

**Perceptions of patients on the fulfilment of their basic
needs while receiving surgical emergency care**

By

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**A mini Thesis submitted in fulfilment of the requirements
for the degree of Master's in Nursing, School of Nursing,
University of the Western Cape**



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Declaration

I declare that the work on **Perceptions of patients on the fulfilment of their basic needs while receiving surgical emergency care** is my own work, that it has not been submitted for any degree or examination in any other university, and that all the sources I have used or quoted have been indicated and acknowledged by complete references.

Chantal Settle

2016



Signed.....



Acknowledgment

I would like, first, to thank my Almighty God for having strengthened me when I was completing this thesis. He showed me His love and tender care whenever I was weak. May Your name be glorified.

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Abstract

Academic hospitals do recognise that all patients have basic human needs. Nurses have been obliged to pay attention to conditions that destabilise patient's health. An academic hospital in the Western Cape is dedicated to living up to its vision to deliver excellent nursing services, which include the fulfilment of the basic needs of patients who are making use of surgical emergency department. Emergency surgical departments should be created in a manner that provides safety and comfort to patients. Patient satisfaction is influenced by the manner in which their expectations about the successful addressing of their basic needs are met. At the moment, the extent of meeting these basic needs during the delivery of nursing care in the surgical emergency department of the academic hospital is unclear.

The purpose of this study was to explore and describe the perceptions of patients about the fulfilment of their basic needs during nursing care in a surgical emergency department at an academic hospital in the Western Cape. The study was conducted according to a quantitative non-experimental descriptive survey design. A convenience sampling method was used to select patients (n = 150) after they were discharged from a surgical emergency department.

A self-administered questionnaire was compiled within the framework of Alderfer's theory, with closed and a few open questions, that was for distribution to respondents. Descriptive statistics were extracted. The responses to items were indicated on a continuum starting at 1 (never) to 7 (always) on a 5-point Likert scale. Respondents signed informed consent before they completed the instrument in a private room that took around 30 minutes. In this study, validity and reliability were maintained during the research process, and ethical principles were adhered to. Descriptive data was presented through mean values and standard deviations and a factor analysis performed. The findings were presented according to six factors that indicated that the responses varied on the basic existence, relatedness and growth needs of patients in a surgical emergency unit. From the findings, recommendation was described for the operational nursing managers in the surgical emergency department to take action during addressing patients' basic needs in the delivery of nursing care.

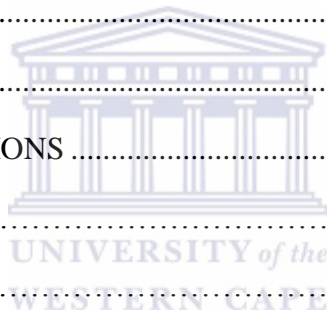
It can be concluded that patients perceive that many of their basic needs are not being met while receiving surgical emergency care.

Key concepts: Patient; Perception; Basic needs; Fulfilment; Nursing care; Surgical emergency department; Academic Hospital; Existence needs; Relatedness needs; Growth needs.



TABLE OF CONTENTS

Declaration	i
Acknowledgements	ii
Abstract	iii
List of Appendices	vii
List of Tables	iv
List of Figures	viii
List of Acronyms	ix
CHAPTER 1: OVERVIEW OF THE STUDY	1
1.1 INTRODUCTION.....	1
1.2 BACKGROUND TO THE PROBLEM	2
1.3 PROBLEM STATEMENT	3
1.4 AIM OF THE STUDY.....	4
1.5 OBJECTIVES	4
1.6 THEORETICAL ASSUMPTIONS	5
1.6.1 Alderfer's theory.....	5
1.6.2 Other definitions.....	5
1.7 RESEARCH DESIGN.....	7
1.8 POPULATION AND SAMPLE.....	7
1.8.1 Inclusion criteria.....	7
1.8.2 Exclusion criteria.....	7
1.9 DATA COLLECTION METHOD.....	8
1.10 DATA ANALYSIS.....	9
1.11 RELIABILITY AND VALIDITY.....	9
1.12 ETHICAL CONSIDERATIONS.....	10
1.13 LIMITATIONS OF THE STUDY.....	11
1.14 SIGNIFICANCE OF THE STUDY.....	11
1.15 CONCLUSIONS.....	11



CHAPTER 2 LITERATURE REVIEW	12
2.1 INTRODUCTION.....	12
2.2 MASLOW'S BASIC NEEDS THEORY.....	12
2.3 ERG THEORY.....	13
2.3.1 EXISTENCE NEEDS.....	15
2.3.1.1 <i>Safety needs</i>	15
2.3.1.2 <i>Physiological needs</i>	15
2.3.1.3 <i>Material needs</i>	16
2.3.2 RELATEDNESS NEEDS.....	17
2.3.2.1 <i>Relationships with family and friends</i>	17
2.3.2.2 <i>Relationships with nursing personnel</i>	18
2.3.2.3 <i>Barriers to effective communication</i>	18
2.3.3 GROWTH NEEDS.....	19
2.3.3.1 <i>Patient participation</i>	19
2.3.3.2 <i>Health education</i>	20
2.3.3.3 <i>Patient internal esteem</i>	21
2.4. BASIC DIFFERENCES BETWEEN ALDERFER'S AND MASLOW'S THEORIES..	22
2.5 CONCLUSION.....	22
CHAPTER 3 RESEARCH METHODOLOGY	23
3.1 INTRODUCTION.....	23
3.2 OBJECTIVES OF THE STUDY.....	23
3.3 RESEARCH DESIGN.....	23
3.3.1 Quantitative design.....	24

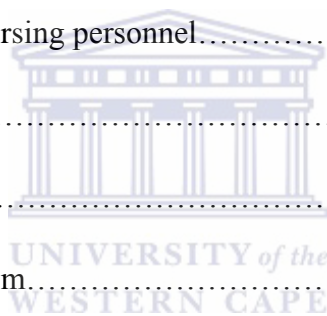
3.3.2 Exploratory design.....	24
3.3.3 Descriptive design.....	24
3.4 POPULATION.....	24
3.5. SAMPLE AND SAMPLING METHOD.....	25
3.5.1 Inclusion criteria.....	25
3.5.2 Exclusion criteria.....	25
3.6 METHOD.....	26
3.6.1 Data collection instrument.....	27
3.7 DATA COLLECTION.....	28
3.8 DATA ANALYSIS.....	29
3.9 VALIDITY AND RELIABILITY.....	32
3.9.1 Validity.....	32
3.9.2 Reliability.....	33
3.10 ETHICAL CONSIDERATION.....	33
3.10.1 Respect for human dignity.....	33
3.10.2 Beneficence.....	34
3.10.3 Justice.....	34
3.10.4 Permission to conduct the study.....	35
3.10.5 Informed consent.....	35
3.11 CONCLUSION.....	35



CHAPTER 4: DATA FINDINGS	36
4.1 INTRODUCTION.....	36
4.2 THE RESPONDENTS.....	36
4.2.1 General characteristics of sample.....	36
4.2.2 Age of respondents.....	36
4.2.3 Gender of respondents.....	37
4.2.4 Highest education level of respondents	37
4.3 PRESENTATION OF THE FINDINGS ON BASIC NEEDS (ERG NEEDS).....	38
4.3.1 Factor 1:Power affirmation.....	39
4.3.1.1 <i>Care</i>	39
4.3.1.2 <i>Communication</i>	42
4.3.1.3 <i>Outcomes</i>	45
4.3.2 Factor 2:Positivity.....	47
4.3.2.1 <i>Relationships</i>	47
4.3.2.2 <i>Attributes</i>	51
4.3.2.3 <i>Other support</i>	52
4.3.3 Factor 3:Less concrete desires.....	54
4.3.3.1 <i>Administrative needs</i>	54
4.3.3.2 <i>Non- administrative needs</i>	57
4.3.4 Factor 4:Physiological needs.....	58
4.3.5 Factor 5:Needs necessary for voluntary survival.....	61
4.3.6 Factor 6:Needs necessary for involuntary survival.....	63
4.4 OPEN ENDED QUESTIONS.....	65
4.4.1 Existence needs.....	65
4.4.2 Relatedness needs.....	67



4.4.3 Growth needs.....	68
4.5 CONCLUSION.....	68
CHAPTER 5: CONCLUSIONS AND RECOMMENDATIONS.....	69
5.1 INTRODUCTION.....	69
5.2 CONCLUSIONS.....	69
5.2.1 Safety needs.....	69
5.2.2 Physiological needs.....	70
5.2.3 Material needs.....	71
5.2.4 Relationship with friends and family.....	71
5.2.5 Relationship with nursing personnel.....	72
5.2.6 Patient participation.....	72
5.2.7 Health education.....	72
5.2.8 Patient internal esteem.....	73
5.3 RECOMMENDATIONS FOR OPERATIONAL MANAGERS TO FULFIL THE PATIENTS' BASIC NEEDS DURING THE DELIVERY OF NURSING CARE IN A SURGICAL EMERGENCY DEPARTMENT.....	73
5.3.1 Recommendation 1.....	75
5.3.2 Recommendation 2.....	76
5.3.3 Recommendation 3.....	76
5.3.4 Recommendation 4.....	77
5.3.5 Recommendation 5.....	77
5.3.6 Recommendation 6.....	77
5.3.7 Recommendation 7.....	78



5.3.8 Recommendation 8.....	78
5.3.9 Recommendation 9.....	78
5.3.1 Recommendation 10.....	79
5.3.11 Recommendation 11.....	79
5.3.12 Recommendation 12.....	80
5.3.13 Recommendation 13.....	80
5.3.14 Recommendation 14.....	80
5.3.15 Recommendation 15.....	81
5.3.16 Recommendation 16.....	81
5.3.17 Recommendation 17.....	82
5.3.18 Recommendation 18.....	82
5.3.19 Recommendation 19.....	83
5.3.20 Recommendation 20.....	83
5.3.21 Recommendation 21.....	84
5.4 LIMITATIONS OF THE STUDY.....	84
5.5 IMPLICATIONS FOR RESEARCH.....	84
5.6 CONCLUSION.....	84
REFERENCES.....	85



LIST OF APPENDICES

Annexure A:INFORMATION SHEET

Annexure B:WRITTEN INFORMED CONSENT

**Annexure C:LETTER OF REQUEST TO PARTICIPATING HOSPITAL TO
CONDUCT THE RESEARCH**

Annexure D:QUESTIONNAIRE

**Annexure E:LETTER OF APPROVAL FROM ETHICAL COMMITTEE TO
CONDUCT RESEARCH**

Annexure F:PERMISSION LETTER

LIST OF TABLES

Table 3.1 Kaiser Meyer sampling adequacy and Bartlett’s test of Sphericity.....	31
Table 3.2 Factor names and reliability of factors.....	32
Table 4.1 Sample.....	36
Table 4.2 Age distribution of respondents.....	37
Table 4.3 Factor 1: Power affirmation.....	40
Table 4.4 Factor 2: Positivity.....	48
Table 4.5 Factor 3: Less concrete desires.....	55
Table 4.6 Factor 4: Physiological needs.....	60
Table 4.7 Factor 5: Needs necessary for voluntary survival.....	62
Table 4.8 Factor 6: Needs necessary for involuntary survival	64
Table 4.9 Classification of existence needs from responses on open ended questions.....	65
Table 4.10 Classification of relatedness needs from responses on open ended questions.....	67
Table 4.11 Classification of growth needs from responses on open ended questions.....	68
Table 5.1 Recommendations of the study.....	74

LIST OF FIGURES

Figure 2.1 Maslow’s hierarchy of needs.....	12
Figure 4.1 Distribution of gender of the respondents (n=150).....	37
Figure 4.2 Distribution of level of education of the respondents (n=150).....	38
Figure 4.3 Responses on Factor 1: Power affirmation- Care.....	41
Figure 4.4 Responses on Factor 1: Power affirmation- Communication... ..	43
Figure 4.5 Responses on Factor 1: Power affirmation- Outcomes.....	45
Figure 4.6 Responses on Factor 2: Positivity- Relationships.....	49
Figure 4.7 Responses on Factor 2: Positivity- Attributes.....	51
Figure 4.8 Responses on Factor 2: Positivity- Other support.....	52
Figure 4.9 Responses on Factor 3: Less concrete desires- Administrative needs.....	56
Figure 4.10 Responses on Factor 3: Less concrete desires- Non administrative needs	57

Figure 4.11 Responses on Physiological needs.....60
Figure 4.12 Responses on needs that are necessary for involuntary survival62
Figure 4.13 Responses on needs that are necessary for involuntary survival63

LIST OF ACRONYMS

- ERG Existence Relatedness and Growth
- ED Emergency department
- SPSS Statistical Package for the Social Sciences
- SD Standard deviation
- PCC Patient centred care



CHAPTER 1

OVERVIEW OF THE STUDY

1.1 INTRODUCTION

Nursing is a compassionate profession with the core of care focussing on attaining the physical, emotional, social and psychological health of the individual to promote their well-being (Cole-King & Gilbert, 2011:32). Nursing care is a discipline that focuses on assisting with attaining, recovering, maintaining health and functioning in a healthy manner, thus a conceptual model (Althammer, 2007:1), integrating concepts into a meaningful composition (Fawcette, 2005:1). Nursing care can therefore be explained as applying judgement in clinical areas when delivering care, in order to assist people with improving or maintaining health, with the aim to achieve the best possible quality of life. Certain basic needs exist for all human beings. The word “needs” refers to a wide spectrum of possible meanings including basic survival needs which are satisfied by necessities, cultural, intellectual and social needs (Business Dictionary, 2015).

This study focused on the Existence, Relatedness and Growth Theory (ERG) of Alderfer (1969). Academic hospitals do recognise that all patients have basic human needs like food, water, shelter and a sense of belonging. The researcher conducted this study in order to explain the basic needs of patients, admitted in the surgical emergency department, in exploring how their needs were attended to.

Nurses are obliged to pay attention to conditions that destabilise patients’ health (Johnstone, 2010:34). The behaviour of the nursing staff should support the specific needs of a patient. It might lead to a higher rate of satisfaction during the hospital visit. Subsequently, patients will feel safer and more confident in an effective environment (Oterhals, Homestad, Eide & Hannsen, 2006:304; Paavilainen, Salminen-Tuomaala, Kutikka & Paussu, 2009:2218). In addition, nursing staff in emergency departments should always consider the patient’s level of knowledge, personal values and attitude, towards care and the manner in which safety and comfort are ensured (Virtanen, Leino-Kilpi & Salanterä, 2007:142; Paavilainen *et al.*, 2009:2218). Patient satisfaction is thus influenced by expectations of the achievement of their basic human needs (Howard, Goertzen, Hutchison, Kaczorowski & Morris, 2007:4).

Literature recognises the importance of further research on the topic of the perceptions of patients on the fulfilment of their basic needs, while receiving surgical emergency care, to foster better coping of the patient and their families in relation to their illnesses. Paavilainen *et al.* (2009:2219) concluded, that patients desired more educational information about their illnesses, especially regarding the action and adverse reactions of their medication and how to manage an acute onset of ill-health. Patients attending the emergency department for the first time, reported that the instructions they received, improved their coping at home after treatment at the emergency department (Paavilainen *et al.*, 2009:2220).

When taking a closer look at Maslow's hierarchy of needs, often represented as a pyramid that include physiological needs being the lowest level of needs, followed by safety, love and belonging, esteem and self-actualisation needs, the more physical needs are placed at the bottom of all hierarchies. Less basic needs and non-physical needs like love, confidence and morality are placed at the top (Galtung, 1990:330). Galtung (1990:330) argued against such a hierarchy of needs under normal circumstances as he believed in situations of utter deficiency.

Maslow identified that in general, people will aim at fulfilling the higher order basic needs, irrespective of the fact whether lower order basic needs were met or not. People experience negative or positive emotions, based on situations or dilemmas they are experiencing. It might even pose threats to the individual, hence the development of a need for conditions that will satisfy them and cause healthy survival to occur (Mitchell & Haroun, 2016:336).

1.2 BACKGROUND TO THE PROBLEM

The study was conducted in one of the largest hospitals in the Western Cape Province, South Africa. The hospital also serves as an academic hospital for various tertiary institutions. The vision of the hospital aims at being recognised for world class health care. To realise this objective, patient satisfaction about privacy, waiting time and effectiveness of staff need to be addressed in emergency departments. The four surgical emergency departments at this institution, attends to about 22 500 patients annually; between 1 000 and 1 500 of these patients present with major injuries at the hospital. The duration of the stay of patients at this surgical emergency department is usually between 2 and 6 days. Space, personnel and equipment in emergency and triage areas may be limited. Most staff members have some relevant post-graduate qualification in addition to their existing degree or diploma. If a

patient is not referred, more than the average waiting time of about three to six hours may occur (French, Lindo, Jean & Williams-Johnson, 2014:123; Batt & Terwiesch, 2015:41), before being attended to by a doctor, and this could increase dissatisfaction in the emergency department. Measuring patient satisfaction levels in emergency departments could assist with determining; the staffing needs that exists in the delivering of health services by personnel, how infrastructure is assisting when patients are being examined, and how methods of cutting down on waiting time or easing the length thereof can be implemented.

Certain protocols do exist in the surgical emergency department at this particular academic hospital in the Western Cape. For instance, the usage of cell phones is prohibited for nursing staff since it disturbs patients and on the other hand the patient care could be disrupted (Basson 2006:1). Patients might feel that nurses do not focus on the care that they deliver; their psychological needs might be influenced; the empathy need might be compromised since emotional distance will increase; and patient-nurse relationships might be influenced negatively.

Another protocol addresses the handling of an admitted patient's property. It includes documents, money, clothes and cell phones. The patient needs to know that his or her property is safe and being kept locked away while they are going for procedures. It is of great concern since admitted patients to emergency wards are not always accompanied by family or friends to e.g. keep their belongings safe. Patients should be given the choice whether their valuables should be kept safe in the hospital, kept by themselves (on their own risk), or sent home (Basson, 2006:1). Protocols, like these examples, assist with the fulfilment of the basic needs in the emergency department, to put the patient at ease, help the patient during recovery, and indicate the patient rights and responsibilities.

1.3 PROBLEM STATEMENT

The need for research was identified in the field of the perceptions of patients on the fulfilment of their basic needs while receiving surgical emergency care (You, Aiken, Sloane, Ke Liu, He, Hu, Jiang, Li, Liu, Shang, Kutney-Lee & Sermeus, 2013:160; Bell, Walton, Chevis, Davies, Manson, Wypych, Yoxall, Kirkby & Alexander, 2013:238).

A study by Howard *et al.* (2007:4) indicated that patients who visited their family physician, were generally more satisfied than patients who received care at the emergency departments.

Nurses have a tendency to focus on a medical model of health care, i.e. taking a history, examining the patient, doing investigations of illnesses, treating these illnesses accordingly and subsequently measuring clinical outcomes. The importance of the scientific model and the interrelation between the quality of life and health needs need to be understood. The researcher has observed certain shortcomings in the delivery of health care in the surgical emergency department; as far as the basic patient needs are concerned:

- Nurses did not prevent the existence of patients' fear and anxiety when these patients were being separated from their families. As a result, patients uttered fear for the unknown (existence needs).
- There were nurses who did not deliver their services with sufficient compassion to form meaningful relationships as observed by the researcher (relatedness needs). The researcher observed scenarios where patients attempted to initiate conversations about certain matters, either personal or health-related with nurses, and nurses avoided to take part in these conversations. Instead, they answered abruptly or responded by saying that they were in a hurry.
- Patients, who were being discharged, did neither receive proper health education nor any health education at all (growth needs). Patients were ill-informed about their health status, health improvement or the degrading thereof (Nigussie, Belachew & Wolancho, 2014:6).

It was unclear to what extent the basic needs of patients were fulfilled at these surgical emergency departments.

1.4 AIM OF STUDY

The aim of this study was to explore and describe the perceptions of patients about the fulfilment of their basic needs, during nursing care at surgical emergency departments in the Western Cape Province. The findings of the study inform the recommendations for operational nurse managers on how to ensure the fulfilment of their patients' basic needs during the delivery of nursing care within surgical emergency departments.

1.5 OBJECTIVES

The objectives of this study were to:

- Explore and describe the perceptions of patients about the fulfilment of their basic needs during their stay in a surgical emergency department; and to

- Describe recommendations for operational nurse managers to fulfil the patients' basic needs during the delivery of nursing care in a surgical emergency department.

1.6 THEORETICAL ASSUMPTIONS

1.6.1 Alderfer's theory

Alderfer's theory (1969) condenses Maslow's five human needs (biological and physiological needs; safety needs; love and belonging; esteem and need for self-actualization) into three categories (existence, relatedness and growth) and this study assumes that a patient had the following basic needs:

Existence needs - refer to physical aspects and include physiological and material components; such as safety and security, psychological and material needs.

Relatedness needs - reflect the degree to which an individual wants healthy relationships such as patient-nurse relationships and patient-patient relationships needs.

