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

For any additional information please contact Mrs G Khumalo on 033-395 3189.

Yours Sincerely

Dr E Lutge
Chairperson, Health Research Committee
KwaZulu-Natal Department of Health

Date: 22/08/2012

uMnyango Wezempilo . Departement van Gesondheid

Fighting Disease, Fighting Poverty, Giving Hope



24 October 2012

Prof P Brysiewicz
C/o Health Sciences
University of KwaZulu-Natal
e-mail bantu1@telkomsa.net

Dear Prof Brysiewicz

PROTOCOL: Lived experiences of ICU patients after discharge: REF: BE049/12

EXPEDITED APPLICATION

A sub-committee of the Biomedical Research Ethics Committee has considered and noted your application received on 27 February 2012.

The study was provisionally approved pending appropriate responses to queries raised. Your responses received on 16 October 2012 to queries raised on 25 June 2012 have been noted by a sub-committee of the Biomedical Research Ethics Committee. The conditions have now been met and the study is given full ethics approval and may begin as from 24 October 2012.

This approval is valid for one year from **24 October 2012**. To ensure uninterrupted approval of this study beyond the approval expiry date, an application for recertification must be submitted to BREC on the appropriate BREC form 2-3 months before the expiry date.

Any amendments to this study, unless urgently required to ensure safety of participants, must be approved by BREC prior to implementation.

Your acceptance of this approval denotes your compliance with South African National Research Ethics Guidelines (2004), South African National Good Clinical Practice Guidelines (2006) (if applicable) and with UKZN BREC ethics requirements as contained in the UKZN BREC Terms of Reference and Standard Operating Procedures, all available at <http://research.ukzn.ac.za/Research-Ethics/Biomedical-Research-Ethics.aspx>.

BREC is registered with the South African National Health Research Ethics Council (REC-290408-009). BREC has US Office for Human Research Protections (OHRP) Federal-wide Assurance (FWA 678).

The sub-committee's decision will be **RATIFIED** by a full Committee at its next meeting taking place on **13 November 2012**.

We wish you well with this study. We would appreciate receiving copies of all publications arising out of this study.

Yours sincerely

Professor D.R Wassenaar
Chair: Biomedical Research Ethics Committee

ANNEXURE 1

Bracketing

Bracketing

I have a fair understanding of the experiences of critically ill patients because of my own experience of nursing ill patients. Patients come from families and patients' needs, therefore, do not exist in isolation. Even in an ICU, patients should not be separated from their families because of the bond that exists between them, and the needs of all members of the family should be taken into account. I feel that novice nurses often feel insecure and uncomfortable at having families at the bedside of their patients in case they might be scrutinising the nurses' performance. In addition, the critical care environment is currently not set up to accommodate the constant presence of families at the bedsides of patients. I believe that patients do not receive sufficient information about their critical illnesses or the ICU environment. Furthermore, patients come from different cultural, educational and religious backgrounds, the dynamics of which affect their experiences while spending time in an ICU. The traditional healers play a vital role in the lives of the patients.

ANNEXURE J

PRESENT: Researcher

40 year old man

DATE: 23 November 2012

FIRST INTERVIEW - VENUE: Hospital

HOSPITAL: PORT SHEPSTONE

Mzulu was the first participant of the study. He asked if I was a nurse and I told him that I was a researcher. I started to introduce myself and explained to Mzulu the purpose as well as the objectives of the study. I invited him to participate in the study. I gave him the information about the ethical considerations such as voluntary participation in the study. After giving written consent, the fact that the interview will be recorded and translated by the researcher with another person was explained to MZULU. The fact that he could withdraw from the study if he did not feel comfortable was explained. The issue of confidentiality was explained. After those explanations Mzulu told me with a smile that he wanted to participate in the study. I explained to him that the process of data collection would be carried out in two parts. Before I started the interview Mzulu had signed the written consent.

Researcher	Good morning Mzulu. Are you scared of the interview? Don't worry I'll make it easy for you.
Mzulu	There are no wrong answers.
Researcher	If you don't feel comfortable with my questions tell me.
Mzulu	Okay, we can start
Researcher	WHAT IS YOUR AGE IN YEARS?
Mzulu	I am 40 years old
Researcher	WHAT IS YOUR CULTURAL OR RELIGIOUS AFFILIATION?
Mzulu	Zionist.
Researcher	HOW MANY DAYS DID YOU SPEND IN THE ICU?