Growth needs - represent the desire of an individual to make a relevant impact in what he/she does, to feel involved and reach accomplishments, to mature and enhance life; such as self-esteem and self-actualisation needs; patient competence, confidence and independence (Kessler, 2013:254; Sekaran, 2004:68).

1.6.2 Other definitions

Patient

A person who is under medical care or treatment (Smeltzer & Bare, 2003:5). For the purpose of this study, a patient referred to an adult individual of 18 years of age or older, who was making use of the services at the surgical emergency department of the academic hospital.

Perception

A perceptual process is used by human beings to gain information about elements of the environment that is critical to survival (Otara, 2011:21).

Fulfilment

Not primarily emotions but a sense of accomplishment, enjoyment of life and caring for other people (Weiner, 2003:611).

Basic needs

These are needs that require immediate fulfilment, usually; they ought to be addressed on the basis of priority. For certain human beings, some needs are more urgent to fulfil than for other people. Once an essential need has been met, a higher level need can subsequently be met (Smeltzer & Bare, 2004:5). In this study, basic needs referred to existence, relatedness and growth needs according to Alderfer (1969).

Surgical emergency department

The section of a health care facility or hospital intended to provide rapid treatment for individuals of sudden onset or illness or surgical trauma (Emergency Nurses Association, 2007). Four departments of an academic hospital were included in this study.

Nursing care

Rendering of care which is practised by a person who is registered at the South African Nursing Council as a professional nurse; who supports and assists to maintain the health of an individual until death (Nursing Act, 2005:5).

Nursing operational manager

A professional nurse, who supervises, organises and directs the work of nursing units and departments and who coordinates personnel to assure that effective nursing services are provided, and quality standards are maintained (Reagan & Rodriguez, 2011:101).

1.7 RESEARCH DESIGN

The study followed a quantitative non-experimental descriptive survey design. Quantitative research is useful in providing knowledge. It draws on philosophies of empiricism and positivism (Cowan, 2009:68). The study was regarded as non-experimental since it described the phenomena of basic needs of a patient in a surgical emergency department. Numbers, percentages and averages was used to present the data. A descriptive method was followed since the researcher wished to explore and describe to what extent the patients' basic needs were being met in a surgical emergency department (Cotrell & McKenzie, 2011:9).

1.8 POPULATION AND SAMPLE

An accessible population is defined as those respondents who were available to participate in a study (Johnson & Christensen, 2010:257). The accessible population in this study were all patients in the four surgical emergency departments, who made use of surgical emergency services at the academic hospital. The respondents were chosen consecutively. A convenient sampling method was used since the participating individuals were accessible due to the availability and willingness to participate. Patients were selected over a period of three months (n = 150). Respondents were also selected based on the following eligibility criteria:

1.8.1 Inclusion criteria

To be included in the study, patients had to have been admitted to and have received basic nursing care in a surgical emergency department, for at least two consecutive days before being discharged.

1.8.2 Exclusion criteria

Patients were excluded from the study if they:

- Were discharged to go home without being attended to by a doctor;
- Left the surgical emergency department without being formally discharged;
- Had a psychiatric history (based on medical history or collateral information)
- Participated in the pre-testing of the instrument.
- Patients 18 years and younger.

1.9 DATA COLLECTION METHOD

A survey was used by developing a questionnaire to determine certain improvements or recommendations that could be made to the delivery of nursing care services in a surgical emergency department (Cotrell & McKenzie, 2011:10). The questionnaire contained open and closed questions to explore the phenomena of fulfilment of patients' basic needs. The questionnaire was flexible and custom-designed to meet the objectives of the study (McNabb, 2008:136).

The closed-ended questions which addressed the needs, within the framework of Alderfer (1969), elicited responses about the participating patients' perceptions of the extent to which their basic needs were met, during nursing care delivered in the surgical emergency department. A 7- point Likert type scale was used to measure the levels of perceived fulfilment of basic needs. Respondents stated the extent to which they agreed with questions or statements (Kothari, 2008:86). Responses were indicated on a continuum starting from 1 (never) to 7 (always) on the rating scale. Questionnaires were answered anonymously.

An open question was additionally formulated for each of the sections on existence, relatedness and growth needs. Once the questionnaire (instrument) was developed from the literature, the researcher requested 5 respondents that complied with the criteria of the main study, to complete it, for the purpose of pre-testing it. Pre-testing of the instrument revealed areas for improvement and identified whether each and every one of the respondents understood the items, what was asked of them (Dickson & Flynn, 2009:50).

Collecting the data from the facilities required that the researcher secured an appointment with the nursing manager at the academic hospital. In order to demonstrate fair treatment during the whole process, the researcher met with the manager and respondents to explain what the research was about and to answer any questions around the research process.

The researcher then arranged a visit to the four surgical emergency departments on discharge days. The researcher approached possible respondents, and for the purpose of assimilating essential information, the researcher provided the respondents with information sheets that explained the purpose of the research and the expected duration of the patient's participation.

Respondents completed the questionnaires in a private room (Burns & Grove, 2005:190). It contributed to protecting the respondents from discomfort and harm. Respondents had to provide written informed consent before completing the research survey. The extent of

confidentiality was explained to all respondents (Burns & Grove, 2005:193). Completing the questionnaires did not exceed 30 minutes.

1.10 DATA ANALYSIS

The instrument was developed from a literature review and a statistician was consulted with regard to the statistical tests to be conducted. Data was analysed with the assistance of this statistician at a university who uses the SPSS statistical software program Version 20. Descriptive data analysis presented a holistic picture of the results by indicating the frequencies, mean values and standard deviation(s) of items. According to Burns and Grove (2009:472), the mean is the sum of the scores divided by the number of scores being added together. The standard deviation indicated the degree of error that will result when the mean were singularly used to interpret the data (Burns & Grove, 2007:418). The data was visually presented in the format of charts, tables and figures. The three open questions was also analysed quantitatively.

1.11 RELIABILITY AND VALIDITY

Reliability was ensured in this study, due to the fact that the completion of the self-administered questionnaire required no direct involvement of the researcher. *Accuracy* was taken into account by means of pre-testing the instrument. In the instrument, the researcher took care, of formulating relevant items to the respondents in a clear and an unambiguous manner. Reliability of the instrument was also ensured as the 5 respondents (patients) that took part in pre-testing of the instrument, received the questionnaire again, after 30 minutes that revealed the same results. This evaluated whether the instrument measured what it was supposed to measure, namely the perceptions of respondents on the fulfilment of their basic needs on a 7-point Likert scale. Validity cannot be achieved without reliability in research (Polit & Beck, 2012:539).

Face validity verifies that the instrument is constructed to measure the fulfilment of basic needs (the concept). The researcher also requested five professional nurse experts in the field of emergency nursing, to study the instrument for face and content validity, and to evaluate if the content reflected the concept intended to be measured. It was done to determine readability and clarity of content (LoBiondo-Wood & Haber, 2006:339). *Content validity* of the instrument was also ensured by the extent to which the instrument included a representative sample of items of each of the 3 constructs namely existence, relatedness and

growth (ERG) of the domain (basic needs). The researcher provided information about the Alderfer's theory to experts for content validity, as the items should reflect the concepts of Alderfer's theory adequately (LoBiondo-Wood & Haber, 2006:338). After she had completed this task, she submitted the instrument to the supervisor and the statistician for final approval. Also see further description in Chapter 3.

1.12 ETHICAL CONSIDERATIONS

The research proposal and instrument was submitted to the Ethics Committee of the Faculty of Community and Health Sciences at The University of Western Cape for obtaining permission to undertake the research. Permission to conduct research was obtained from the Department of Health and the relevant hospital management. The researcher ensured that the respondents were not unduly influenced by others during their participation in the proposed study (Cotrell & McKenzie, 2011:8). Respondents provided written voluntary informed consent. The purpose of the study was made clear to the respondents and they had the right to withdraw consent at any stage (LoBiondo-Wood & Haber, 2006:298). No harm for respondents was envisaged. However, a counsellor was available if needed to provide support for any emotional experiences of discomfort; however it was needed during this study.

To ensure privacy, the researcher did not use any elements in the study that would identify the respondents; such as their names, geographic areas, telephone numbers, facsimile numbers, e-mail addresses and any other element that might have identified the respondents (LoBiondo-Wood & Haber, 2006:298). The data gathering took place in a private room. It took around 30 minutes to complete the instrument. The researcher allocated code numbers instead of using the respondent's names to ensure complete anonymity, for example the questionnaires did not have names but were allocated code numbers. Only the researcher and supervisor had access to the data. The data and a master list of the respondents' names and their code numbers are being kept under lock and key, for at least two years after publication of the results, after which it will be destroyed. Signed consent forms were stored separately from instruments and other data collecting tools (LoBiondo-Wood & Haber, 2006:298). The researcher conducted the research in an honest manner. Conducting the study; and reporting and publishing the results occurred with the goal of producing scientific knowledge (Burns & Grove, 2007:1).

1.13 LIMITATIONS OF THE STUDY

The study is limited to an academic hospital in the Western Cape. The results, therefore, cannot be generalised to all hospitals in the Western Cape or surrounding areas.

1.14 SIGNIFICANCE OF THE STUDY

The study might be of great significance to the Provincial Government of the Western Cape, and the Department of Health since it could reveal the necessity of nurses, delivering services in surgical emergency departments, to improve the delivery of their services. It might also indicate how infrastructure in settings of surgical emergency departments should be developed, for contributing to higher levels of fulfilment of patients' basic needs. Results of this study could provide surgical emergency departments with information about the extent to which basic needs of patients were met and provide possible recommendations for ensuring that the satisfaction rates could improve. This study in these four surgical emergency departments could assist with improving the delivery of health services by personnel, the infrastructure for examining patients and methods to reduce, e.g. the waiting time or easing the length of waiting time.

The results of this study could be used during clinical interventions of nurses to satisfy the basic needs of patients that lead to quality improvement in nursing care.

1.15 CONCLUSION

This chapter provided an outline of the study and background to the problem. An introduction to the design and data collection method was provided followed by an outline of the ethics and validity and reliability principles. Chapter 2 will address the literature review and Chapter 3 discusses the methodology of the study. Chapter 4 addresses the results of the study and Chapter 5 concludes the study.

CHAPTER 2

LITERATURE REVIEW

2.1 INTRODUCTION

Literature is information on what has been published on a topic by accredited researches and scholars who usually specialize in a specific field (Brink, Van der Walt & Van Rensburg, 2012:71). The literature has been retrieved to explore viewpoints of patients regarding their basic needs being met in the field of study. The aim of the study sought to expand previous recommendations, in taking action in addressing patient's basic needs during the delivery of nursing care in a surgical emergency unit. Sources of information were retrieved from books, journals, theses and dissertations.

2.2 MASLOW'S BASIC NEEDS THEORY

Abraham Maslow (1954:1; 1965:33; 1968:1), a clinical psychologist, theorized that every human being have five basic levels of needs, which they tend to gratify in a hierarchical manner and they are:(1) physiological needs, (2) safety and security needs, (3) social needs, (4) self-esteem needs and (5) self-actualization needs (Sekara, 2004:66; Adler & Carlton, 2015:132; Kuruvilla, 2007:39). This pyramid of needs is represented in Figure 2.1.



Figure 2.1 Maslow's hierarchy of needs (What's Your Motivation Maslow's Hierarchy of Needs, 2012)

Maslow suggested that people strive from a basic level of physiological needs toward a level of self-actualization. In essence, each level of needs must be satisfied before an individual can proceed to the next level (Adler & Carlton, 2015:132). An individual's pursuit of higher level needs points toward the movement to psychological health and well-being. Kuruvilla (2007:39) suggests that Maslow's hierarchy of needs is a useful framework in assessing a patient's strengths, limitations and need for nursing interventions, and that it is applicable in assessing, planning, implementing and evaluation of patient care.

Physiological needs are of a lower order, in which the individual seeks to satisfy to the very basic level. These needs include the satisfaction of the needs of hunger, thirst and shelter (Sekara, 2004:66). Maslow suggested that only once these needs are met, the individual then feels the urge to satisfy their *safety and security needs*. These needs occur from the individual's interest to shield themselves from harm and danger, as well as their anxiety for stability and security against the uncertainties in life. Once this level is satisfied, individuals begin to feel concerned about the next level. *Social needs* are concerned with the desire to feel a sense of belonging. This is where emotional needs for friendship, warmth, love and affection are met (Sekara, 2004:66). *Self-esteem needs* pertain to the need for respect, acknowledgement and appreciation from others. Fulfillment of these needs gives the individual a sense of self-worth and enhances their ego. *Self-actualization* is an intense craving to be the best one can possibly be. Higher level goals are attained (Sekara, 2004:67).

Maslow indicated that once a need at a certain level is satisfied, individuals aim to meet needs at the next level, and that the satisfied need is no longer active. This was referred to as a deprivation-gratification approach to the satisfaction of needs. Maslow postulated that a need that is unfulfilled or deprived would cause an individual to engage in behavior that would satisfy that need, and once fulfilled, the next level of needs will surface as the one in need of satisfaction (Sekara, 2004:67). It could thus be assumed that Maslow's hierarchy of needs; consists of five levels, which are hierarchically organized and once a need is satisfied, it ceases to be a need (Sekara, 2004:67).

2.3 ERG THEORY

Alderfer (1969) expanded on the hierarchy of human needs that encompassed physiological needs; safety needs, needs for love, affection and belonging; needs for esteem and needs for self-actualisation. Alderfer refined these needs into existence needs, relatedness needs and

growth needs (Schneider & Alderfer, 1973). The ERG theory is better supported than Maslow's hierarchy of needs theory (Kessler, 2013:255; Sekara, 2004:68).

The ERG theory by Clayton Alderfer does not oblige a person to satisfy a lower level need for a higher level need to become the driver of a person's behaviour; thus it does not require strict ordering. Research support the fact that cultural needs and the ranking of satisfying these different needs do differ between cultures (Fletcher & Crawford, 2014:122). In emergency care, the needs of patients differ, but emphasis should be placed on all needs in order to address them all. Alderfer (1969:123) suggested that a hierarchy does not exist where a lower level need must be satisfied before an individual can move on. If a higher level need is frustrating, the desire of an individual to increase a lower level need, occurs.

The manner in which basic fundamental care is delivered, which includes the delivery of basic needs, is a growing concern, as to how it is experienced by patients (Francis, 2013:1; Garling, 2008:1). Simultaneously, there is an acknowledgement that many health systems do not make use of the full potential of their nursing workforce (Kitson, Wiechula, Conroy, Muntlin & Whitaker, 2013:332). Findings of a study have indicated evidence around nursing's failure to provide basic care to patients who are admitted in hospital (Francis, 2013:1).

Regardless of various policy initiatives concerned with the importance of dignity in practice, establishing nursing strategies around care and compassion and emphasizing the importance of patient centered care (Guastello & Frampton, 2014:2), there seems to be no clear reasons for the provision of suboptimal patient care services in e.g. surgical emergency units.

Patient satisfaction is primarily based on the perception of how well basic needs have been met by nursing staff (Meade, Bursell & Ketelson, 2006:62). A priority of academic hospitals is to maintain and uphold high quality services and excellent clinical care (Shaw, 2008:14). 'Needs' are being defined by the Merriam-Webster Dictionary (2016) as things required to live a satisfactory life. As a result, illness happens when individuals are not able to satisfy their basic needs, and since nursing is about caring, much of the career is based around helping patients to satisfy these needs (Fajemilehin, Ayandiran, Olubiyi & Nwana, 2010:2). With regard to emergency nursing and patients' needs it is important to bear in mind that

patients are not just physiological beings, their needs are multidimensional and nurses need to address their needs in order for optimal health recovery to take place.

2.3.1 Existence needs

Existence needs refer to (i) safety, (ii) physiological and (iii) material needs. When existence needs are satisfied, one feels protected and physically comfortable. Existence needs by Alderfer encompassed Maslow's physiological and safety needs (Clark, 2008:227).

2.3.1.1 Safety needs

An environment should be created for patients in the emergency department that enabled them to feel safe and comfortable when they have to make use of the facility (Paavilainen *et al.*, 2009:2218). Safety needs imply the prevention of fear, anxiety, threats, danger and tension. Patients admitted in hospital are dependent on family members and friends as far as their personal affairs were concerned. Being separated from them, increases anxiety for both family members and friends (Yousefi, Abedi, Yarmohammadian & Elliot, 2009:1894). Patient's emotional needs and social contexts are regularly not taken into account as what it should be (Liljeroos, Snellman & Ekstedt, 2011:27). Allowing patients to talk about their feelings and worries and to reflect over the immediate situation, help them to process fear and anxiety (Liljeroos *et al.*, 2011:30). Nurses making rounds to patient rooms and checking up on them, significantly increase patient perception of nursing care. It also addresses safety concerns that patients might have (Doyle, 2009:1; Weisgram & Raymond, 2008:429). Routine checkups on patients contributed to a decrease in e.g. the number of falls. It therefore aids as a preventative and protective measure for harm (Weisgram & Raymond, 2008:429).

A study conducted by Wilson, Michel, Olsen, Gibberd, Vincent, El-Assady, Rasslan, Qsous, Macharia, Sahel, Whittaker, Abdo-Ali, Letaief, Ahmed, Abdellatif and Larizgoitia (2012:344) in the Middle East Africa and Africa, provided evidence on the extent and nature of patient harm, and regarded patient safety as a huge concern. Wilson *et al.* (2012:344) also concluded that studies are required to identify underlying causes to patients and solutions to harm should be implemented.

2.3.1.2 Physiological needs

The physiological needs of a patient are important. These needs refer to an individual's quest for satisfaction at a level of vitality; such as leisure, exercise and sleep. Patients have a perception or expectation that they will be waiting for quite some time before receiving care

at the emergency departments. The physical environment plays a significant role in patient needs as privacy help the patients feel at ease.

Jack, West and Grocott (2011:468) concluded in their study that pre-surgical exercise improves patient fitness levels, functional capacity, the quality of life, and on the other hand lowers mortality and morbidity. Improvement of these, influences patient vitality positively. A study by Stegen, Derave, Calders, Van Laethem and Pattyn (2011:69) summarized that implementation of an exercise training program post-operatively, is effective and should be promoted. Petito, Esteves, Elias, Facina, Nazario and Gutierrez (2014:3091) confirm that initiation of exercise post-operatively, is beneficial to patients who had undergone surgical interventions, in order to prevent complications.

Studies by Bano, Chiaromanni, Corrias, Turco, De Rui, Amodio, Merkel, Gatta, Mazzotta, Costa and Montagnese (2014:4) and Desai, Feldman, Brown, Dezube, Yeh, Punjabi, Afshar, Grunwald, Harrington, Naik and Cofrancesco (2013:653) showed that compliance with efficient sleep of patients in hospitals, are low. Furthermore, Yoder, Staisiunas, Meltzer, Knutson and Aror (2012:68) agreed that patients slept drastically less in a hospital environment than their self-reported baseline sleep. Studies have suggested that patients might be exposed to too low luminance levels, with little differences in day-night light exposure (Lack & Wright, 2007:637).

Findings by Karnik, Printz and Finkel (2014:60) demonstrated that comfort has an effect on patient experience, and that higher anxiety levels increase the discomfort of patients, admitted in hospitals.

2.3.1.3 Material needs

Patients also have material needs. These needs are for, e.g. food, clothing and resources needed for living (Yang, Hwang & Chen, 2011:7887; Alderfer, 1969). In the study by Liljeroos *et al.* (2011:19), the scarcity of resources in hospitals, made patients feel that they did not want to be a burden, and for this reason they would not initiate communication with nurses.

A study conducted by Bell *et al.* (2013:237) demonstrated that packaging of food, that appears to need good hand strength, is shown to influence the ability of patients who are hospitalized, to open their food and beverage meal. According to Bell *et al.* (2013:238) staff

members are aware of the problematic packaging, as some of them are also unable to open certain food and beverage packages. Also, a decreased nutritional intake, could result in patient healing being prolonged and recovery time, and a burden on hospital costs.

2.3.2 Relatedness needs

Relatedness needs involve relationships with other people. Individuals wish to be acknowledged by groups and to form meaningful relationships (Yang *et al.*, 2011:7886). Patients wish to experience a sense of caring and empathy from the personnel caring for them since these people added value to the patients' existence (Yang *et al.*, 2011:7887).

The study by Yousefi *et al.* (2009:1896) revealed issues that had an impact on respondents' (patients') comfort needs, e.g. having a friend in hospital, avoiding suffering and access to a suitable environment for religious ceremonies. These issues were related to social comfort. Yousefi *et al.* (2009:1896) stated that kind, verbal communication is needed. Communication skills could have an influence on the content and outcome of the visit to emergency departments. Yousefi *et al.* (2009:1896) also revealed a lack of interpersonal relationships between nursing staff and patients, even though it was considered to be an important element, during the delivery of health care and attending to basic needs of the patients.