Mzulu I stayed in the ICU for three days.

Researcher WHEN WERE YOU ADMITTED TO THE ICU?

Mzulu Last week Friday.

Researcher WHEN YOU WERE DISCHARGED FROM THE ICU?

Mzulu I was discharged Tuesday evening round about 22h00 hours and I heard nurses saying that they were going to admit another patient who was very sick.

Researcher PLEASE CAN YOU DESCRIBE THE EXPERIENCES YOU REMEMBER DURING YOUR STAY IN THE ICU?

Mzulu I was shaking, scared and my heart was pounding. I see different machines you know what; it was my first time to be admitted since I was born. Nurses were connecting me to machines. Electrodes in my chest. I heard one nurse say “electrodes”. I didn’t even know the use of the machines. They put an oxygen mask on me immediately they changed me and gave me oxygen. Oh, the noise of the machines, they were beeping, it sounded like frogs in the river. My neck was sore where they pricked me with needles. Other doctors said to me, “This is your medication” and it was very painful. I did not listen at all, I felt pain. I remember the nurses giving me medication telling me that it’s for pain, but the pain was still there. When they suctioned me I felt pain and discomfort when they inserted drips and put tubes in my nose. I felt pain when they were taking sputum from my throat. I was mad feeling more pain. I didn’t tell them that I had pain and they asked me, “How is the pain?” and I said “No better” because I wanted to go so that I could go and see my traditional healer. I was embarrassed at first, but felt guilty when small girls lifted me from the bed and I was shy during the bed-bath when they washed my genitalia.

Researcher Mmm....

Mzulu The nurses didn’t tell me why I was here but I didn’t mind. I was sweating and I was very depressed with no one to talk to. I heard people talking opposite to me, I thought it was a ghost because I was sleeping while they were talking. The nurses closed the curtains but I asked them why they were doing that because I was scared. I will tell you if I remember more things. Oh! and scary dreams.! When I ate food I vomited, but the nurses gave me medication.

Researcher PLEASE CAN YOU TELL ME ABOUT ANY POSITIVE

EXPERIENCE YOU HAD DURING YOUR STAY IN THE ICU?

Mzulu Mhm... I was always scared of the white doctors, especially when they said to me, "Good morning how are you? I am a doctor so I'll examine you. Do you understand English?" I nodded my head and he called a nurse to explain. The doctors were so gentle, nurses were near or close to me, everything I needed they gave me. I felt pain but it was better than before. Nurses always asked if there was anything that I needed but you know they didn't talk about your personal problems, only asked about pain. I was scared. I thought I was going to die, leaving my kids alone. I was restless trying to take out the tube and I had never slept in hospital in my life.

Researcher CAN YOU TELL ME MORE ABOUT YOUR SPIRITUAL OR RELIGIOUS BELIEF?

Mzulu Mmm... I did not believe in English medicine. I came to the hospital just for a drip because I was dying. I wanted to be discharged early so that I could see my traditional healer. Last month I didn't slaughter a goat for my ancestors, and they are cross after I bought a car. My church is Zion and I also pray...

Researcher Mmm...

Mzulu Because, in hospital I can't have my traditional medicines. You see this bottle is full of water, my priest prays for me and my water so that I can avoid the dryness. After I am discharged I will be able to drink my traditional medicine. It's difficult to drink it and traditional medicine is not allowed in the hospital that's why I wanted to go home. Nurses opened my drawers during bath time so that they could see and couldn't hide it. I am not allowed to exposed *isiphanga* in the hospital because of the infection. According to my culture, this is not allowed. The nurses said I have to cover it.

Researcher CAN YOU TELL ME ABOUT ANY DREAMS THAT YOU HAD AND HOW LONG THEY LASTED?

Mzulu Um, according to my culture dreaming is normal and if you don't dream that means there is a problem. My dream was scary because my ancestors were angry. I told myself that is it because of that that my dream was like this. I was surrounded by elderly tribal people who were held in high esteem. They have some spiritual symbolic connections. I was very confused but not aggressive. I did not know what went on around me, a perfume bath. I know there was more, but I can't remember much.

Researcher HOW LONG DID YOUR DREAMS LAST?

Mzulu They only lasted for two days that is why I wanted to be discharged so that I could perform my rituals.

Researcher CAN YOU EXPLAIN TO ME ANY SOUNDS OR NOISES THAT YOU HEARD WHILST IN THE ICU?