Collaboration with the rest of the multidisciplinary team and the patient's loved ones, has to take place for comfort to be maintained (Yousefi *et al.*, 2009:1896). Matters like spiritual support and care are welcomed by patients. Patients felt that anyone coming into contact with them and supporting with spiritual care, resulted in their comfort, while they were being confined to the emergency department (Deal, 2010:859).

Relatedness needs refer to relationships with noteworthy others. It is usually satisfied by the sharing of thoughts and feelings, recognition, positive reception, agreement and understanding (Borkowski, 2009:1). When relatedness needs are met, individuals feel a sense of identity and position within their immediate group. Relatedness needs encompassed Maslow's needs of love, belonging and self- esteem needs (Clark, 2008:227).

2.3.2.1 Relationships with family and friends

Family members and friends play important supportive roles for patients (Al-Hassan & Omran, 2005:15; Stone & Lammers, 2017:27). A study done by Zani, Marcon, Tonete and

Parada (2014:143) outlined that communication between the patient and his/her family is important for the process of healing, and that family and patients have specific needs and when not met, causes stress, mood disorders and anxiety.

A study conducted by Manias (2013:864) concluded that communication between health professionals and the families of patients was largely insufficient, despite family members being willing to speak with them. Family members are e.g. a useful resource in determining an accurate medication list at the time of patient admission (Manias, 2013:865).

2.3.2.2 Relationships with nursing personnel

A study by Liljeroos *et al.* (2011:6) proved that the presence and non-verbal and verbal communication of a nurse, establish a trustful relationship between a nurse and patient. It enhances the motivational strength for life-style changes. Quantitative studies have also reflected on the importance of a trusting relationship between the nurse and the patient (Dinc & Gastmans, 2013:505). The formation of relationships with nurses, helped patients in feeling secure and increased their confidence in their own bodies (Lileroos *et al.*, 2011:18). Being empathetic and tolerant allowed for communication around worries. Patients are entitled to attention of staff in emergency departments (Frank, Asp & Dahlberg, 2009:18; Larsson, Nordlund, Nygord, Lexell & Bernsprang, 2007:1419; Tutton, 2005:144).

A study conducted by Cottrell, Jonas, Bergsten, Blaas, Aboki, Howse, Korandova, Löfman, Logtenberg, Lupton, Mallon, Oliver, Pickles and Bullinckx (2012:66), whereby the unmet management of needs of patients was found, concluded that supplementary involvement of nurses, other than just basic nursing care, should address unmet needs.

2.3.2.3 Barriers to effective communication

Poor communication is related to poor health (Covinsky, Chren, Harper, Way & Rosenthal, 2000:170). Poor communication and inconsistent information lead to confusion and loss of confidence in nurses. A barrier in patient- centered communication is the lack of time nurses and patients have to communicate in an emergency area (Hoglund, Winblad, Arnetz & Arnetz, 2010:247).

2.3.3 Growth needs

Growth needs refer to self-esteem needs and self-actualization (Clark, 2008:227). Self-esteem is relative to the ability to pursue and seek knowledge; and to achieve, control, and inspire confidence. The growth needs also include competence, confidence and independence (Konrad, Moore, Doherty, Eddy & Breward, 2012:117). Integrity and well-being are essential for growth. Nurses need to be familiar with the medical needs of their patients since it is beneficial to managing the environment for optimal growth/health to occur.

There is little known about counseling in emergency departments (Paavilainen *et al.*, 2009:2217). In the emergency departments, patient counseling about their illnesses, aims at fostering optimum coping after being discharged and putting expectations into perspective. It could also predict situations (Paavilainen *et al.*, 2009:2218). Paavilainen *et al.* (2009:2218) defined counseling or health education as giving information and advice concerning illnesses and care.

Self-accomplishments refer to achieving goals and developing confidence in personal matters. Patients need to realise their own potential for recovering from injury, trauma and / or medical discomfort. Patients need to develop independent behavior for promoting and identifying their own resources and strengths. It will assist them with realizing positive possibilities in their experiences in life (Virtanen *et al.*, 2007:142). Growth needs by Alderfer can be defined as a person making a creative or productive effect on him- or herself and can include the environment (Borkowski, 2009:110). Flourishing growth means that a sense of wholeness, accomplishment and fulfillment exists (Clark, 2008:227).

2.3.3.1 Patient participation

Patient participation can be described as a circumstance where an amount of power and control is being given to a patient by a nurse in e.g. decision-making. The sharing of information and knowledge is manifested through active engagement in either intellectual and or physical activities (Sahlsten, Larson, Sjostrom & Plos, 2008:4). Patient involvement in decision-making has been emphasized recently to assisting problem-solving rather than just to comply with decisions made (Lileroos *et al.*, 2011:18). Covinsky *et al.* (2000:170) found that low patient participation is related to poor health.

Lileroos *et al.* (2008:18) found that patients described their need for knowledge about the disease they have, and the current situation. Information given during medical rounds was difficult for them to understand, and doctors gave the impression of being in a hurry. However, patients found nurses more accessible and dialogues with nurses helped them to understand their disease. The way nurses started conversations, was important to them, as the manner how they receive information had an effect on how they remembered it. Nurses sometimes explain standardised information while patient want to know about more complicated information. Patients also described that they got the sense that they should only listen to what is being said, and should not ask questions (Covinsky *et al.*, 2000:171).

Instances where patients learn about their health situations, increase patient participation that is an important indication of the value and worth of healthcare. Participation of patients in their own healthcare management should be promoted by clear healthcare policies and guidelines to staff. Patients admitted or cared for in emergency departments by nurses however express dissatisfaction with participative care received and basic needs being met (Frank *et al.*, 2011:643). Patient participation is problematic to achieve in emergency situations (Arnetz, Winblad, Hoglund, Lindahl, Spangberg & Wallentin, 2010:298).

Patients cared for in emergency departments described that their participation depended on the attitude of nurses, the environment and the organization of care. Frank *et al.* (2009:18) showed that, where patient participation in emergency departments was investigated, patients perceived the filling in of the questionnaire as the only way they became involved in the management of their health. Nurses should bear in mind that patient participation is of great relevance in recovery (World Health Organisation, 2008).

In a study done by Kitson, Marshall, Bassett and Zeitz (2013:11), the core elements of patient-centered care were outlined as (a) the importance of patients being able to actively participate and be involved in their care; (b) having individualized care plans; and (c) the importance of having the right context or environment that promotes participation in care.

2.3.3.2 Health education

A study showed that a fifth of patients reported that no life-style changes were discussed with them during their stay in hospital (Liljeroos *et al.*, 2008:18). Despite aims for informational needs to be met, several studies claim that this goal is not reached (Smith & Liles, 2007:663;

Arnetz & Arnetz, 2009:175). Both nurses and patients differ in what they consider are of cardinal importance regarding information on health. Content of conversations on patients health information given, are mainly based on what the perceptions of nurses are and think patients need to know (Timmins & Kaliszer, 2003:57). It seems that patients cannot identify what questions are relevant prior to being discharged (Burney, Purden & McVey, 2002:56), which is why health promotion must be taught by nurses based on a patient's individual health condition and also the treatment they receive (Attebring, Herlitz & Ekman, 2005:153).

In order for patients' learning needs to be served, and self-management as well as life skills training to be implemented, nurses should be present throughout the rehabilitation process even if the condition of a patient improve (Attebring *et al.*, 2005:154; Covinsky *et al.*, 2000:171).

On the one hand patients are not open to receiving information in early disordered situations, while they on the other hand have an increased need for acquiring knowledge during hospitalization (Decker, Garavalia, Chen, Buchanan, Nugent & Shipman, 2007:459).

2.3.3.3 Patient internal esteem

Presently, the concept of health does not only include the non-appearance of disease but also a complete state of physical, psychological, and social well-being with an increased emphasis on the importance of one's self-esteem (Theofilou, 2012:136). Results in a study by Theofilou (2012:136) indicated that self-esteem had a noteworthy positive association with one's internal health focus of control.

A study by Aasa, Hovback and Bertero (2013:1607) indicated that shortcomings do exist in the management of patients undergoing surgery. Partaking in informative sessions in the study, made patients feeling they were at the center stage which boosted their self-esteem (Aasa *et al.*, 2013:1607).

2.4 BASIC DIFFERENCES BETWEEN ALDERFER'S AND MASLOW'S THEORIES

The primary difference between the two theories is that Alderfer suggested a satisfaction-progression approach as well as a frustration regression process. This means that Alderfer agreed with Maslow that once one level of needs is fulfilled, an individual would proceed to the next level to satisfy the higher order of needs. If an individual's relatedness needs are not fulfilled and the individual is constantly frustrated due to not being able to meet them, the individual would perceive the re-emergence of his existence needs and try concentrate on living a more physically gratifying lifestyle (Chitale, Mohanty & Dube, 2013:173).

Alderfer also implied that more than one need may co-exist at the same time. This means that individuals might work towards satisfying both their relatedness needs and growth needs, simultaneously. Human behavior is thus conceptualized in more adjustable terms by Alderfer than by Maslow. The framework that Alderfer suggested makes it possible to quantify the three levels of needs- existence, relatedness and growth (Chitale *et al.*, 2013:173).

2.5 CONCLUSION

The aim of this literature review was to explore the basic needs under the ERG theory of Alderfer and studies on perceptions of patients perceive on these needs. It emphasizes that, should these needs be fulfilled, patient satisfaction increases. The following chapter focusses on the research methodology used in this study.

CHAPTER 3

RESEARCH METHODOLOGY

3.1 INTRODUCTION

In this chapter the methodology, including the research design, population and sample, data collection and data analysis processes, are outlined and discussed. Methodology is the total strategy for the study and it starts from the identification of the problem to the final plans for the data collection (Uys & Basson, 1991:37). It solves the problem in a “systemic way” and describes how the researcher went about addressing the research phenomena (Rajaseka, Philominathan & Chinnathambi, 2013:1).

3.2 OBJECTIVES OF THE STUDY

The objectives of this study were to;

- explore and describe the perceptions of patients about the fulfilment of their basic needs during their stay in a surgical emergency department; and
- describe recommendations for operational nurse managers to fulfil the patients’ basic needs during the delivery of nursing care in a surgical emergency department.

3.3 RESEARCH DESIGN

The preparation of a research design is an important step in research planning. Research design is a written plan for the study, and the intentions of the researcher to implement the research. The research design is a logical and complete plan prepared for conducting a study and is the end result of a sequence of decisions made by the researcher concerning how the study will be conducted. Often it is compared to a blue print which is prepared by an architect before constructing of a building is commenced (Kumar, 2008:30). The research designs of most quantitative studies are highly structured compared to research designs of qualitative studies which are more unstructured.

The study followed a quantitative, exploratory and descriptive approach to explore and describe the perceptions of the fulfilment of patients on their basic needs being met in a surgical emergency department. The research design provided a clear idea as to the direction of activities in the research process to arrive at solutions and recommendations (Kumar, 2008:30).

3.3.1 Quantitative design

Quantitative research consists of the collection, tabulation, summarisation and analysis of numerical information. This is for the purpose of providing answers to the research questions or hypothesis. Quantitative research is a process where a series of steps are followed by a researcher in conducting a study (Sudbury, 2011:1). Quantitative research designs are important when examining evidence to develop better practice and the researcher understood the difference between qualitative and quantitative research designs, as well as that both are relevant in evidence based practice. This quantitative design was around investigation of a nursing phenomenon that lend itself to precise measurement - a characteristic of quantitative research. This study rated patient perceptions on the fulfilment of their needs by nurses, on a scale in a questionnaire.

3.3.2 Exploratory design

An exploratory design takes a closer look at the phenomenon of interest, by fully investigating it as well as other contributing factors (Costello, 2013:182; Polit & Beck, 2014:12). It allows for a better understanding of the phenomenon. In an attempt to identify new knowledge and insight, exploratory research also studies what has not been studied before by e.g. exploring factors relating to the topic (Polit & Beck, 2014:12). This research aimed to discover how patients perceived their basic needs being met in a surgical emergency department.

3.3.3 Descriptive design

Descriptive research provides an accurate portrayal of characteristics of an individual, situation or group. The purpose is to discover new meaning, describe what already exist, determining the frequency which something occurs and then categorising this information. The descriptive approach was to generate new knowledge on which little research has been conducted through descriptive research (Burns & Grove, 2001:29).

3.4 POPULATION

The target population is defined as all elements (individuals, objects, or substances) that meet certain criteria for inclusion in a given universe (Burns & Grove, 2001:47). Polit and Hungler (1997:33), support this and add that the target population is all the members who are under study that conform to a designated set of specifications. In this study the population consisted

of patients being admitted in the Surgical Emergency Department at an academic hospital over a 3 month period.

An accessible population is defined as those respondents who were available to participate in a study (Johnson & Christensen, 2010:257). The accessible population in this study was patients in the surgical emergency department who made use of emergency services at the academic hospital (n=150).

3.5 SAMPLE AND SAMPLING METHOD

A convenient sampling method was used. Convenience samples provide useful tentative findings especially where care is taken not to overgeneralize their feelings. Convenience sampling is less expensive than other methods and is mainly used because other methods may not be feasible for a particular type of study or population (Rubin & Babbie, 2013:171). The researcher selected respondents on the basis of their availability and willingness to respond (Gravetter & Forzano, 2012:151).

The sample size determines the power of the study (Gerrish & Lacey, 2010:147). For certain statistical tests the sample size should not be less than 150 (Pallant, 2010:172). Patients were selected over a period of three months (n = 150). Respondents were selected based being in one of the four surgical emergency department for at least two consecutive days and who were discharged to go home.

One hundred and fifty (150) questionnaires were distributed and all of them (100.0%) were returned from respondents. A 100.0% response rate was thus achieved and included in analysing the data.

3.5.1 Inclusion criteria

To be included in the study, patients had to have been admitted to and have received basic nursing care in a surgical emergency department, for at least two consecutive days before being discharged.

3.5.2 Exclusion criteria

Patients were excluded from the study if they:

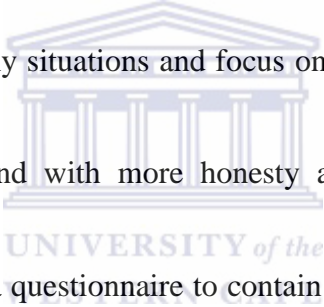
- Were discharged to go home without being attended to by a doctor;

- Left the surgical emergency department without being formally discharged;
- Had a psychiatric history (based on medical history or collateral information)
- Participated in the pre-testing of the instrument.
- Patients 18 years and younger.

3.6 METHOD

According to Uys and Basson (1991:47), survey research is an empirical and logical investigation. It involves the systematic and impartial collection of data from a sample of cases. This also includes the statistical analysis of the findings. A survey is a technique of data collection in which questionnaires (collected by mail or in person) are used to gather information about an identified population that applies to quantitative analysis (Grové, Burns & Gray, 2013:224).

The advantages of a survey are viewed as follows:

- 
- It could be applied in many situations and focus on the chosen topic, meaning it was flexible and broad.
 - Respondents could respond with more honesty as they had a greater chance of remaining anonymous.
 - It was also possible with a questionnaire to contain a large number of questions (Uys & Basson, 1991:65).
 - Standardized information is collected from subjects from a population greater than one hundred.
 - It documents the outcomes of a study and could be generalized to the population (Scott & Mazhindu, 2011:28).
 - It documents and defines associations among variables in a sample.
 - Standardized questionnaires are given to each respondent so that a reasonable conclusion could be drawn in an effort to decrease bias (Glasow, 2005:1).

The researcher did keep in mind some disadvantages of using a survey:

- Understanding of human behavior could not be determined and understood from the questionnaire.
- Questions could be misinterpreted which could lead to unreliable conclusions, and

- Respondents may respond with answers that they think would be correct (Burns & Grove, 2001:256).

Usage of a survey was justified on the benefits it had by uncovering the perceptions of patients on the fulfillment of their basic needs (Polit & Beck, 2012:284).

3.6.1 Data collection instrument

In this study, a structured questionnaire was used to obtain the data (Polit & Beck, 2012:325). A questionnaire (Annexure A) is a series of questions within a document and used to gather information from respondents (Polit & Hungler, 1997:444). The objectives of the study should be reached through the information gathered by the questionnaires (McNabb, 2008:136).

For the purpose of this study, a four-part section questionnaire was developed by the researcher from a literature review. The questionnaire contained open and closed questions to explore the phenomena of fulfilment of patients' basic needs. The closed-ended questions addressed the needs according to Alderfer (1969) as it evoked responses about the participating patients' perceptions of the extent to which their basic needs were met during nursing care delivered in the surgical emergency department.

The questionnaire was completed individually by respondents. A 7- point Likert type scale was used to measure the levels of perceived fulfilment of basic needs. Respondents identified the extent in which they agree with questions or statements (Kothari, 2008:86) on a rating scale;

- 1 never
- 2 rarely
- 3 infrequently
- 4 neutral
- 5 sometimes
- 6 usually
- 7 always.

The questionnaire consisted out of a total of 52 closed ended questions.

- Section A of the questionnaire contained demographic information on the respondents such as age, gender and highest qualification.
- Section B was questions on the perceptions of the fulfilment of the respondents' existence needs. These existence needs referred to needs such as safety, security needs, resources of morality, property, psychological matters like food, water and sleep and material needs.
- Section C was questions on the perceptions of the fulfilment of the respondents' relatedness needs. These needs referred to needs of love and belonging like forming relationships.
- Section D contained questions on the perceptions of the fulfilment of the respondents' need for growth. Growth needs referred to needs of personal growth, self-actualization, self-esteem, confidence and morality.

One open question for each of the sections on existence, relatedness and growth needs (Sections B, C & D in the questionnaire) were formulated.

3.7 DATA COLLECTION

The data collection process commenced after ethical clearance was received from a university in the Western Cape (Number 12/8/15, Annexure E), as well as after permission was granted from the head of the academic hospital. The researcher then arranged meetings with the area manager and operational managers of the different wards, before the collection of data could take place. The purpose and process of the research were explained. A suitable venue that is private, to complete the questionnaires, was identified. Respondents were identified by the nursing personnel (those that met the eligibility criteria) and referred to the researcher for an appointment. The collection of data took place over a three month period according to availability of respondents.

Each respondent was provided with a written consent form before completing the survey (Annexure B). Information on the study was thoroughly explained to the respondents, what was expected from them and the duration of their participation (Annexure C). The information letter explained confidentiality in the study and the purpose of the study (Burns & Grove, 2005:193). The information letter also stated who was responsible for this study, contact details of the researcher, as well as the supervisor involved in the research.

It took around 30 minutes to complete a questionnaire, that was handed back to the researcher in a sealed envelope. Completed questionnaires will be kept under lock and key for at least two years after the results of the study are published.

3.8 DATA ANALYSIS

Systematically organising and synthesising of research data and, in quantitative studies, testing the hypotheses using that data, is data analysis (Polit & Beck, 2012:725). The data analysis responds to the research questions, purpose and framework of the study (Speziale & Carpenter, 2003:218). The instrument items were analysed using the SPSS Version 22 software program with the assistance of a statistician at a university in the Western Cape.

Descriptive statistics are used to describe numerical data. It also portrays the population of concern's characteristics and attributes (Polit & Beck, 2014:215). Descriptive analysis was performed and the mean and standard deviation of variables described. The averages of all scores were determined by the mean value (\bar{x}). The SD is a measure of central tendency (Brink, 2006:181). A standard deviation (SD) indicated the distribution of responses around a mean value.

Data was presented in tables and figures.

Factor analysis

The procedure that 'unscrambles' interrelationships between items is known as a factor analysis. It identifies which items correlate strongly with one another and whether it contains the same underlying construct (Polit & Beck, 2012:503). Factor analysis takes large groups of variables and examines ways in which the data can be summarised by using a small number of factors prior to analysis. It thus reduces the data (Pallant, 2010:182). Three steps were conducted for the factor analysis on Section B, C and D of the questionnaire. All sections were combined for factor analysis purposes.

Step 1: Assessment of the suitability of data for factor analysis to proceed

According to Pallant (2010:172), the suitability of the data for a factor analysis is determined by two main issues: the sample size and the strength of the relationships among the variables. The sample size should not be less than 150 and strength of the inter-correlation coefficient

matrix amongst the items should not exceed 0.3. To determine what has been stated above, two statistical tests generated by SPSS were used. These tests are the Kaiser- Meyer Olkin (KMO) test and Bartlett's test of Sphericity. The KMO test measures the sampling sufficiency and these ranges are normally from 0-1 and a total above 0.6 is advised a minimum (Kaiser 1974:32; Pallant, 2010:174). In this study the sample size was 150 respondents and the KMO of all the variables was 0.934. Bartlett's test for Sphericity was used to examine the strength of the relationship between the variables. This should be less than ($p < 0.05$) (Tabachnick & Fidell, 2001:1; Pallant, 2010:174). In the absence of any relationship, then there is no point in continuing with a factor analysis (Brownlow, Hinton, Mc Murray & Cowsons, 2004:349). In this study, Bartlett's test showed a noteworthy of $p < 0.00$. This established that there is an existence of a relationship between the variables hence the researcher preceded with factor analysis.

Step 2: Factor extraction

Factor extraction is concerned with using the smallest number of factors that is able to “best represent the interrelationships of the variables” (Pallant, 2010:175). There are a variety of factor extraction methods that can be used to extract the number of underlying factors. The extraction method used in this study was the Principal Component Analysis Method; which analysed all variances in the observed variables rather than just the common factor variances. The goal thereof is to extract ‘clusters’ of items from the correlation matrix which are highly correlated (Polit & Beck, 2012:487). These factors are called principal components. There are a number of techniques that can be used to assist in the decision concerning the number of factors to retain. One of these techniques is the Kaiser's criterion or Eigenvalue rule- which was used to verify the number of factors that should be retained in this study (Pallant, 2005:175). This eigenvalue rule implies that only factors with an eigenvalue above 1.0 or more should be retained in the study. All eigenvalues retained were above 1 (Table 3.1).

Table 3.1 Kaiser Meyer sampling adequacy and Bartlett’s test of Sphericity

All Items	Kaizer Meyer Olkin (KMO)	Bartlett’s test of Sphericity			Components with Eigen Values >1
		Chi square	df	p-value	
	0.934	10920.456	1275	0.000	2

Step 3: Factor rotation

In order to better understand and facilitate the interpretation of the factors, a factor rotation was performed on the output (Polit & Beck, 2012:487). Varimax rotation resulted in a factor matrix and these values are called factor loadings. Items with higher loadings on a particular factor were grouped together. It represented a uniform attribute (Polit & Beck, 2012:463). All factor loadings higher and equal to 0.4 were considered significant. The varimax rotation provided by SPSS, allowed for variables to be ‘clumped’ together and the researcher was then able to identify and interpret these components. The principal component analysis revealed six clusters out of a total of 54 items that were extracted. Table 3.2 shows the factor names with a description thereof, the amount of items and the item numbers themselves as well as the Cronbach Alpha of each factor.

The responses to open ended questions were then classified under the appropriate theme (existence, relatedness or growth) and analysed by organizing each response as being either positive or negative (Clarke, 2008:227).

Table 3.2 Factor names and reliability of factors

Factor	Description of factor	Number of items	Items	Cronbach Alpha α
1	Power affirmation	17	1, 2, 8, 9, 10, 12, 43, 44, 45, 46, 47, 48, 49, 50, 51, 53, 54	0.975
2	Positivity	15	27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41	0.970
3	Less concrete desires	11	7, 14, 17, 18, 19, 20, 21, 22, 23, 24, 25	0.959
4	Physiological needs	4	3, 4, 5, 6.	0.917
5	Necessary for survival voluntary	2	11, 13	0.895
6	Necessary for physical involuntary bodily survival	2	15, 16	0.933

3.9 VALIDITY AND RELIABILITY

Validity and reliability are significant criteria's that are taken into consideration when order to evaluate an instrument. In this study, the questionnaire is the referred instrument (Polit & Beck, 2012:457). According to Grové *et al.* (2013:45), confidence in the research conducted by a researcher is evident in the validity and reliability of the findings.

3.9.1 Validity

The validity is the assurance that an instrument measures what it is intended measure and the extent thereof (Davis & Ponnampereuma, 2005:281). Face and content validity was evaluated by five professional nurses. Face validity was ensured through the appearance of the instrument that adequately obtain the desired information. Content validity was also ensured in that it covered the content of the topic that was required to be measured and it made sense. Five patients/respondents completed the questionnaire as part of pre-testing the instrument. The researcher was open to any suggestions made and a statistician was consulted to ensure that the correct scale was used to measure the phenomenon (Davis & Ponnampereuma, 2005:282).

3.9.2 Reliability

The reflection of how well attributes are measured, refers to the reliability of an instrument (Polit & Beck, 2012:457). Internal consistency of the questionnaire was measured by using Cronbach's Alpha (α). The internal consistency reliability test measures the degree to which all items in a measurement and/or test measures the same attribute. Cronbach's Alpha (α) is the most common measure of internal consistency and the normal values for the Cronbach's that were considered to be showing internal consistency is above .7 (Gallagher, 2014:103). In this study all the factors had a Cronbach's Alpha (α) of more than .7.

It is most commonly used when you have multiple Likert questions in a survey questionnaire, that form a scale, and you wish to determine if the scale is reliable (Creswell, 2009:1). Cronbach's Alpha simply provides you with an overall reliability coefficient for a set of variables (Creswell, 2009:1).

Test of reliability of

- growth needs $\alpha = 0.978$ for 12 items
- relatedness needs $\alpha = 0.970$ of 15 items
- existence needs $\alpha = 0.754$ of 27 items.



3.10 ETHICAL CONSIDERATIONS

Ethical considerations encompass the obedience to the professional, legal and social duties of the research process. It is influenced by morality and as this research study included human respondents, it was important to obey to recommended ethical principles (Polit & Beck, 2004:717).

Offensive and sensitive questions were avoided by the researcher and all respondents were aware of their right not to answer. They were also aware of confidentiality. Questionnaires remained anonymous.

3.10.1 Respect for human dignity

The right to self- determination is based on the ethical principle of respect for another individual (Burns & Grove, 2001:196). Individuals had a right to ask questions, to refuse to

give information and to withdraw from the study at any time (Polit & Beck, 2012:84). All respondents were given a choice of whether to participate in the study or not.

Respect for human dignity encompasses individuals' right to make informed and voluntary decisions concerning their study participation. This requires full disclosure (Polit & Beck, 2012:84) and refers to the right of full disclosure. The researcher described the study in full to the respondents; the right to refuse participation was explained as well as all possible risks and benefits. The right to self-determination and the right to full disclosure are important elements on which informed consent was based (Polit & Beck, 2012:84).

3.10.2 Beneficence

Beneficence prevent or minimise harm in studies with humans (Polit & Beck, 2012:83). Polit and Beck (2012:83) state that the avoidance of physical harm is upfront and that psychological consequence should also be avoided. In this research study, the researcher refrained from asking personal and sensitive questions in the questionnaire.

The right to protection from exploitation protects the respondents from placing them in any disadvantage. The information that respondents provided and their participation in the study were not used against them in any way (Polit & Beck, 2012:83). The researcher and respondents in this study engaged in a trusting relationship and respondents were not exploited in any way - the researcher understood that the patients' participation in the study was as a result from their understanding of the researcher's role as nurse, not as researcher (Polit & Beck, 2008:83).

3.10.3 Justice

This refers to the respondents' right to fair treatment and their right to privacy (Polit & Beck, 2012:85). The right to fair treatment was addressed by the researcher who selected the respondents in this research study purely based on the criteria of being two days admitted in the surgical emergency units.

Respondents' right to privacy was maintained by the researcher (Burns & Grove, 2001:201). All data received from respondents were dealt with in strict confidence. Respondents were not required to write their names on questionnaires. Consent forms were distributed

separately with no connotation to a specific questionnaire. Questionnaires were returned to the researcher personally.

3.10.4 Permission to conduct the study

Prior to conducting the research, ethical clearance was obtained from the following:

- Senate Research Ethics Committee from a university in the Western Cape (Annexure E)
- Department of Health for the academic hospital (Annexure F).

3.10.5 Informed written consent

It is every respondent's right to be informed about the details of the study that they are involved in (Denzin & Lincoln, 2011:65). The researcher explained the process of the study and the respondents completed consent forms before completing the questionnaires. This was done to ensure that the researcher obtained written permission from the respondents before conducting the study.

3.11 CONCLUSION

A quantitative, explorative and descriptive design was followed to explore and describe the perceptions of patients on the fulfilment of their basic needs in a surgical emergency department. A 7-point Likert scale questionnaire was completed by the respondents and data analysis conducted by using the SPSS Version 22 program. Chapter 4 will focus on presenting the data.

CHAPTER 4

FINDINGS

4.1 INTRODUCTION

In this chapter a detailed description of the data is outlined. All statistics were calculated using the Statistical Package for Social Sciences (SPSS). The mean and standard deviation for each item were calculated and the items presented according to the six factors rotated by the factor analysis. A number of 150 respondents completed the questionnaire.

4.2 THE RESPONDENTS

Section A presents the biographic and the demographic description of the sample to provide a Back ground against which the results were interpreted. The respondents were asked to answer information about them regarding age, gender and education level (Annexure D).

4.2.1 General characteristics of sample

A total of 150 questionnaires were administered to respondents/patients after being discharged from one of the four surgical emergency units/ department at the academic hospital. Table 4.1 reflects the sample.

Table 4.1: Sample

TYPE OF SURGICAL WARD	n	Percentage (%)
Department/ Ward 1 (Vascular surgery D1)	40	27.0
Department/ Ward 2 (Abdominal Surgery D5)	40	27.0
Department/ Ward 3 (Vascular & Abdominal surgery J1)	35	23.0
Department/ Ward 4 (Abdominal surgery J5)	35	23.0
TOTAL	150	100.0%

4.2.2 Age of the respondents

Nearly half (n=45; 30.0%) of the 150 (100.0%) respondents were between the ages of 23-33 and just 4 (2.7%) were older than 77 years of age (Table 4.2). The mean age of the respondents was 40.47 years.

Table 4.2: Age distribution of respondents

Age	Responses (n)	Percentage (%)
18-22 years old	18	12.0
23-33 years old	45	30.0
34-44 years old	31	20.7
45-55 years old	27	10.0
56-66 years old	20	13.3
67-77 years old	5	3.3
78 years and older	4	2.7
Total	150	100.0

4.2.3 Gender of respondents

Figure 4.1 shows the gender distribution of the respondents (n=150; 100.0%). The majority of the respondents (n=91; 60.7%) were females whereas males were less (n=59; 39.3%). It was also found in another study, that females have a higher rate of visiting emergency departments than males (Weiss, Wier, Stocks & Blanchard, 2014:1).

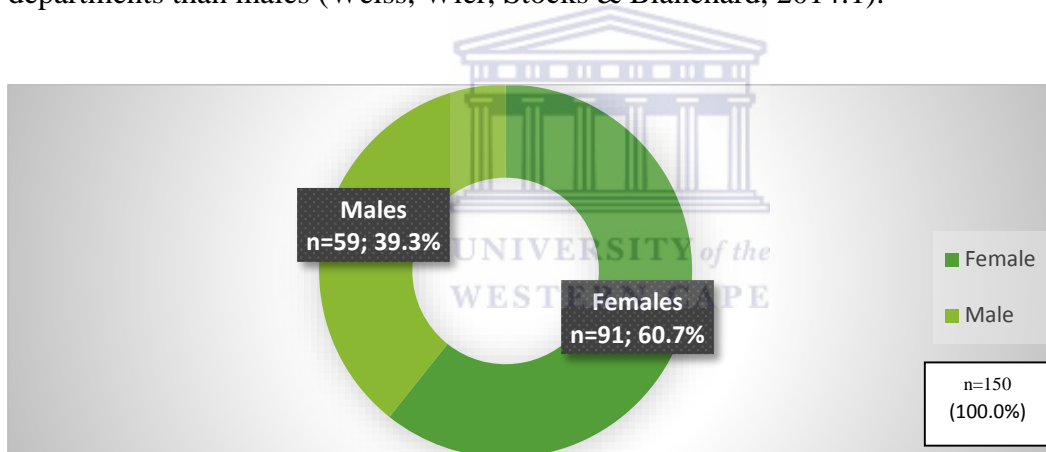


Figure 4.1: Distribution of gender of the respondents (n=150)

4.2.4 Highest education level of respondents

All respondents had some level of education. A small percentage of the respondents (n=33; 22.0%) had primary school education, while the majority (n=105; 70.0%) completed high school education (this includes all grades from grade eight until 12). The other respondents (n=12; 8.0%) had either a diploma and or degree (Figure 4.2).

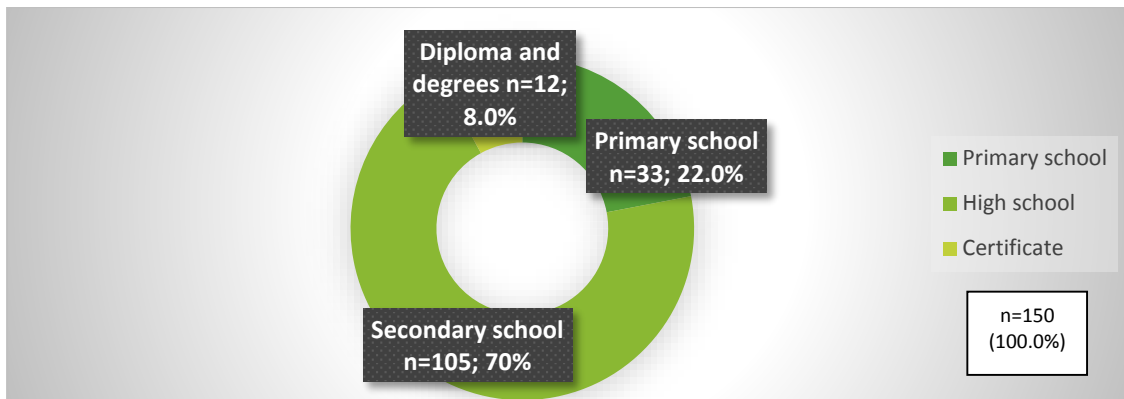


Figure 4.2: Distribution of level of education of the respondents (n=150)

4.3 PRESENTATION OF THE FINDINGS ON THE BASIC NEEDS (ERG NEEDS)

In the questionnaire:

- Section B addressed the basic need for existence
- Section C addressed the basic need for relatedness
- Section D addressed the need for growth.

The findings in this chapter will for each of the three sections in the questionnaire, be presented with reference to:

- the factors that emerged from the factor analysis
- responses on each item that will be grouped and discussed as;
 - never to infrequently (responses 1-3)
 - neutral (responses 4)
 - sometimes to always (responses 5-7)
- relevant responses to open questions.

A factor analysis was performed on Sections B, C and D of the questionnaire. A factor analysis is a data reduction technique that reduces large groups of variables and determines ways where data can be summarized by using a small number of factors (Pallant, 2005:172). Six factors were extracted and named: (i) power affirmation, (ii) positivity, (iii) less concrete desires, (iv) physiological needs, (v) necessary for survival voluntary and (vi) necessary for physical involuntary bodily survival (Table 3.5). The data is presented according to the

factors. For purposes of the discussion the findings are discussed with reference to; *never to infrequently, neutral and sometimes to always*.

All items were answered by the 150 respondents.

4.3.1 Factor 1: Power affirmation

Factor 1 obtained a Cronbach Alpha of 0.975, the highest value of the 6 factors (Items 1, 2, 8, 9, 10, 12, 43, 44, 45, 46, 47, 48, 49, 50, 51, 53 and 54). In the section on power affirmation, mean values between 4.19 and 4.65 was obtained for the response with a wide distribution around the mean value. The standard deviation ranged from 1.640 to 2.006 (Table 4.3).

The items in Factor 1 on power affirmations (Table 4.3) are for discussion purposes grouped as follows:

- Care (Items 1, 10, 12 and 49)
- Communication (Items 8, 9, 45, 46, 47, 48 and 51)
- Outcomes (Items 2, 43, 44, 50, 53 and 54).

4.3.1.1 Care (Items 1, 10, 12 and 49)

The items on care obtained a mean value higher than 4.4 that indicated that the respondents agreed to a large extent to the items. A wide distribution of responses around the mean values was obtained with the lowest standard deviation (SD) of 1.669 (Item 1) ranging to a SD of 2.006 (Item 12).

In Item 1, nearly half (n=72; 48.0%) of the 150 (100.0%) respondents indicated that nurses *sometimes to always* ($\bar{x} = 4.56; SD = 1.669$) aimed at providing the best nursing care. Less than half of the respondents (n=43; 26.0%) indicated that nurses *never to infrequently* aimed at providing the best nursing care and 35 (23.3%) of the respondents were *neutral*.

Even though emergency nursing is, by nature, intermittent and somewhat random, nurses working in emergency departments are expected to deliver the best possible care to their patients no matter what. Furthermore, unintended situations and health problems that are undiagnosed need efficient and precise assessment and interventions.

Table 4.3: Factor 1: Power affirmation

Item	Factor 1	Never		Rarely		Infrequently		Neutral		Sometimes		Usually		Always		Total		Mean \bar{x}	SD
		n	%	n	%	N	%	n	%	n	%	n	%	n	%	N	%		
1	Nursing care	2	1.3	15	10.0	26	17.3	35	23.3	30	20.0	10	6.7	32	21.3	150	100	4.56	1.669
2	Responsibility	4	2.7	10	6.7	28	18.7	33	22.0	31	20.7	16	10.7	28	18.7	150	100	4.58	1.640
8	Feedback	11	7.3	14	9.3	13	8.7	34	22.7	21	14.0	21	14.0	36	24.0	150	100	4.65	1.894
9	Info	20	13.3	11	7.3	10	6.7	34	22.7	28	18.7	20	13.3	27	18.0	150	100	4.38	1.944
10	Physical needs	15	10.0	12	8.0	14	9.3	33	22.0	29	19.3	16	10.7	31	20.7	150	100	4.47	1.896
12	Rest	19	12.7	7	4.7	9	6.0	39	26.0	20	13.3	15	10.0	41	27.3	150	100	4.62	2.006
43	Discover	11	7.3	20	13.3	26	17.3	23	15.3	34	22.7	15	10.0	21	14.0	150	100	4.19	1.800
44	Confident	6	4.0	24	16.0	22	14.7	25	16.7	31	20.7	14	9.3	28	18.7	150	100	4.37	1.815
45	Understood me	9	6.0	13	8.7	27	18.0	23	15.3	30	20.0	23	15.3	25	16.7	150	100	4.47	1.782
46	Well-informed	9	6.0	17	11.3	15	10.0	25	16.7	34	22.7	20	13.3	30	20.0	150	100	4.59	1.825
47	Shared info	9	6.0	12	8.0	23	15.3	23	15.3	33	22.0	21	14.0	29	19.3	150	100	4.59	1.792
48	Health education	14	9.3	11	7.3	25	16.7	20	13.3	34	22.7	22	14.7	24	16.0	150	100	4.41	1.847
49	Health condition	12	8.0	14	9.3	22	14.7	22	14.7	33	22.0	19	12.7	28	18.7	150	100	4.46	1.860
50	Control	11	7.3	14	9.3	28	18.7	25	16.7	31	20.7	17	11.3	24	16.0	150	100	4.32	1.800
51	Better understanding	13	8.7	13	8.7	21	14.0	21	14.0	34	22.7	18	12.0	30	20.0	150	100	4.49	1.885
53	Positive outlook	9	6.0	17	11.3	23	15.3	18	12.0	31	20.7	13	8.7	39	26.0	150	100	4.6	1.925
54	Confidence in conversation	11	7.3	16	10.7	20	13.3	19	12.7	33	22.0	15	10.0	36	24.0	150	100	4.57	1.922
Care Items 1, 10, 12 and 49						Communication Items 8, 9, 45, 46, 47, 48 and 51						Outcomes Items 2, 43, 44, 50, 53 and 54							

The emergency nurse thus needs to have knowledge on a wide scope of illnesses to deliver the best possible care. Respondents stated that: *"The nurses could have handled me with more care"* and *"...the nurses did not handle me with care"* (See Table 4.9).

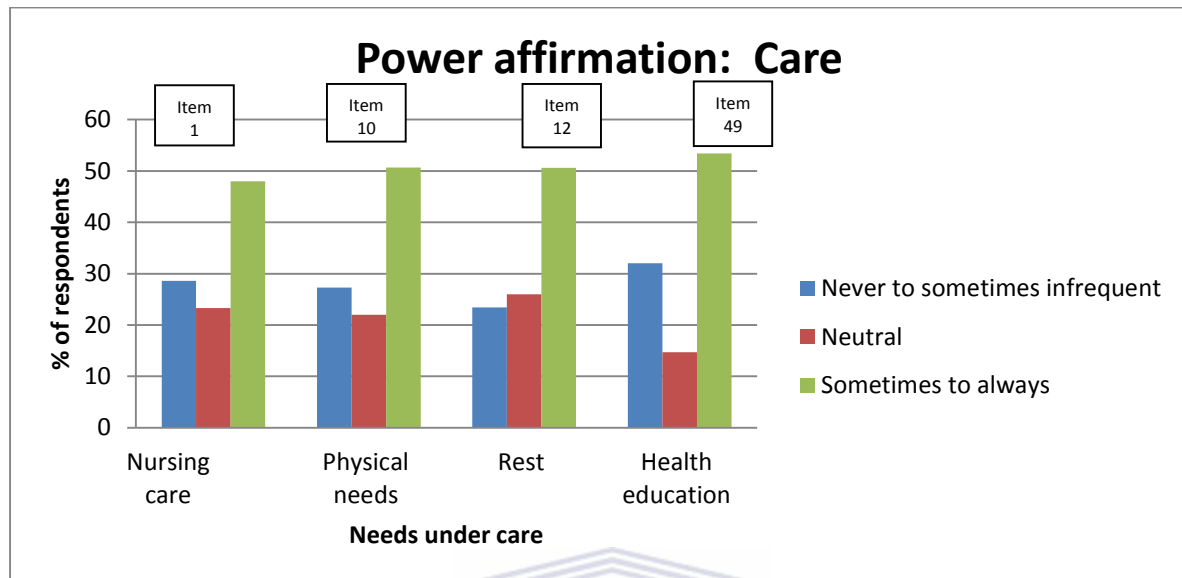


Figure 4.3: Responses on Factor 1: Power affirmation- care

More than half (n=76; 50.6%) of the 150 (100.0%) respondents, agreed that their physical needs were *sometimes to always* attended to by the nursing personnel, oppose to 41 (27.3%) respondents that indicated that their physical needs were *never to infrequently* attended to ($\bar{x} = 4.47$; $SD = 1.896$). Less than one quarter of respondents (n=33; 22.0%), felt *neutral* on whether their physical needs were attended to by nurses (Item 10).