Mzulu Umm... That was worse than the pain. I heard noises from the patients shouting as if they were mad. Day and night phones were ringing, sounds of dropping objects and I woke up very early. I couldn't sleep even when the nurses gave me sleeping tablets. Church people came and sang on top of my head. They prayed for the sick people. I found it noisy but I couldn't do anything as it is important to pray .The machines made a noise as if there was a snoring man near me and phones were ringing.

Researcher DO YOU RECALL BEING GIVEN ASSURANCE AND EXPLANATIONS ABOUT THE CARE YOU WERE GIVEN?

Mzulu No, not exactly. Doctors tried to explain and some nurses reassured me when they changed my position. always asking me if I am comfortable and saying I will be fine. Nurses did not tell me why I am here but I didn't mind because I was sweating, depressed with no one to talk to.

Researcher CAN YOU TELL ME IF IT WAS DAY OR NIGHT?

Mzulu No I can't tell you. In ICU, you can't even see the view all you see is the wall, bed, machines. The lights were on 24 hours a day, nurses were busy.

Researcher HOW DO YOU FEEL ABOUT THAT?

Mzulu It's not good at all, it looked like I was in jail. I had to keep on asking the time. My watch was far away, I couldn't see it. I couldn't have my cell phone because nurses said it was not allowed since it caused interferences with the machines.

Researcher CAN YOU EXPLAIN TO ME HOW YOU FELT ON BEING TRANSFERRED BACK TO THE WARD?

Mzulu Okay! It was quite comfortable, but it was sort of disappointing not telling me where I was going. I was unhappy about that and I was unhappy, but I settled down again. Now it wasn't difficult because I was comfortable in the way I was laying down. I know that I will be discharged soon. Doctors visit me but this ward is very hot, there are no fans like

in the ICU. I was ringing the bell for a long time, nurses are too busy to attend to me and come late to attend to me.

Researcher CAN YOU TELL ME ABOUT THE ICU VISITING TIMES?

Mzulu I felt good about the visits, for example, my friends and family came and visited me, but some of my other friends stay far away so the transport is scarce. The time is very small so nurses must give us more time.

Researcher DO YOU HAVE ANY SUGGESTIONS AS TO HOW THE ICU EXPERIENCES FOR PATIENTS MAY BE IMPROVED?

Mzulu Yes, ICU makes me scared. Nurses must tell me the use of the machines and what am I supposed to expect or not. I expect them to reduce the noise.

Researcher Thank you.

Mzulu It's a pleasure.

ANNEXURE K

PRESENT: UMcwaningi
Indoda emashumi mane ubudala

USUKU: 23 uNovemba 2012

I- INTHAVYU OKUQALA - INDAWO: Esibhedlele

ESIBHEDLELE: PORT SHEPSTONE

UMzulu wayeyingxenye yokuqalakulesifundo wangibuza ukuthi ngingumhlengikazi ngamtshela ukuthi ngingumcwaningi. Ngaqala ngokuzazisa, ngachaza kuMzulu Inhloso yesifundo. Ngammema ukuthi abeyingxenye yesifundo. Ngamnika ulwazi malunga nobayingxenye kulesifundo awuphoqwa. Uma ngimnike imvume ebhaliwe uMzulu uvivinyo luzoqoshwa. Nokuthi angahoxa kulesifundo uma ezizwa engeneme. Udaba lokubayimfihlo lwachazwa. Emuva kwalo ncaza uMzulu wamamatheka wafuna ukuba yingxenye yesifundo. UMzulu wavuma ngokubhala phantsi

UMcwaningi	Sawubona Mzulu Uyesaba loluhlolo ungesabi ngizokwenza kubelula
UMzulu	Akunazimpendulo ongaifunile
UMcwaningi	Uma uzizwa ungeneme ngemibuzo yami ungitshela
UMzulu	Kulungile singaqala
UMcwaningi	Mingaphi iminyaka yakho
UMzulu	Nginama ishumi mane ubudala
UMcwaningi	Usonta phi
UMzulu	Ngingumzayoni
UMcwaningi	Zingaki izinsuku ulana egunjini labagula kakhulu
UMzulu	Ngahlala izinsuku ezintathu egunjini labagula kakhulu