More than half (n=76; 50.6%) of the respondents indicated that they *sometimes to always* had the opportunity to rest, while being admitted in the surgical emergency department (Item 12). Less than one quarter (n=35; 23.3%) indicated that they *never to infrequently* had this opportunity ($\bar{x} = 4.62$; $SD = 2.006$). More than one quarter (n=39; 26.0%) of the respondents felt *neutral* on this statement.

In Item 49, more than half (n=80; 53.3%) of the respondents indicated that they *sometimes to always* learned about their health condition, while a third (n=48; 32.0%) responded that they *never to infrequently* learned about their health condition. A minority of 22 (14.0%) of the respondents felt *neutral* on this item ($\bar{x} 4.46$; $SD 1.86$).

4.3.1.2 Communication (Items 8, 9, 45, 46, 47, 48 and 51)

Items on communication obtained mean values of between 4.3 to 4.6 and respondents agreed slightly less on communication of nurses than being cared for (previous section on care). Distribution of responses around the mean values (SD) ranged from 1.782 (Item 45) to 1.847 (Item 48).

In Item 8, the feedback that nurses gave that made patients feel better, obtained the highest mean value in Factor 1. More than half (n=78; 52.0%) of the respondents indicated that *sometimes to always* the feedback received from nurses made them feel better ($\bar{x} = 4.65$; $SD = 1.894$).

One quarter (n=38; 25.3%) of the respondents indicated that the feedback given to them from nurses, *never to infrequently* made them feel better, similarly, nearly one quarter (n=34; 22.7%) felt *neutral* on this matter. This could be interpreted that patients who undergo procedures should receive instructions and verbal feedback to ensure a good outcome in health (Heinrich, Fruehauf, Sauter, Steingotter, Fried, Schwizer & Fox, 2013:237). Patient feedback is also a significant indicator of patient experience and has the potential for improving quality and safety (Raleigh, Hussey & Seccombe, 2009:347).

Kruzik (2009:381) states that verbal instruction and feedback should occur throughout a patient's stay in hospital when receiving surgery. It is thus ideal to implement a well-designed education program for patients. On answering Item 42 in the questionnaire, patients responded by stating: "*I received no feedback from nurses on investigations done on me*" (See Table 4.1).

In Item 9, on nurses addressing the information about locations, e.g. bathrooms, cafeterias to patients, a mean value of 4.38 (SD 1.944) was obtained.

Half (n=75; 50.0%) of the 150 (100.0%) respondents claimed that the information about locations of bathrooms, etc. in the surgical emergency department, was *sometimes to always* given. Less than half (n=41;27.3%), of the respondents felt that the information was *never to infrequently* received to make their stay comfortable, and 34 (22.7%) of the respondents indicated that they felt *neutral* about information received by nurses on locations of the bathrooms, etc.

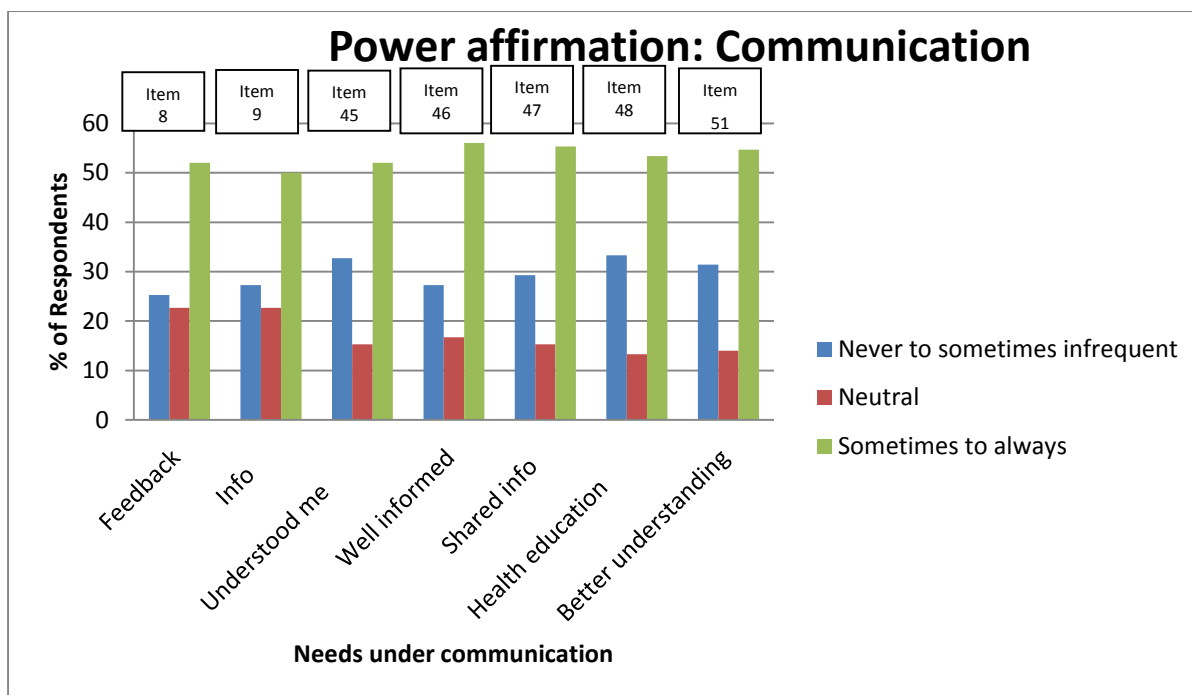


Figure 4.4: Responses on Factor 1: Power affirmation- communication

The responses on Item 26 indicated poor facilities, even if information around it was provided: “*I was not happy with the bathrooms*”, “*The toilets were dirty*”, “*...the toilets were broken*”, “*...poor toilets and bathrooms in the ward*” and “*...I was not happy with the bathroom and toilet conditions*” (See Table 4.9) were obtained. These responses addressed the overall state of the patient’s toilets and bathrooms in the surgical emergency department in the hospital.

In Item 45, half (n=78; 52.0%) of the 150 (100.0%) respondents indicated that they *sometimes to always* felt that the nursing staff made them feel, that they understood their basic needs. Nearly one third (n=49; 32.7%) indicated that they *never to sometimes* felt that their basic needs were understood, while 23 (15.3 %) felt *neutral* on whether nurses understood their basic needs. Item 45 obtained a mean value of 4.47 (SD 1.782). A study by Bolster and Manias (2010:162) recommended that nurses should on an ongoing basis assess patient’s needs as the outcome may influence the provision of individualized care.

More than half (n=84; 56.0%) of the respondents in Item 46, indicated that they *sometimes to always* felt that the nursing staff in the surgical emergency department seemed well-informed about their health conditions, to treat them adequately towards recovery. More than one quarter (n=41;27.3%), indicated that they *never to infrequent* were well-informed about their health conditions and 25 (16.7%) indicated they were *neutral* in this regard . The mean value

obtain by Item 46 was 4.59 (SD 1.825). Findings by a study by Wysing and Driver (2009:36) indicate that patient's perceptions on the needed nursing skills included acquisition and application of critical thinking, technical skills, interpersonal skills, clinical judgment and caring practices.

In Item 47, more than half (n=83; 55.3%) of the respondents indicated that the nursing staff *sometimes to always* shared information on their health with them in the surgical emergency department. A mean value of 4.59 was obtained (SD 1.792). Nearly one third (44; 29.3%) of the respondents 150 (100.0%) respondents indicated that nurses *never to infrequently* shared information with them regarding their health and 23 (15.3%) were *neutral*. Schoenfelder, Klewer and Kugler (2011:508) state that information about anesthesia, medication or undergoing operations is highly relevant to patients for future hospital stays. Understanding the illness better and having open discussions about the prognosis contributes to respectful treatment of patients (Gerlich, Klindtworth, Oster, Pfisterer, Hager & Schneider, 2012:301).

Half (n=80; 53.3%) of the respondents indicated that the nursing staff *sometimes to always* provided them with health education throughout their stay in the surgical departments (Item 48). One third of the respondents (n=50; 33.3%) indicated that they *never to infrequently* were provided with health education and 20 (13.3%) responses were *neutral* ($\bar{x} = 4.41; SD = 1.847$).

With regards to health education, on the question, "What could have been done to assist you in meeting your goal to become a healthy person? (Item 55), respondents indicated: "I did not receive information when I left the ward", "I wanted nurses to tell me what to do", "...they did not even tell me what is wrong with me when I left" and "I did not get any health tips" (See Table 4.11).

More than half (n=82; 54.7%) of the respondents indicated that they *sometimes to always* understood their condition better, after being informed about the reasons therefore (Item 51). Nearly one third (n=47; 31.3%) indicated that they *never to infrequently* understood their condition better, after receiving reasons therefore. A minority of 21(14.0%) respondents were *neutral*. This item had a mean value of 4.49 (SD = 1.885).

Items 47, 48, 49, 50 and 51 addressed the impact of health education on the patient during and after admission to the surgical emergency department. Health education and information

on the patient's illness is important as it enhances the patient's ability to cope with the illness (Perk, De Backer, Gohlkel *et al.*, 2012:1661).

Communication related needs mostly obtained *sometimes to always* responses (Figure 4.4).

4.3.1.3 Outcomes (Items 2, 43, 44, 50, 53 and 54)

Responses on these items obtained mean values between 4.1 and 4.6. The SD around the mean values had a distribution from 1.640 (Item 2) to 1.925 (Item 53).

In Item 2, half of the respondents (n=75; 5.0%) indicated that they *sometimes to always* felt the responsibility of the nurse during receiving patient care, 42 (28.0%) indicated a response of *never to infrequently* and more than one quarter (n= 31;20.7%) indicated being *neutral* ($\bar{x} = 4.58$; $SD = 1.64$).

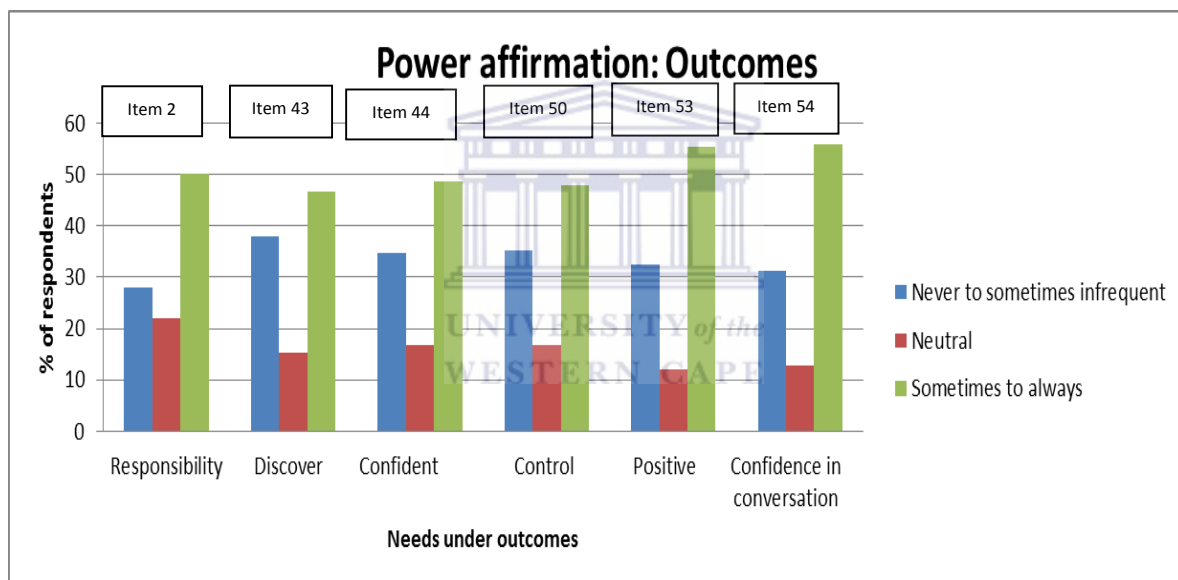


Figure 4.5: Responses on Factor 1: Power affirmation- outcomes

Nearly half (n=70; 46.7%) of the respondents indicated in Item 43, that nursing staff helped them increase their self-esteem, e.g. respecting their opinions. More than a third (n=57; 38.0%) indicated that the nursing staff *never to infrequently* helped them with their self-esteem, while 23 (15.3%) respondents were neutral. Item 43 obtain a mean value of 4.19 (SD = 1.8).

Patient autonomy is when patients have the opportunities and abilities to control, as far as possible, the impact of their illness on and treatment of their health (Williams, 2007:5). This includes patient's opinions. Higher trust and satisfaction levels of patients are a result of

autonomy and the support received from health care professionals. It also increases patient health outcomes (Lee & Lin, 2010:1816).

Half, namely 73 (48.7%) of the respondents, indicated that they *sometimes to always* felt more confident about their future health status, after receiving support from nurses (Item 44). A third 52 (34.6%) of the respondents felt that they never to infrequently were confident about their future health status. Nearly one third 45 (30.0%) of the respondents were neutral. Item 44 obtained a mean of 4.37 (SD = 1815). The support provided by nurses and caregivers is important as it aids in maintaining the individual's healthy habits, self-esteem and enable them to follow the regime (Perk *et al.*, 2012:1661).

Nearly half (n=72; 48.0%) of the respondents felt that health education was *sometimes to always* given to them in the surgical emergency department, that led to acute onsets of their condition (Item 50). More than a third (n=53; 35.3%) indicated that they *never to infrequently* felt that their condition was controlled while 25 (16.7%) responses were *neutral*. Item 50 obtained a mean value of 4.32 (SD = 1800).

In Item 53, more than half (n=83; 55.3%) of the respondents indicated that they *sometimes to always* had a more positive outlook on their condition after treatment. A third, namely 49 (32.7%) respondents indicated that they *never to infrequently* felt that they gained a more positive outlook on their condition and 8 (12.0 %) were neutral. The mean value on Item 53 was 4.6 (SD=1.925). Respondents stated in the open ended question (Item 42) that: "*I am not interested whether these needs have been met*" and "*I do not care*" (See Table 4.1).

More than half (n=84; 56.0%) of the respondents, felt they *sometimes to always* were more confident after engaging in conversations with the nursing personnel concerning their condition. Item 54 obtained a mean value of 4.57 (SD = 1.922). Less than one third (n=47; 31.3%) respondents indicate that they *never to infrequently* felt more confident after engagement with nurses and 19 (12.7%) *neutral* responses were obtained. Conversations between care givers and patients could help to identify the accurate diagnosis and most suitable treatment plan and possibly help with self-care and health beliefs resulting in better physical health (Street, Makoul, Arora & Epstein, 2009:299). This could lead to greater confidence, as good well-being is associated with mental health (Heginbotham & Newbigging, 2014:30). Responses on the needs related to health outcomes where mostly rated *sometimes to always* (Figure 4.5).

4.3.2 Factor 2: Positivity

Factor 2 (27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40 and 41) obtained a Cronbach Alpha of 0.970 (the second highest mean value of the 6 factors). In this section on positivity, the mean values ranged from 3.95 to 4.43 with standard deviations between 1.740 to 1.873 (Table 4.4).

The items in Factor 2 (Table 4.4) are for discussion purposes grouped as follows:

- Relationships (Items 27, 28, 33, 34, 37 and 39).
- Attributes (Items 29, 30, 31, 32 and 35).
- Other support (Items 36, 38, 40 and 41).

4.3.2.1 Relationships (Items 27, 28, 33, 34, 37 and 39)

The items under the heading relationships, obtained a highest mean value of 4.43 and lowest mean value of 3.95. Factor 2 obtained the widest distribution around the mean values (SD) ranging from 1.7400 (Item 39) to 2.940 (Item 34).

In Item 27, that addressed whether respondents felt that they could form a relationship with the nurse, more than a third of the respondents (n=59; 39.3 %) indicated that they could *sometimes to always* form a relationship with the nurse(s), and more than one third of respondents (n=64; 42.7%) indicated that they *never to infrequently* could form a relationship with the nurse(s). Less than one quarter of respondents (n=27; 18.0 %) indicated that they felt *neutral* on whether they could form a relationship with the nurses(s). A mean value of 4.01 (SD 1.812) was obtained.

Nurse-patient relationships are important for patient participation in nursing care (Millard, Hallet & Luker, 2006:142). The nurse-patient interaction might possess a supporting potential (Haugan, 2014:112). Nurse-patient relationships concentrate on caring for human needs, the limitations thereof and the potentials of the patient (Gámez, 2009:126) as well as respect between the two groups (patient and nurse).

From the open question posed to respondents (Item 26), responses indicated that disrespect was perceived from nurses: "*I wish to have received more respect from nurses*", "*I was not respected by nurses*" and "*There was no respect received from staff*" (Table 4.9).

Table 4.4: Factor 2: Positivity

Item	Factor 2	Never		Rarely		Infrequently		Neutral		Sometimes		Usually		Always		Total		Mean	SD
		N	%	n	%	n	%	n	%	n	%	N	%	n	%	n	%	\bar{x}	
27	Relationship with nurse	14	9.3	19	12.7	31	20.7	27	18.0	25	16.7	15	10.0	19	12.7	150	100	4.01	1.812
28	Relationships other people	10	6.7	22	14.7	24	16.0	30	20.0	34	22.7	7	4.7	23	15.3	150	100	4.13	1.773
29	Acknowledgement	11	7.3	14	9.3	28	18.7	29	19.3	32	21.3	15	10.0	21	14.0	150	100	4.24	1.748
30	Caring	11	7.3	20	13.3	24	16.0	30	20.0	32	21.3	12	8.0	21	14.0	150	100	4.15	1.774
31	Kind	9	6.0	19	12.7	23	15.3	34	22.7	28	18.7	16	10.7	21	14.0	150	100	4.23	1.743
32	Empathy	9	6.0	17	12.0	25	16.7	34	22.7	27	18.0	15	10.0	22	14.7	150	100	4.23	1.747
33	Kind to others	18	12.0	16	10.7	20	13.3	28	18.7	31	20.7	17	11.3	20	13.3	150	100	4.13	1.873
34	Professional	14	9.3	14	9.3	22	14.7	31	20.7	30	20.0	15	10	23	15.3	150	100	4.43	2.940
35	Explained matters	15	10.0	18	12.0	22	14.7	32	21.3	31	20.7	10	6.7	22	14.7	150	100	4.09	1.826
36	Permission	13	8.7	15	10.0	21	14.0	40	26.7	22	14.7	17	11.3	22	14.7	150	100	4.21	1.793
37	Spiritual support	13	8.7	19	12.7	30	20.0	32	21.3	24	16.0	10	6.7	22	14.7	150	100	4.02	1.840
38	Support	10	6.7	16	10.7	37	24.7	28	18.7	22	14.7	10	6.7	27	18.0	150	100	4.16	1.817
39	Assistance relationships	10	6.7	21	14.0	36	24.0	28	18.7	24	16.0	16	10.7	15	10.0	150	100	3.95	1.740
40	Importance	10	6.7	24	16.0	34	22.7	23	15.3	26	17.3	9	6.0	24	16.0	150	100	4.03	1.828
41	Input	15	10.0	15	10.0	29	19.3	38	25.3	26	17.3	9	6.0	18	12.0	150	100	3.96	1.734
Relationships Items 27, 28, 33, 34, 37 and 39				Attributes Items 29, 30, 31, 32 and 35								Other support Items 36, 38, 40 and 41							

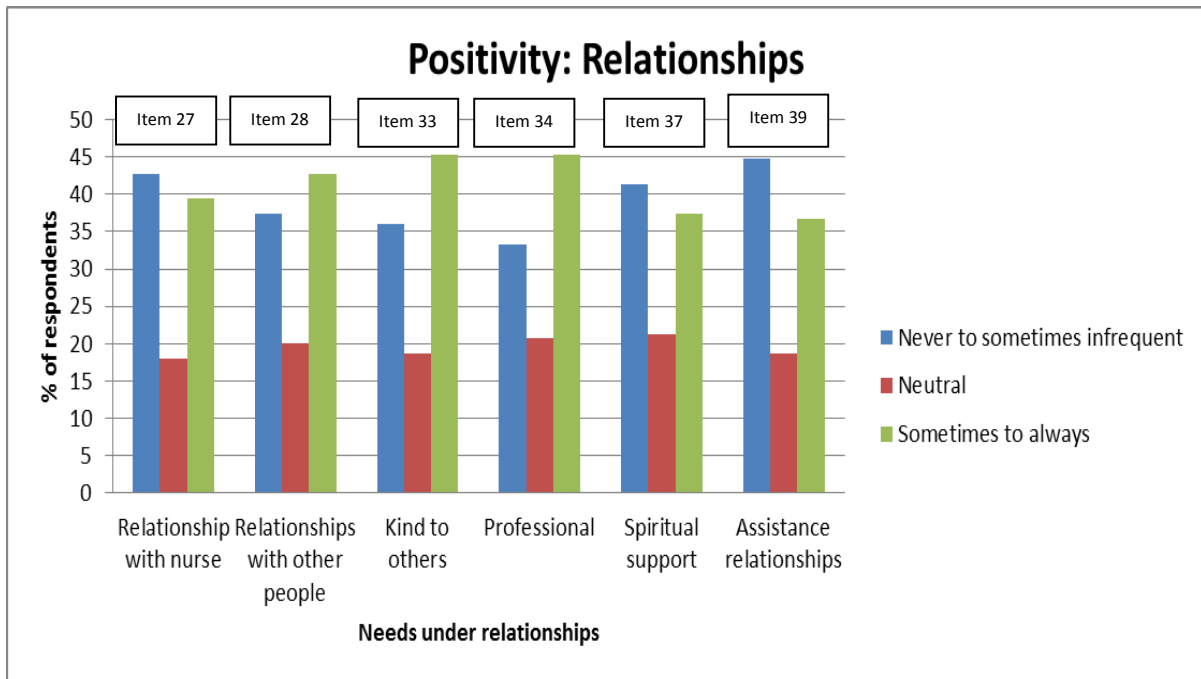


Figure 4.6: Responses on Factor 2: Positivity- relationships

Poor relationships were further perceived in Item 42, that asked: “What could have been done to assist you in meeting your need for relationships with other people?”. Among these responses were: “...nurses should act ore professionally”, “...not happy with the way nurses addressed me”, “...nurses lack compassion and do not communicate”, “...I received no empathy from nurses”, “...the nurses did not smile with me”, “I felt ignored by nurses”, “The nurses were not friendly”, “...there was no help from nurses”, “The nurses did not communicate with me”, “Nurses should go for training on people skills”, “...they never smiled” and “The nurses seemed stressed” (Table 4.1). These comments from patients clearly indicate examples of poor relationships between patients and nurses.

Nearly half (n=64; 42.7%) of the respondents indicated that they *sometimes to always* formed meaningful relationships with other people, while 56 (37.3%) of the respondents *never to infrequently* formed relationships during their stay in hospital. Thirty (20.0%) of the 150 (100.0%) respondents indicated that they felt *neutral* on Item 28. A mean value of 4.13 (SD 1.773) was obtained.

Item 33, addressed the kindness of nurses to patients with a mean value of 4.13 (SD 1.873). Nearly half, 68 (45.3%) of the respondents, indicated that they *sometimes to always* noticed nurses were kind to other people, while more than a third, 54 (36.0%) *never to infrequently*

noticed it. Nearly one quarter (n=28; 18.7%) of the respondents were *neutral* on whether they noticed that nurses were kind to other people.

A number of respondents (n=68; 45.3%) indicated that they *sometimes to always* were addressed in a professional manner by the nursing personnel. One third (n=50; 33.3%) indicated that they *never to infrequently* were addressed in a professional manner, while 31 (20.7%) respondents were *neutral* on this. Item 34 obtained a mean value of 4.43 with the highest SD (2.904) in Factor 2.

More than one third (n=56; 37.3%) of respondents indicated that they *sometimes to always* received spiritual support from nurses. Item 37 had a mean value of 4.02 with a SD of 1.804. Less than half (n=62; 41.3 %) of the respondents *never to infrequent* received support while 32 (21.3%) of respondents were *neutral* on the item. Receiving spiritual support from the medical team is associated with better patient quality of life. Individuals who received spiritual support are less inclined to access hospice care. Spiritual support is a key component of medical care guidelines (Balboni *et al.*, 2010:448).

Items 39 (similar to Items 40 and 41) showed that the majority of respondents indicating that their needs were *never to infrequently* met. Nearly half, 67 (44.7%) of the 150 (100.0%) respondents, indicated that they *never to infrequently* formed meaningful relationships with nurses, versus only a third 55 (36.7%) of the respondents that indicated that they *sometimes to always* were assisted by nursing staff. This item obtained the lowest SD in Factor 2 (SD= 1.74) around a low mean value of 3.95.

Findings by Birkelund and Larsen (2013:612) suggest that, to patients, interpersonal interaction is important with fellow patients when it comes to care.

Responses on Item 42 in the questionnaire, whether assistance was delivered by nurses in the department to patients in forming relationships with other individuals, were mentioned: "*Nurses could have helped me form relationships with them and with other people*" and "*...they did not assist me in forming relationships*" (see Table 4.1).

4.3.2.2 Attributes (Items 29, 30, 31, 32 and 35)

In the items under the heading attributes, the highest mean value of 4.43 and the lowest mean value of 4.09 were obtained. A wide distribution of responses around the mean values was obtained from the lowest SD being 1.743 to the highest SD being 1.826.

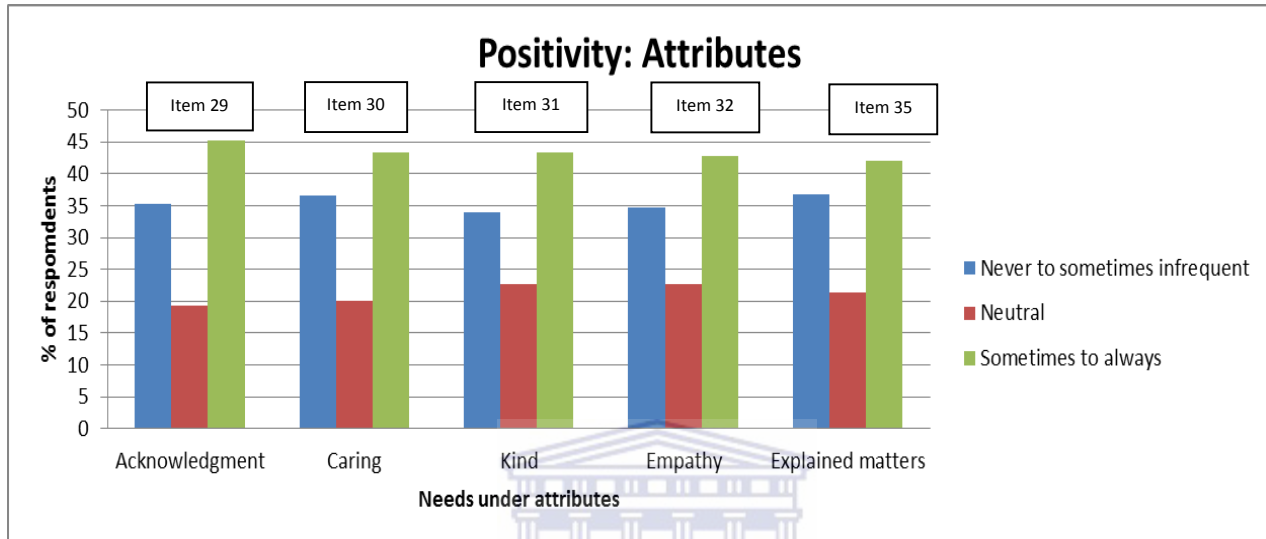


Figure 4.7: Responses on Factor 2: Positivity- attributes

In Item 29, on acknowledged of patients in matters that concerned them ($\bar{x} = 4.24$; $SD = 1.748$) nearly half ($n=68$; 45.3%) of the respondents were *sometimes to always* acknowledged by nurses on matters that concerned their care. More than one third ($n=53$; 35.3%) of respondents were *never to infrequently* acknowledged on matters concerning their care and nearly a fifth ($n=29$; 19.3%) of respondents felt *neutral*.

Item 30 had a mean value of 4.15($SD = 1.774$) with more than one third ($n=65$; 43.3%) of the respondents that indicated that they *sometimes to always* felt a sense of caring from the nursing staff. More than a third, namely 55 (36.7%) respondents *never to infrequent* felt this sense of caring. Less than one quarter 31(20.0%) of respondents indicated that they felt *neutral* on a sense of caring from nursing staff.

Close to half ($n=65$; 43.3%) of the respondents indicated that nurses were *sometimes to always* kind to them through word or deed, while one third ($n=51$; 34.0%) indicated that *never to infrequent* perceived them as kind to them. Nearly a quarter, 34 (22.7%) of the respondents felt *neutral* on this. Item 31 obtained a mean value of 4.23 ($SD = 1.743$). The

kindness that nurses exhibit to patients is essential for recovery (Schoenfelder *et al.*, 2011:507).

In Item 32, 64 (42.7%) respondents indicated that they were *sometimes to always* showed empathy and more than one third (n=54; 36.0%) indicated that they *never to infrequently* perceived empathy. Respondents also indicated they were *neutral* (n=34;22.7%) on this item, that received a mean value of 4.23 (SD = 1.747). The empathy that a nurse shows contributes to a caring environment (Cunico, Sartori, Marognolli & Meneghini, 2012:2016).

Less than half (n=63; 42.0%) of the respondents indicated that nurses *sometimes to always* explained matters to them in an understandable manner, while more than one third (n=55; 36.7%) indicated that *nurses never to infrequently* gave understandable explanations. More than a fifth of the respondents were *neutral* (n=32;21.3%) and Item 35 obtained a mean value of 4.09 (SD = 1.826).

4.3.2.3 Other support (Items 36, 38, 40 and 41)

Items under this heading, obtained lower mean values ranging from 3.96 to 4.21. The distributions of responses around the mean values (SD) ranged from 1.734 (Item 41) to 1.828 (Item 40).

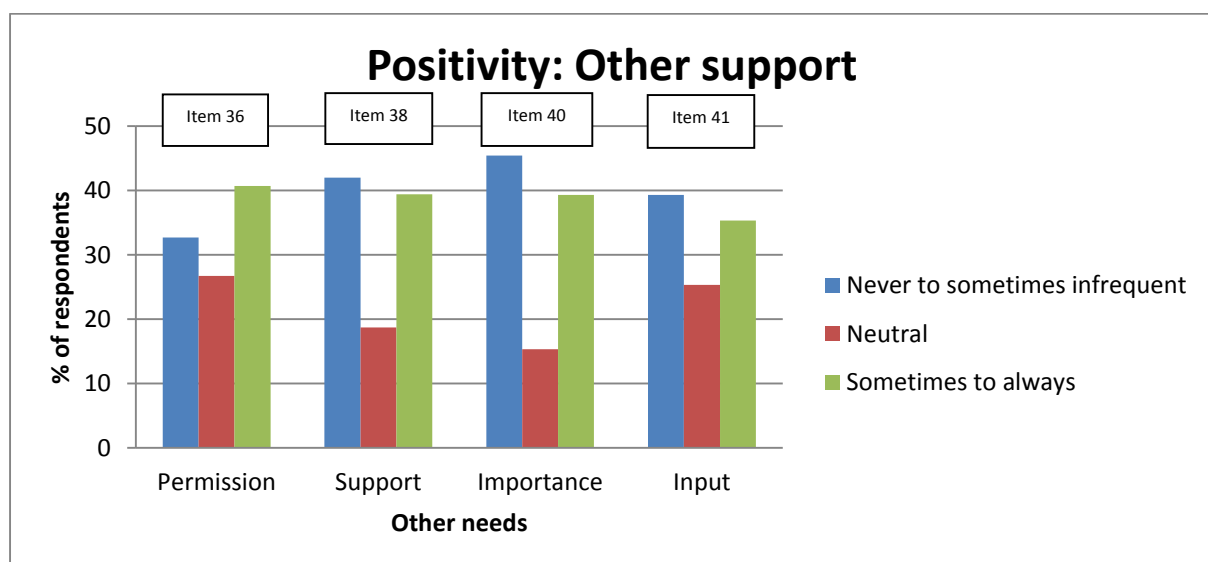


Figure 4.8: Responses on Factor 2: Positivity- other support

In Item 36, 61 (40.7%) respondents indicated they *sometimes to always* gave permission for procedures to be done on them, while nearly one third (n=49; 32.7%) of respondents *never to infrequently* gave permission. Nearly a quarter (n=40; 26.7%) of the respondents were *neutral*. The mean value of 4.21 (SD 1.793) was obtained.

Over one third (n=59; 39.3%) of respondents indicated that they *sometimes to always* perceived that the support received from the nursing personnel, made them feel comfortable. More respondents, 63 (42.0%) perceived that they *never to infrequently* were supported while 28 (18.7%) respondents were neutral. Item 38 obtained a mean value of 4.16 (SD 1.817). A study by Mattila, Kaunonen, Aalto and Astedt-Kurki (2014:308) indicated that for many patients, the foundation for a significant relationship is constituted by receiving nursing support. Patients feel that they are unique individuals and therefore important to the nurse whenever they received support. Support in the forms of friendliness and positive nurse attitude, an openness atmosphere and equality could increase patient comfort (Mattila, *et al.*, 2014:309). In an open question on the fulfillment of growth needs (Item 55), responses indicated: "*I received no support from the nurses*" and "*I wish I have received more support from the nurses*" (Table 4.11).

In Item 40, 59 (39.3%) respondents indicated that they *sometimes to always* were treated as important by the nurse. However more respondents, namely 68 (45.3 %) indicated that they *never to infrequent* felt important As stated previously, supporting patients increases their perception of feeling important (Mattila, *et al.*, 2014:308). A Response obtained from one of the open questions (Item 42) was: "*I felt unimportant while admitted in the hospital*" (Table 4.1).

Only a third, 53 (35.3%) of the respondents, indicated that they *sometimes to always* were allowed to give input in decisions taken about their nursing care, while more respondents, namely 59 (39.3%) *never to infrequent* perceived this input (Item 41). Thirty (20.0%) respondents stayed neutral. A response on Item 42, indicated: "*I was not involved in decisions that were made*" (Table 4.1), thus not ensuring patient participation. Items 39, 40 and 41 obtained low mean values of 3.95 (SD = 1.704), 4.03 (SD= 1.828, and 3.96 (SD = 1.828) respectively. Decision-making should be shared between the nurse and patient. It can also include the patient's partner and or family to as far as possible. This ensures the active participation of both the patient and family in lifestyle changes and pharmacological obedience (Perk *et al.*, 2012:1661).

From the responses it can be gathered that the needs within Factor 3, other than relationships and attributes, were *never to infrequently* met as seen in Figure 4.8.

4.3.3 Factor 3: Less concrete desires

Factor 3 obtained a Cronbach Alpha of 0.959 (Items 7, 14, 17, 18, 19, 20, 21, 22, 23, 24 and 25). In the section on less concrete desires, the lowest mean value was 3.71 and the highest mean value was 4.19. The standard deviations ranged from 1.720 to 1.969 (Table 4.5). Respondents mostly felt neutral on their needs being met (Figure 4.5).

The Items in Factor 3, on less concrete desires (Table 4.5), were for discussion purposes grouped as follows:

- Administrative needs (Items 19, 21, 22, 23, 24 and 25).
- Non-administrative needs (Items 7, 14, 17, 18 and 20).

4.3.3.1 Administrative needs (Items 19, 21, 22, 23, 24 and 25)

The items under the heading administrative needs obtained low mean values between 3.71 and 4.10. The distribution of responses around the mean values (SD) for these items ranged from 1.88 (Item 21) to 1.969 (Item 25). Figure 4.9 indicates that the majority of the patients felt that their administrative needs were *never to infrequently* met.

Only a third, 46 (30.6%) respondents indicated that they *sometimes to always* could lie in a comfortable position in bed, while 61 (40.7%) respondents indicated that this could *never to infrequently* (Item 19). About one quarter of respondents (n=37; 24.7%), indicated *neutral* response on whether they could lay in a comfortable position in the bed. Item 19 obtained a low mean value of 3.71 (SD 1.868). This item obtained the lowest mean value under administrative needs. In an open question (Item 26), a respondent gave a reason for the uncomfortable bed by stating: “...*the linen was very poor*” (Table 4.9).

Item 21, indicated a mean value of 4.01 (SD = 1.808) and one third (n=52; 34.7%) of the 150 (100.0%) respondents indicated that they *sometimes to always* felt at ease regarding the safety of their valuables in the surgical emergency department. More than one third (n=61; 40.7%) of respondents *never to infrequently* felt their valuables and property were safe while 37 (24.7%) respondents felt *neutral* on the safety of their valuables.

Table 4.5: Factor 3: Less concrete desires

Item	Factor 3	Never		Rarely		Infrequently		Neutral		Sometimes		Usually		Always		Total		Mean	SD
		n	%	n	%	n	%	n	%	n	%	n	%	n	%	n	%	\bar{x}	
7	Anxiety	12	8.0	16	10.7	21	14.0	39	26.0	27	18.0	15	10.0	20	13.3	150	100	4.19	1.747
14	Fluids	17	11.3	22	14.7	22	14.7	22	14.7	43	28.7	20	13.3	8	5.3	18	12	3.82	1.780
17	Recovery	15	10.0	18	12.0	25	16.7	48	32.0	17	11.3	10	6.7	17	11.3	150	100	3.88	1.720
18	Pain control	14	9.3	21	14.0	26	17.3	37	24.7	23	15.3	9	6.0	20	13.3	150	100	3.94	1.784
19	Bed	21	14.0	22	14.7	24	16.0	37	24.7	20	13.3	11	7.3	15	10.0	150	100	3.71	1.868
20	Staff touching	18	12.0	20	13.3	21	14.0	34	22.7	22	14.7	9	6.0	26	17.3	150	100	4.02	1.930
21	Valuables	13	8.7	23	15.3	25	16.7	37	24.7	19	12.7	6	4.0	27	18.0	150	100	4.01	1.880
22	Visits	14	9.3	21	14.0	16	10.7	42	28.0	21	14.0	7	4.7	29	19.3	150	100	4.15	1.891
23	Family sitting	17	11.3	19	12.7	22	14.7	35	23.3	21	14.0	10	6.7	26	17.3	150	100	4.05	1.914
24	Messages	17	11.3	23	15.3	16	10.7	36	24.0	25	16.7	8	5.3	25	16.7	150	100	4.02	1.990
25	Privacy	19	12.7	23	15.3	16	10.7	30	20.0	28	18.7	7	4.7	27	18.0	150	100	4.03	1.969
Administrative needs Items 19, 21, 22, 23, 24 and 25									Non-administrative needs Items 7, 14, 17, 18 and 20										

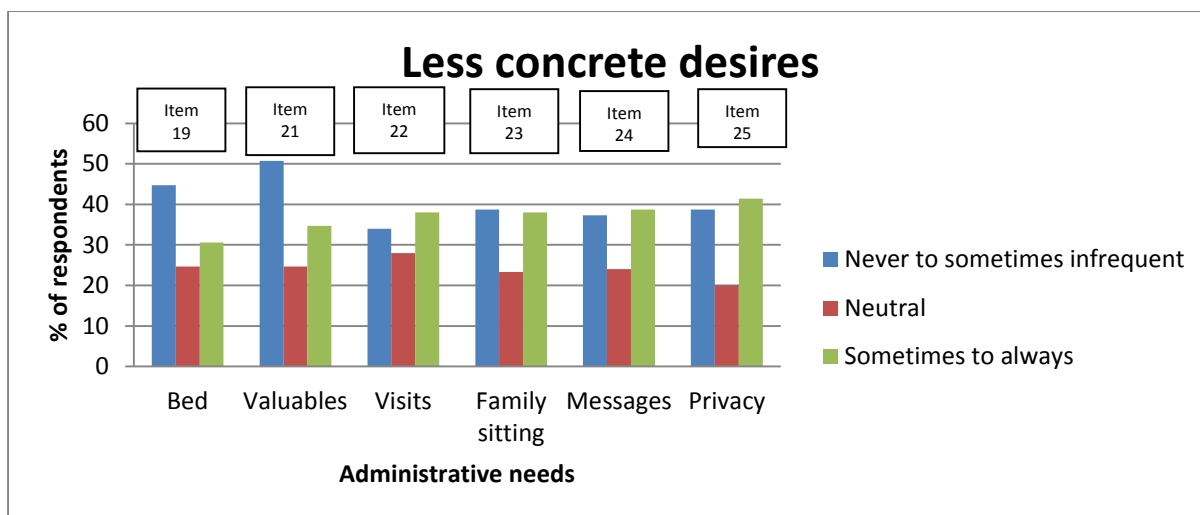


Figure 4.9: Responses on Factor 3: Less concrete desires- administrative needs

Just over a third, 57 (38.0%) respondents, indicated that they *sometimes to always* could be visited by family or friends who brought them necessities during their stay in hospital. On the other hand, a third (n=51; 34.0%) of the respondents *never to infrequently* could be visited and nearly 42 (28.0%) respondents indicated they were *neutral* (Item 22). This item obtained a mean value of 4.14 (SD 1.891). On answering an open ended question (Item 26), a respondent stated that: "My family was sent away rudely by the nurses". Another response was: "...visiting hours should be longer" (Table 4.9).