UMcwaningi	Wangena nini egunjini labagula kakhulu
UMzulu	Ngesonto eledlule ngolwesihlanu
UMcwaningi	Waphuma nini egunjini labagula kakhulu
UMzulu	Ngaphuma ngolwesibini ebusuku ngabo 10 Ngezwabahlengikazi besithi bazofakomnye ogula kakhulu
UMcwaningi	Ngiyacela ungangitshela ngolwakhu lwazi osakukhumbula ngenkathi uhlel'egunjini labagula kakhulu
UMzulu	Ngangingcangcazela, ngesaba inhliziyo yam ishaya kakhulu. Ngabona umshini eyahlukene uyazi kwakukokuqala ukulaliswa kelokho ngazalwa abahlengikazi babengixhuma komashini kwakubekwe izinto ezincane esifubeni sam ngezwa umhlengikazi esithi lokhu kuncane ngangingakwazi nokusebenza komashini. Bafaka ioksijini ngokushesha. Uva umsindo womashini, wawufana namaselesele emfuleni. Intamo yayibuhlungu bengijova ngemijovo Abanyodokotela bathi kimi lokhu yithi yakho Kwakubuhlungu kakhulu. Zange ngalalela ngezwa Ubuhlungu. Ngikhumbula abahlengikazi benginika Imithi bangitshela ukuthi yeyenhlungu kodwa Inhlungu zazisekhona. Uma befaka uphayiphi Esifubeni ngezwa ubuhlungu nokungezwa Bumnandi mna befaka amanzi ngemithambo Bafak'uphayiphi emakhaleni ngezwa inhlungu, uma Bethatha izikhohlela emqaleni wam ngangihlanya Ngizwa inhlungu. Zange ngabatshela ukuthi

ngizw'inhlungu, bangibuza ukuthi inhlungu
zinjani ngathi kungcono ngoba ngifuna bangidedele
ngiyekhaya ngiyohlangana nabelaphi bendabuko
nganginamahloni ekuqaleni uma ingane zesifazane
zingiphakamis'embhedeni. Nginamahloni uma
bengigeza ubudoda bam.

UMcwaningi

Mmh

UMzulu

Abahlengikazi zangebangitshele ukuthi yinindaba
ngilana nami zange ngibabuze. ngangijulukile
ngikhathazekile uma kungekho engikhuluma naye.
Ngezwa bantu bekhuluma ngale kwami ngangicabanga
ukuthi yisipoki ngoba ngangilele ngenkathi
bekhuluma. Abahlengikazi bavale amakhetina kodwa
ngababuza ukuba yinindaba ngoba bengisaba.
Ngizokutshela uma ngikhumbul'okuningi. Oh amaphupho
Asabisayo. Uma ngisidla ngiyaphalaza abahlengikazi
Bangiphe imithi

UMcwaningi

Ngiyacela ungangitshele okuhle okutholile ngenkathi
usegunjini labagula kakhulu.

UMzulu

Mmh ngangibesaba odokotela abamhlophe ngakumbi
uma bengibingelela bethi "sawubona unjani,
ngingudokotela ngingakuhlola, uyasizwa isingisi"
ngashukumis'ikhanda lam wabiza abahlengikazi
bazochaza. Odokotela babelungile abahlengikazi
babeseduzane nami engikufunayo bayanginika.
Ngezwa ubuhlungu kodwa kwakungcono nakuqalo.
Abahlengikazi babesoloko bengibuza ukuthi kukhona na
Engikudingayo uyazi abakhulumi ngokuthi inkinga yam
Yini babuza ngenhlungu. Ngangesaba ngicabanga ukuthi
ukuthi ngizofa ngishiye ingane zam zodwa.
Ngangingaphathekile kahle ngezwa kukhishwa

Iphayiphi, zange ngalala esibhedlele ebomini.

UMcwaningi

Ungangitshela kabanzi ngenkolo yakho

UMzulu

Mmh angikholelwa emthini yesingisi ngeza esibhedlele
Ukuba ngithole uphayiphi ohambis'amanzi ngoba
ngangifa. Ngifuna ngikhululwe ngokushesha ngizokwazi
ukubona umelaphi wam wendabuko. Ngenyangedlule
zangengikwazi ukuhlab'imbuzi ngenzel'amadlozi
bathukuthele emuva kokuthengimoto. Isonto lam
yizayoni ngiyasonta