More than one third (n=57; 38.0%) of the respondents indicated that their family and friends were *sometimes to always* allowed to sit next to their bed, during their stay in the surgical emergency department (Item 23). The total of respondents who indicated that their family and friends were *never to infrequently* allowed to sit next to their bed, were more, namely 58 (38.7%). Only 35 (23.3%) respondents indicated *neutral* on this item. Item 23 had a mean value of 4.05 (SD = 1.914).

In Item 24, the statement on staff members carrying over messages e.g. telephone calls, obtained a mean value of 4.02 (SD = 1.909). More than one third (n=58; 38.7%) of the respondents indicated that messages were *sometimes to always* carried over to them by staff members, similarly 56 (37.3%) respondents indicated that this *never to infrequently* happened. Close to one quarter (n=36; 24.0%) of responses were *neutral*.

More than a third (n=58; 38.7 %) of the respondents indicated that their privacy was *never to infrequently* maintained, while 30(20.0%) were *neutral*. Less than half (n=62;41.4%) of the respondents indicated that privacy was *sometimes to always* maintained. Item 25 had a mean

of 4.03 (SD = 1.969). in an open ended question (Item 26) it was mentioned: "...I had to wash in front of other patients" and "...I had no privacy" (Table 4.9).

4.3.3.2 Non-administrative duties (Items 7, 14, 17, 18 and 20)

Items obtained mean values between 3.82 (Item 14) and 4.19 (Item 7). The distribution of responses around the mean values (SD) for these items ranged from 1.700 to 1.930.

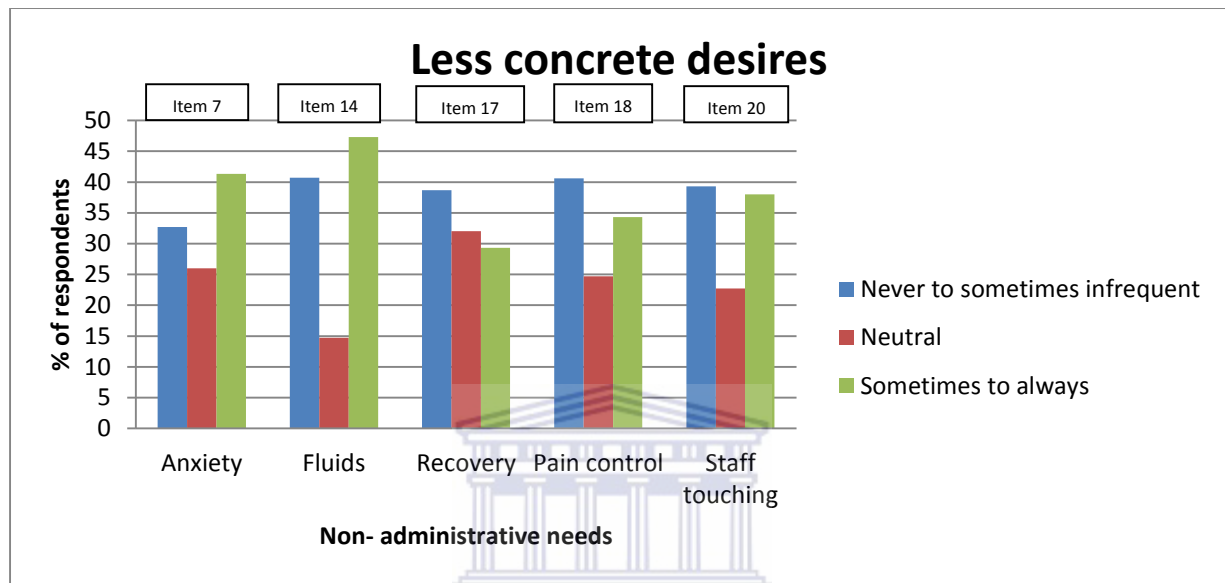


Figure 4.10: Responses on Factor 3: Less concrete desires- non administrative needs

Less than half (n=62; 41.3%) of the respondents indicated they *sometimes to always* felt anxious when they did not understand the procedures conducted on them. Almost a third (n=45;30.0%) of the respondents indicated they *never to infrequently* felt anxious while 39 (26.0%) indicated they were *neutral* on this item. Item 7 obtained a mean value of 4.19 (SD = 1.747).

Providing information to patients lessens patient anxiety (Jlala, French, Foxall, Hardman & Bedforth, 2010:369). Respondents in an open question in Item 55 said: "...procedures were not explained to me" and "...I wish I knew what I was going for" (Table 4.11), when asked about the fulfillment of their growth needs.

Nearly half (n=71; 47.3%) of the respondents in Item 14, indicated that they *sometimes to always* took in adequate fluids in the surgical emergency department. A low mean value of 3.82 was obtained (SD=1.78). More than one third (n=61; 40.7%) of the respondents indicated that they *never to infrequently* took in adequate fluids and 22 (14.7%) of respondents

indicated they felt *neutral* on the item. The acutely ill patient becomes dependent on others to help him or her to maintain a sufficient fluid intake. Being acutely ill is associated with poor appetite, fluid loss occurs and results in an imbalance in homeostasis (McMillen & Pitcher, 2010:117).

In Item 17, less than a third, namely 44 (29.3%) respondents, indicated that they *sometimes to always* perceived the surgical emergency department contributing to their recovery. More respondents (n=58; 38.7%) indicated that they *never to infrequently* were assisted to recover. Almost a third (n=48;32.0%) of respondents were neutral.

Sleep is vital in both protecting against and healing from sickness. Conservation and restoration of energy are the main functions of sleep (Moorcroft, 2013:12). Sleep is necessary for physiologic restoration and maintaining cognitive and emotional wellbeing. While patients sleep, noise can cause arousal by affecting cardiovascular function and brain activity (Buxton, Ellenbogen & Wang, 2012:70) which changes the treatment care pathway for patients.

More than one third (n=52; 34.7%) of respondents indicated that they *sometimes to always* had their pain under control during service delivery. More respondents (n=61; 40.7%) indicated their pain was *never to infrequently* under control. Respondents who felt neutral were 37 (24.7%). Item 18 obtained a low mean value of 3.94 (SD= 1.784). Pain relief has been recognized as a basic human right by the World Health Organization (Brennan, Carr & Cousins, 2007:205) and failure to relieve pain is seen as an unethical breach of human rights.

More than one third (n= 57; 38%) of the respondents indicated that they *sometimes to always* were carefully touched or turned during procedures. Responses provided a mean value of 4.01 (SD=1.930 on Item 20). Similarly, more than a third (n=59;39.3%) of the respondents indicated that they *never to infrequently* were touched or turned during procedures, whilst 34 (22.7%) respondents felt *neutral* on this item. Touch is a satisfying and important part of care (Connor & Howett, 2009:134).

4.3.4 Factor 4: Physiological needs

Factor 4 (Items 3, 4, 5 and 6 in Table 4.6), obtained a Cronbach Alpha of 0.917, being the second lowest value of the 6 factors. In Factor 4, the lowest mean value was 4.45 (Item 6) and the highest mean value was 4.89 (Item 4). Item 4 had the highest mean value among all items in the factor analysis. Standard deviations in Factor 4 ranged from 1.653 to 1.721

(Table 4.6). Respondents mostly tend to be *neutral* on their physiological needs being met (Figure 4.11).

Close to half (n=73; 48.7%) of the respondents indicated that they *sometimes to always* felt safe during their stay in the surgical emergency department, and 33 (22.0%) respondents *never to infrequently* felt safe. Item 3, obtained a mean value of 4.61 (SD = 1.690). Patient safety is crucial to health care quality (Chen & Li, 2010:1). Answers obtained from an open question (Item 26) on the fulfillment of their safety needs were as follows: "...I did not feel safe in the ward", "I felt so unsafe in the room", "...I also felt that my belongings were not safe", "Emergency buttons were not in sight- I did not feel safe at all" and "...there were no security officers close by and it did not make me feel safe" (Table 4.9).

More than half (n=87; 58.0%) of the respondents indicated they *sometimes to always* felt secure when having a nurse near them and only 26 (17.3%) respondents *never to infrequently* felt safe. Item 4 reached the highest mean value in Factor 4 as well as among all the 6 factors obtained ($\bar{x} = 4.89$; $SD = 1.653$).

More than half (n=82; 54.7%) of the respondents indicated that they *sometimes to always* felt that the nurse delivered nursing care, in a manner that made them feel comfortable. Item 5 obtained a mean value of 4.86 (SD=1.660). Under a fifth, 27 (18.0%) of the respondents were *never to infrequently* feeling comfortable, however 41 (27.3%) had neutral responses. In an open question (Item 26), responses such as: "I was uncomfortable in the bed", "I wish I was in a comfortable single room", "...it was a very uncomfortable bed that I had", "...the nurses could have done more to make me more comfortable", "I was uncomfortable all of the time....", "...I was not comfortable during my stay in hospital", "...I felt uncomfortable in the ward" and "...the bed I slept on was so uncomfortable" (See Table 4.9) were mentioned.

Item 6, on the statement that the nursing care received decreased fear of the unknown, 74 (49.3%) respondents indicated that they *sometimes to always* perceived their fear decreased, while 40 (26.7%) respondents *never to infrequently* perceived decreasing fear of the unknown. Almost a quarter (n=36;24.0%) of the responses were neutral.

Table 4.6: Factor 4: Physiological needs

Item	Factor 4	Never		Rarely		Infrequently		Neutral		Sometimes		Usually		Always		Total		Mean	SD
		n	%	n	%	n	%	n	%	n	%	n	%	n	%	n	%	\bar{x}	
3	Safe	4	2.7	18	12.0	11	7.3	44	29.3	25	16.7	19	12.7	29	19.3	150	100	4.61	1.690
4	Secure	4	2.7	11	7.3	11	7.3	37	24.7	33	22.0	17	11.3	37	24.7	150	100	4.89	1.653
5	Comfortable	4	2.7	10	6.7	13	8.7	41	27.3	28	18.7	16	10.7	38	25.3	150	100	4.86	1.660
6	Fear	9	6.0	14	9.3	17	11.3	36	24.0	33	22.0	17	11.3	24	16.0	150	100	4.45	1.721

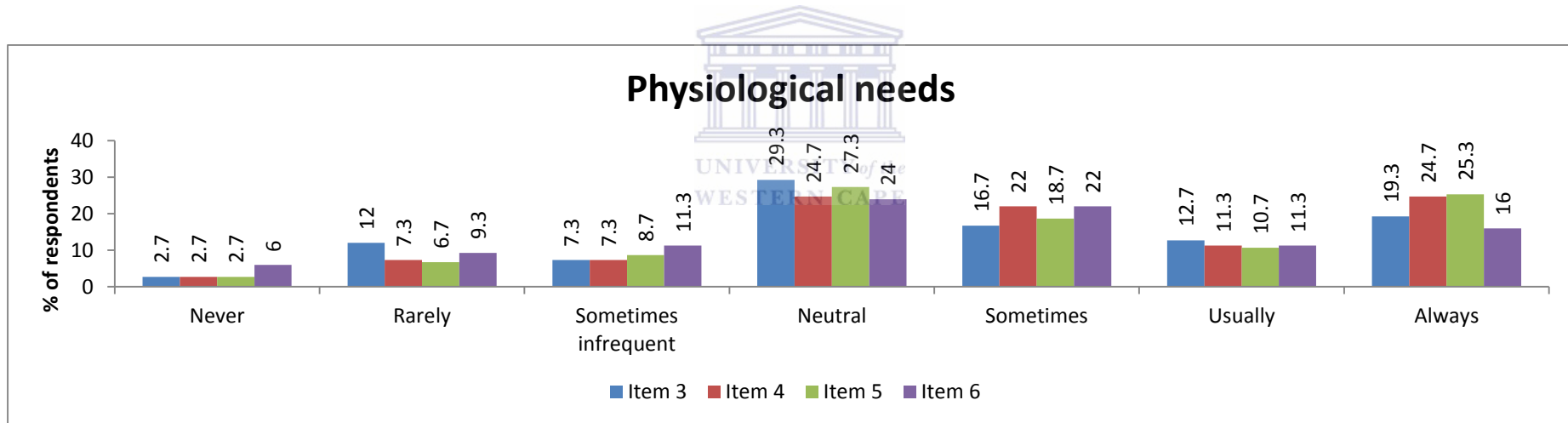


Figure 4.11: Responses on physiological needs

4.3.5 Factor 5: Needs necessary for voluntary survival

Factor 5 (Items 11 and 13) obtained a Cronbach Alpha of 0.895 with mean values of 4.24 to 4.36 (Table 4.7). Respondents mostly indicated *neutral* responses on their needs being met (Figure 4.12).

More than one third (n=71; 47.3%) of the respondents indicated that they *sometimes to always* received adequate meals on time. Item 11, had a mean value of 4.36 (SD = 1.974). More than one quarter (n=43; 28.7%) of respondents *never to infrequently* received adequate meals on time and nearly one quarter (n=36; 24.0%) of respondents were *neutral*. On the question (Item 26); “What could be done to assist you in meeting your safety, physiological matters and material needs?”, respondents stated: “*The food was not good enough*”, “*.....the food was not warm...*”, “*...the food was poor...*”, “*The food was bad*” and “*The cleaning staff should not be handing out food. It does not help me*” (Table 4.9).

Nearly a half (n=66; 44.0%) of the respondents indicated that they could *sometimes to always* sleep adequate hours during their stay in the surgical emergency department, whilst 45 (30.0%) respondents could *never to infrequently* sleep adequate hours. More than one quarter (n=39; 26.0%) of the responses were *neutral*. The mean value of Item 13 was 4.25 (SD = 1.985). Sleep is important for physiological restoration and maintaining cognitive and emotional wellbeing (Buxton, *et al.*, 2012:70). Deprivation of sleep impinges on healing, ability to resist infection and causes neurological problems (Friese, 2008:697).

Table 4.7: Factor 5: Needs necessary for voluntary survival

Item	Factor 5	Never		Rarely		Infrequently		Neutral		Sometimes		Usually		Always		Total		Mean	SD
		n	%	n	%	N	%	n	%	N	%	N	%	n	%	n	%	\bar{x}	
11	Meals	21	14	9	6	13	8.7	36	24	24	16	17	11.3	30	20	150	100	4.36	1.974
13	Sleep	22	14.7	12	8	11	7.3	39	26	25	16.7	11	7.3	30	20	150	100	4.24	1.985

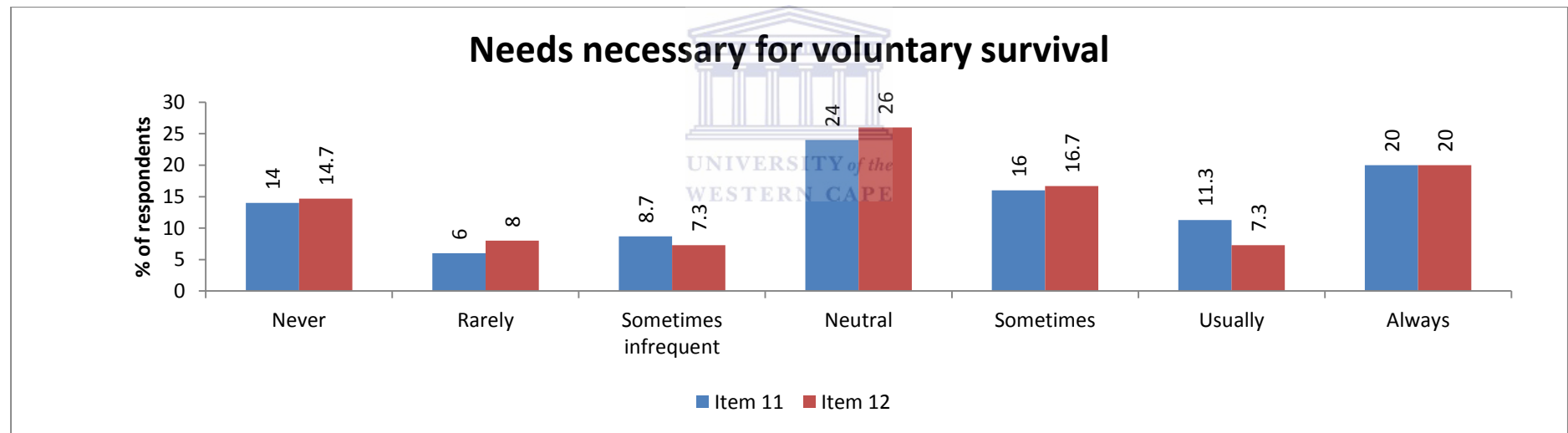


Figure 4.12: Responses on needs that are necessary for voluntary survival

4.3.6 Factor 6: Needs necessary for involuntary bodily survival

Factor 6 obtained the lowest Cronbach Alpha value (0.933) for Items 15 and 16 (Table 4.9). The mean values for both these items were 3.73 (SD = 1.834). Respondents had a high neutral response on their needs being met (Figure 4.13).

Less than one third (n=44; 29.3%) of respondents indicated they *sometimes to always* was given oxygen (Item 15). More respondents (n=63; 42.2%) indicated they *never to infrequently* received oxygen. Neutral responses were received from 43 (28.7%) respondents.

About one third (n= 51; 34.0%) of respondents were *sometimes to always* assisted when they had to pass urine or a bowel (Item 16) and more than one third (n= 63; 42.0%) *never to infrequently* were assisted. Nearly a third of the respondents were neutral (n=43;28.7%).

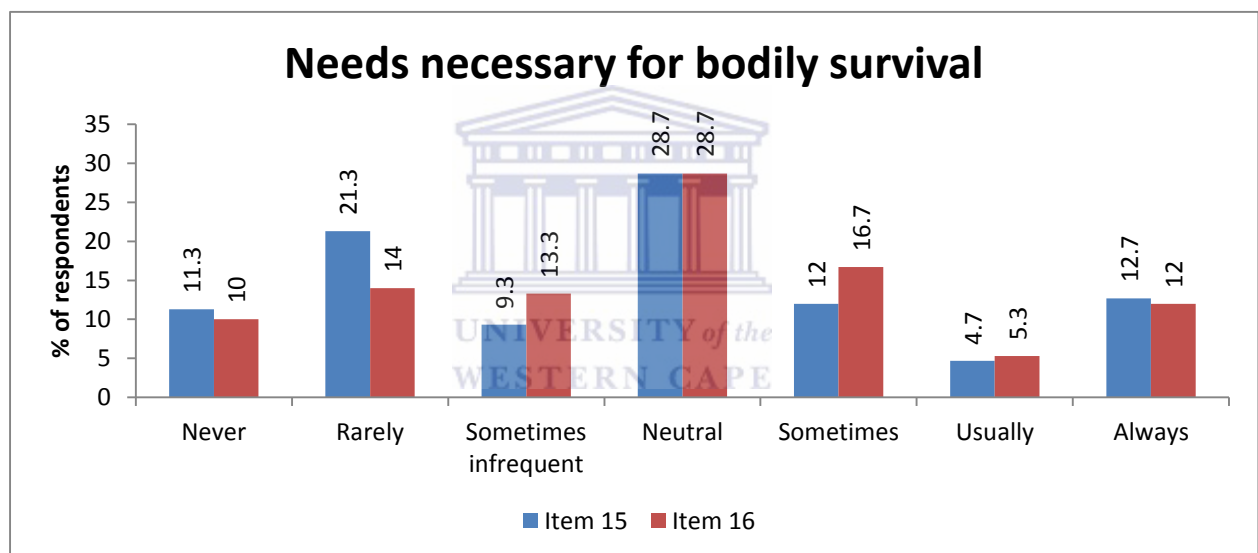


Figure 4.13: Responses on needs that are necessary for involuntary survival

Table 4.8: Factor 6: Needs necessary for bodily survival

Item	Factor 6	Never		Rarely		Infrequently		Neutral		Sometimes		Usually		Always		Total		Mean	SD
		n	%	n	%	n	%	n	%	n	%	n	%	n	%	n	%	\bar{x}	
15	Oxygen	17	11.3	32	21.3	14	9.3	43	28.7	18	12.0	7	4.7	19	12.7	150	100	3.73	1.834
16	Defecation	15	10.0	21	14.0	20	13.3	43	28.7	25	16.7	8	5.3	18	12.0	150	100	3.73	1.834



4.4 OPEN ENDED QUESTIONS

Sections B, C and D (existence, relatedness and growth needs), each included one open question to be answered by respondents. Responses were calculated regardless of whether they were identified previously by other respondents. Responses were then classified under the appropriate theme (existence, relatedness or growth) being either positive or negative (Clarke, 2008:227).