UMcwaningi

Mmh

UMzulu

Ngobesibhedlele angikwazi ukuleth'imithi yam
yendabuko. Yabona ibhodlela ligcwel'amanzi
umfundisi wam uyangithandazela ukuthi
ngikuvimbe ukoma. Uma sengiphumile ngizophuza
imithi yam yendabuko. Kunzima ukuphuza imithi
yendabuko esibhedlele ayivumelekanga, yingako
ngifuna ukugoduka, abahlengikazi bavule
amadrowa wam ngenkathi ngigeza befuna uwabona
angikwazi ukufihla. Angikwazi ukubekobala
isiphandla esibhedlele ngenxa yokuthelelana
kwezifo, ngeyami nkolo lokhu akuvumelekile.
Abahlengikazi bathi mangiwamboze

UMcwaningi

Ungangitshela ngamaphupho obenawo
Athathi sikhathi esingakanani

UMzulu

Ngokwenkolo yam ukuphupha yinjwayelo ukuba
Awuphuphi kusho ukuthi kunenkinge. Iphupho
lam liyesabeka ngoba amadlozi akwatile.
Ngazitshela ukuthi yingako amaphupho enjena.
Ngangizingelezwe ngabantu abadala, ngangididekile
kodwa ngingathukuthele. Angazi kwenzekani ngayazi

kuningi kodwa angisakhumbuli.

UMcwaningi

Kwathatha isikhathi esingakanani owagcina ukuphupha.

UMzulu

Mmh kwakuqale kunobuhlungu, ngezwa umsindo weziguli bememeza bengathi bayasangana. Ilanga nobusuku kukhalu cingo nezinto eziwayo, ngavuka kwakusasa. Angikwazi ukulala abahlengikazi banginika amapilisi okulala. Abantu besonto bafika becula phezu kwekhanda lam bekhulekela bagulayo ngithol'umsindo kodwa akukho engingakwenza umkhuleko ubalulekile umashini nokukhala kocingo besengathi kunomuntu orhonqayo duzane nam

UMcwaningi

Usakhumbula unikwa isiqiniseko ngosizo ozolunikwa

UMzulu

Cha odokotela bazama ukuchaza abanye abahlengikazi Banginika isiqiniseko uma bengishinsha bimana Bengibuza ukuba kusalungile na. abahlengikazi zange Bangitshela ukuthi yinindaba ngilana, zange nginake ngoba ngangijulukile, ngikhathazekile kungekho engingamtshela

UMcwaningi

Ungangitshela ukuba kwakusemini noba ebusuku

UMzulu

Cha anginakutshela, egunjini labagula kakhulu akukho onokubona kukho indonga imibhede nomashini. Izibane zikhanya amahora awu 24 abahlengikazi baxakekile

UMcwaningi

Uzizwa njani ngalokho

UMzulu

Angizizwa mnandi ngempela sengathi ngisejele ,njalo Ngibuz'ikhathi, iwashi lisekudeni angikwazi ukusibona. anginawo umakhale khukwini abahlengikazi bathi abavumelekile baphazamisa ukusebenza komahini.

UMcwaningi	Ungangitshela ukuthi kwakunjani ukubuyiselwa emuva egunjini labagulayo.
UMzulu	Ok kwakungconywa kodwa ngangiphoxekile zangabangitshela ukuthi ngiyaphi lokho kwangiphatha kabi. Ngangikhathazekile ngabuya ngaxolo kwakhona. Kwakunzima kodwa ngangikhululekile yindlela yokulala. Ngangazi ukuthi ngizodedelwa maduze. Odokotela babengivakashela, kwakushisa kakhulu egunjini labagulayo kungafani nasegunjini labagula kakhulu.
UMcwaningi	Ungangitshela ngesikhathi zokuvakasha egunjini labagula kakhulu.
UMzulu	Ngizizwa kamnandi ngesikhathi zokuvakasha, umzekelo abangane bama umndeni wam uyeza kuzongivakashela kodwa abanye abangane bam bahlala ekudeni manje into yokugibela ayitholakali kalula. Abahlengikazi basiniki sikhathi esincane
UMcwaningi	Ungabunazo izeluleko ukuhlenga egunjini labagula kakhulu kungathuthukiswa kanjani.
UMzulu	Yebo egunjini labagula kakhulu liyangisabisa. Abahlengikazi mabangitshela umsebenzi womashini noba mandikulindele behlise nomsindo
UMcwaningi	Ngiyaboga
UMzulu	Kulungi