The negative responses referred to complains or matters that the respondents felt were neither conducive nor assisting in their recovery while being admitted in the surgical emergency department. The positive responses indicated protocols or procedures that were already in place and also applauded the meeting of basic needs by nurses in the surgical emergency department.

4.4.1 Existence needs

Table 4.9 provides an overview of the dimensions/ responses addressed under existence needs in the open question (Item 26). Some of the responses were also integrated in the discussion.

Table 4.9 Classification of existence needs from responses on open ended questions

Existence need	Description	Total responses of respondents
Comfortability	<i>"I was uncomfortable in the bed".</i>	19
	<i>"...the linen was very poor".</i>	1
	<i>"I wish I was in a comfortable single room".</i>	1
	<i>"...it was a very uncomfortable bed that I had".</i>	1
	<i>"...the nurses could have done more to make me more comfortable".</i>	1
	<i>"I was uncomfortable all of the time...."</i>	1
	<i>"...I was not comfortable during my stay in hospital".</i>	1
	<i>"...I felt uncomfortable in the ward".</i>	1
	<i>"...the bed I slept on was so uncomfortable".</i>	1

Improvement on existence needs should take place.	<i>"These needs should be improved upon by the nurses".</i>	14
	<i>"...a psychologist should have assisted me during my stay in hospital".</i>	1
	<i>"The nurses could have done more to meet my existence needs".</i>	1
	<i>" I should have been seen by a psychologist".</i>	1
	<i>"...these existence needs were poorly met. More could have been done".</i>	1
	<i>"It is important that these needs get met. Enough was not done".</i>	1
Respect	<i>"...these needs were not met at all".</i>	1
	<i>"I wish to have received more respect from nurses".</i>	10
	<i>"...I was not respected by nurses".</i>	1
Safety	<i>"There was no respect received from staff".</i>	1
	<i>"...I did not feel safe in the ward".</i>	9
	<i>"I felt so unsafe in the room".</i>	1
	<i>"..I also felt that my belongings were not safe".</i>	1
	<i>"Emergency buttons were not in sight- I did not feel safe at all".</i>	1
	<i>"...there were no security officers close by and it did not make me feel safe".</i>	1
Food	<i>"The food was not good enough".</i>	6
	<i>".....the food was not warm..."</i>	1
	<i>"...the food was poor..."</i>	1
	<i>"The food was bad".</i>	1
	<i>"The cleaning staff should not be handing out food. It does not help me".</i>	1
Bathrooms/ toilets	<i>"I was not happy with the bathrooms".</i>	6
	<i>"The toilets were dirty".</i>	1
	<i>"...the toilets were broken".</i>	1
	<i>"...poor toilets and bathrooms in the ward".</i>	1
	<i>"...I was not happy with the bathroom and toilet conditions".</i>	1
Privacy	<i>"...I had to wash in front of other patients".</i>	5
	<i>"...I had no privacy".</i>	1
Care	<i>"The nurses could have handled me with more care".</i>	4
	<i>"...the nurses did not handle me with care".</i>	1
Staff	<i>"...more staff should be appointed to see to patient's needs".</i>	3
	<i>"...more staff should be working in the ward so that there are no problems".</i>	1
Equipment	<i>"...there are so many broken equipment".</i>	2
	<i>"The stuff they used on me to take my blood pressure was poor and old".</i>	1

Other	<i>"My family was sent away rudely by the nurses".</i>	4
	<i>"...visiting hours should be longer".</i>	1

4.4.2 Relatedness needs

Table 4.1 provides an overview of the dimensions addressed under relatedness needs in the open question (Item 42). Some of the responses were integrated in the discussion.

It is evident from the responses that most negative matters that had aroused most in the relatedness section came from complaints about nurses.

Table 4.10 Classification of relatedness needs from responses on open ended questions

Relatedness need	Description	Total of respondents
Complaints about nurses	<i>"...nurses should act ore professionally".</i>	28
	<i>"I received no feedback from nurses on investigations done on me".</i>	1
	<i>"...not happy with the way nurses addressed me".</i>	1
	<i>"...nurses lack compassion and do not communicate".</i>	1
	<i>"...I received no empathy from nurses".</i>	1
	<i>"...the nurses did not smile with me".</i>	1
	<i>"I felt ignored by nurses".</i>	1
	<i>"The nurses were not friendly".</i>	1
	<i>"I felt unimportant while admitted in the hospital".</i>	1
	<i>"There was no spiritual support from the nurses".</i>	1
	<i>"...there was no help from nurses".</i>	1
	<i>"The nurses did not communicate with me".</i>	1
	<i>"Nurses should go for training on people skills".</i>	1
	<i>"I was not involved in decisions that were made".</i>	1
<i>"...they never smiled".</i>	1	
<i>"The nurses seemed stressed".</i>	1	
Improvement on relatedness needs should take place	<i>"I am not happy with these needs being met".</i>	20
	<i>"More could have been done to see that these needs were met".</i>	1
	<i>"These needs were not met".</i>	1
Relationships	<i>"Nurses could have helped me form relationships with them and with other people".</i>	8
	<i>"...they did not assist me in forming relationships".</i>	1

Lack of interest from patients	<i>"I am not interested whether these needs have been met".</i>	5
	<i>"I do not care".</i>	1
		1
Other	<i>"There were no chairs for my visitors to sit".</i>	1

4.4.3 Growth needs

Table 4.11 provides an overview of the dimensions addressed under growth needs in the open question (Item 55). Some of the responses were integrated in the discussion.

Table 4.11 Classification of growth needs from responses on open ended questions

Growth need	Description	Total of respondents
Overall growth needs	<i>"...no growth took place".</i>	14
	<i>"...more should have been done to help me grow".</i>	1
Support	<i>"I received no support from the nurses".</i>	6
	<i>"I wish I have received more support from the nurses".</i>	1
Procedures	<i>"...procedures were not explained to me".</i>	4
	<i>"...I wish I knew what I was going for".</i>	1
Health education	<i>"I did not receive information when I left the ward".</i>	3
	<i>"I wanted nurses to tell me what to do".</i>	1
	<i>"...they did not even tell me what is wrong with me when I left".</i>	1
	<i>"I did not get any health tips".</i>	1

4.5 CONCLUSION

The focus of Chapter 4 was to analyse and display the analysed data with graphs and figures. The findings have shown that some of the existence, relatedness and growth needs of patients were poorly met. Chapter 5 concludes the study with recommendations and the limitations of the study.

CHAPTER 5

CONCLUSIONS AND RECOMMENDATIONS

5.1 INTRODUCTION

The focus of Chapter 5 is to provide conclusions derived from the major research findings drawn from the study. Recommendations for the implementation guidelines are included in this chapter as the second objective of this study was: “to describe recommendations for operational nurse managers to fulfill the patients’ basic needs during the delivery of nursing care in a surgical emergency department.”

5.2 CONCLUSIONS

The purpose of this study was to explore and describe the perceptions of patients about the fulfilment of their basic needs during nursing care in a surgical emergency department at an academic hospital in the Western Cape. The study was commenced as it could aid in being significant to the Provincial Government of the Western Cape, Department of Health since it could reveal the necessity of nurses, in surgical emergency departments, to improve the delivery of their services. It might also indicate how infrastructure in settings of surgical emergency departments should be developed for contributing to higher levels of fulfilment of patients’ basic needs.

Results of this study could provide surgical emergency departments with information about the extent to which basic needs of patients were being met and provided recommendations for addressing the needs of patients.

Generally, the responses of respondents varied on their needs related to existence, relatedness and growth needs and some needs were not fulfilled.

5.2.1 Safety needs

The majority of respondents felt that their need for safety was fulfilled whilst admitted in the surgical emergency department. Only a few patients were concerned about the safety of their belongings. Patients also mentioned that they were not close to emergency buttons during their stay in the surgical emergency department and they commented that there was no visible protection like security guards allocated to the area. Entrance to the surgical emergency

wards was not restricted. Patient safety is thought to be the foundation of good quality care and is also a meeting point for numerous other concerns (You *et al.*, 2013:155).

Ebben, Vloet, Verhofstad, Meier, Mintjes-de Groot and Van Achterberg (2013:8) stressed that policies and protocols have to be standardized for patient safety to occur as the occurrence of patient harm can be prevented (2013:9). A gap between protocols and clinical practice often exists and this results in patients not receiving appropriate care which ultimately influences patient safety. There is a lack of adherence to following protocols in emergency settings (Ebben *et al.*, 2013:8).

5.2.2 Physiological needs

From this study it is clear that more attention should be paid to carrying over telephonic messages between the patient and the family. It is important to many patients that they receive messages from family and friends whether it is telephonically or in person. It greatly contributes to their recovery and it should be taken into consideration that, for the family members of the individual admitted in hospital, it may not be easy to get out of their everyday routine to visit the patient in hospital.

Respondents have also indicated that the wards are noisy. Many patients felt anxious during their stay especially before procedures had to be conducted. Levels of anxiety should remain minimal to patients admitted in hospitals. It seemed that patients were hesitant to ask for assistance in defecation. Respondents indicated that they did not receive adequate assistance in getting these needs met. Comfort levels were furthermore compromised as patients indicated that they were uncomfortable in bed and many felt that they were not handled with care as they were not carefully touched.

An association exists between physical fitness and the clinical outcome post-operatively. The association is that physically fit patients have a lower incidence of perioperative morbidity and mortality. Hence this, preoperative interventions to avoid post-operative complications are ideal (Jack *et al.* 2011:461). Recovery of patients from surgery depends on physical and psychological factors which include the resumption of bowel function, adequate pain management and physical activity (Aasa *et al.*, 2013:1605) hence the importance of post-operative information that could aid in recovery. While the patient is in hospital, assistance is primarily provided by the nursing staff who should create optimal conditions for recovery while encouraging the patient to participate in their own care. Informing the patient regarding

his/her surgery recovery methods post-operatively, is important to prevent complications and the possible return of the patient to the surgical emergency ward.

Patients sleep drastically less when admitted to hospital than their self-reported baseline sleep (Yoder *et al.*, 2012:68). Factors that influence sleep compliance could be light/darkness and noise levels, and sleep-wake disturbances have been correlated with a longer length of hospitalization in hospitalized patients (Bano *et al.*, 2014:1). According to Kamdar, Needham and Collop (2012:97) the main causes for interruptions in sleep are therapeutic and diagnostic procedures, noise and light.

Environmental design in hospital facilitates comfort. Patients have to understand their environments as it influences the comfort they experience (Mackrill, Cain, Jennings & England, 2013:392).

A number of respondents indicated that they were not always assisted when needing to pass a bowel or urinate. This could mean that they might not have been physically able to go to the toilet or they were not assisted in the sense that they were not always given a bedpan on request. Bedridden patients tend to avoid fluid intake (Gattinger, Werner & Saxer, 2013:2216) as they feel dependent from others asking for a bedpan.

5.2.3 Material needs

From the findings of this study, material needs were fairly met. It is important that patient diets and cultural variations be taken into consideration. Adequate fluids should be given to the patient and it is important to document these. Oxygen should be administered as basic nursing care and also adhered to doctors requests.

It is important to take into consideration that hospitalized patients and especially those undergoing surgery may suffer from decreased strength (Bell *et al.*, 2013:238). They may find it difficult to open containers, jugs with lids or even using utensils to consume food.

5.2.4 Relationships with family and friends

The findings from this study indicate that more could be done to facilitate the relationship between the patient and his/her family in order to optimise the healing or recovery process of the patient.

Rosland, Heisler and Piette (2010:221) stated that social support has an influence on clinical outcomes. Many of the patients admitted in the surgical emergency department end up with chronic illnesses. Family behaviour and interconnectedness with the ill patient have an impact on chronic illness management (Lutz, Chumbler, Lyles, Hoffman & Kobb, 2009:402). Rosland *et al.* (2010:234) emphasized that the relationship that exists between family and friends and the ill patient predicts better psychological control and patient survival. Patient engagement with family and friends is considered a unique need and is a central aspect in healthcare as it improves the quality of care (Berger, Flickinger, Pfoh, Martinez & Dy, 2014:548).

5.2.5 Relationships with nursing personnel

From the findings of this study, it is clear that patients need a good relationship with the nursing personnel. Communication is necessary for shared decision-making and to encourage patients to take responsibility for their own health as proven in studies done (Zoffmann, Harder & Kirkevold, 2008:671). Nurses should keep in mind that the perspective of the patient is to be the foundation of the dialogue. In addition, social, psychological and emotional factors should be recognized as being important as somatic symptoms (Smith & Liles, 2007:663). A nurse, who calms the patient and clarifies information or instructions to a patient, secured a patient and security indicated by patients is increased by nurses' presence (Lileroos *et al.*, 2011:19).

5.2.6 Patient participation

Patients perceived that they have not been included in decision-making on their health as much as they have wished to. And those who were included in the decision-making with regard to their health condition, felt well-informed thereof. It is important to keep the patient informed in order for them to take responsibility and participate in their recovery. Patients rely on caregivers in order for them to participate in their own care (Aasa *et al.*, 2013:1604) hence why it is important that nurses need to make patients aware of their responsibilities for participation in their own recovery and care.

5.2.7 Health education

It is clear that the patients who have received some form of information on their illness and health education either during their stay or at discharge, felt more informed.

Information to patients can be given daily from different personnel members as patients do feel that information from several different healthcare professionals increases their confidence in staff (Aasa *et al.*, 2013:1607). Information given to patients encourages trusting relationships to develop. Written information refreshes memories of patients.

5.2.8 Patient internal esteem

Speaking to a nurse regarding surgery improves the patient's outlook on his/her condition (Aasa *et al.*, 2013:1607). It is a certainty that higher self-esteem levels have a noteworthy positive association with internal health focus of control (Theofilou, 2012:138). It also seems that personal control regarding the patients' health status makes the patient evaluate his/her quality of life more favorable and they may feel more confident. Patients who hold more internal beliefs than beliefs held by others, experience more confidence and self-worth. Perceptions appear to be an important predictor of self-confidence (Theofilou, 2012:139).

5.3 RECOMMENDATIONS FOR OPERATIONAL NURSE MANAGERS TO FULFIL THE PATIENTS' BASIC NEEDS DURING THE DELIVERY OF NURSING CARE IN A SURGICAL EMERGENCY DEPARTMENT

A recommendation is described as a suggestion on what should be done or that expresses commendation (Merriam-Webster Dictionary, 2016). In this study recommendations were developed for operational nurse managers to fulfill the patients' basic needs during the delivery of nursing care in a surgical emergency department. The recommendations of the study are presented in Table 5.1.

Table 5.1: Recommendations of the study

NEED	NEED TYPE	RECOMMENDATION
EXISTENCE	1) Safety	<u>Recommendation 1</u> :Establish a patient safety culture.
	2) Physiological	<u>Recommendation 2</u> :Promote physical fitness both preoperatively and post-operatively. <u>Recommendation 3</u> :Optimize sleeping compliance of patient. <u>Recommendation 4</u> :Familiarize the patient with current environment. <u>Recommendation 5</u> :Provide assistance in defecation (if needed).
	3) Material	<u>Recommendation 6</u> :Establish patient biological variation with regard to patient diet whilst adhering to prescribed diet. <u>Recommendation 7</u> :Ensure adequate packaging of food and beverages and assist in feeding where needed. <u>Recommendation 8</u> :Provide adequate fluid. <u>Recommendation 9</u> :Administer oxygen as required and within reach.
RELATEDNESS	4) Relationships with family and friends	<u>Recommendation 10</u> :Encourage communication between patient and family and friends with approval of patient. <u>Recommendation 11</u> :Facilitate and encourage family and friends involvement on decision-making on treatment with permission of the patient. Do not disclose information to individuals without patient consent.
	5) Relationships with nursing personnel	<u>Recommendation 12</u> :Calm patient and clarify information. <u>Recommendation 13</u> :Communicate with patient. <u>Recommendation 14</u> :Provide adequate attention to patient.
GROWTH	6) Patient participation	<u>Recommendation 15</u> :Include patients in decision-making and problem – solving regarding their own care. <u>Recommendation 16</u> :Keep patient informed on health status.
	7) Health education	<u>Recommendation 17</u> :Ensure in-service training/ training schedule for personnel. <u>Recommendation 18</u> :Provide patient with oral and written information on further management on illness <u>Recommendation 19</u> :Telephonic/sms’s. follow- ups
	8) Patient internal esteem	<u>Recommendation 20</u> :Acknowledge patient on achievements regarding illness. <u>Recommendation 21</u> :Encourage spirituality if necessary

Guidelines for operational nurse managers to fulfill the patients' basic needs during the delivery of nursing care in a surgical emergency department with regard to existence needs are addressed in recommendation 1, 2, 3, 4, 5, 6, 7, 8 and 9

5.3.1 Recommendation 1: Establish a patient safety culture

The following actions could be implemented by operational managers regarding Recommendation 1:

Patient safety and patient safety culture are the foundations of excellent health care delivery on which all other care is based (Kear & Ulrich, 2015:113).

- Keep patient belongings and valuables safe at all times. Patients should be encouraged to leave valuable items at home. If they refuse to do so, they should be informed that they shall keep their possessions on own risk and it is advisable that they sign a liability waiver. If possible, the patients should be offered space to lock away their valuables. If however the condition of the patient does not allow him/her to take responsibility for their property, the valuables should be listed and described, with a witness. If the patient insists that the valuables be safeguarded by nursing personnel, the patient should sign after the items have been listed and should receive a receipt thereof and also sign on receipt of the items.
- Emergency buttons should be within reach. The use of the emergency button is fundamental for patient safety. Patients view the “call”/ “emergency button” as their lifeline and potentially lifesaving as they believe that the nurse would know what to do in case of emergency (Lasiter, 2011:2649). On admission of the patient to the hospital room, the patient should be orientated to the use of this button. This will also aid in the patient feeling less anxious due to admission.
- Visible protection/knowing that entry to a ward is limited. Patients may feel comfortable and safe knowing that ward entry is limited. Knowing that security measures are in place will lessen their anxiety levels and levels of concern. Doors to the surgical emergency departments should be locked at all times and if possible security should be at doors asking people to identify themselves and informing these security guards where their destination within the ward is. This shall apply to all individuals not wearing identification tags and who are not employees of the hospital. In addition, this information should be written and kept for possible future reference.
- Routine checkups by nursing staff. Nursing presence is accepted as a core relational skill within the nursing profession (McMahon & Christopher, 2011:71). Nurse

presence does not involve extensive time and the presence of a nurse means that a patient will feel secured, relaxed and comfortable. This in return, will support healing, well-being and sense of value in the patient (Smith, Turkel & Wol, 2013:297).

- Emphasize the importance of policies and protocols. Operational managers should ascertain that they are in possession of these and should often emphasize the importance of correct implementation to policies and protocols towards patient care. Many protocols and policies are already in place and updated and latest researched protocols and policies should be adhered to. Staff should frequently be informed of existing protocols and policies in the deliverance of nursing care where appropriate.

5.3.2 Recommendation 2: Promote physical fitness both preoperatively and post-operatively

The following actions could be implemented by operational managers regarding Recommendation 2:

- Provide pre-operational information to patient. Pre operational information results in better care and recovery after surgery. Information should be given to patients as soon as the operation is scheduled in order for the patient to absorb the information received. Information given should include pre operational exercises and possible lifestyle changes that might aid in the healing process to the specific operation and avoid possible complications. In addition, written information complements verbal information. It also allows the patient to refresh his/her memory when needed.
- Provide post-operational information to the patient. Provide post-operative information to the patient after surgery (again). Written information should be given to the patient.

5.3.3 Recommendation 3: Optimize sleeping compliance of patient

The following actions could be implemented by operational managers regarding Recommendation 3:

- Address therapeutic and diagnostic procedures on the concerns that the patient might have.

- Minimize noise levels. Keep noise levels low during the day and relatively low at night.
- Maximize light exposure during the day and limit light exposure at night. The circadian phase becomes delayed due to light exposure in the morning and evening (Gradisar, Smits & Bjorvatn, 2014:200) hence individuals find it difficult to fall asleep at night.

5.3.4 Recommendation 4: Familiarize the patient with current environment

The following actions could be implemented by operational managers regarding Recommendation 4:

- Familiarise the patient to the soundscape of the ward. The sounds of machinery like IVAC'S, oxygen masks and ventilators, can sometimes be a disturbance to patients. Familiarizing patients to sounds in the ward will cause them to become more accepting of the sounds in the environment, and will contribute towards understanding which is an important aspect of coping (Mackrill *et al.*, 2013:392).
- Familiarise the patient to the landscape of the ward, like the location of bathrooms, nursing station, kitchen and waiting rooms. It will lessen anxiety and make the patient feel safe.

5.3.5 Recommendation 5: Provide assistance in defecation (if needed)

The following actions could be implemented by operational managers regarding Recommendation 5:

- Determine who might require assistance in using bedpans and delegate that 'bedpan rounds' to be implemented. Bedridden patients should be supported as toileting is one of the daily activities. Nurses should, throughout the day offer bedridden patient's bedpans with empathy and supportive measures (Gattinger *et al.*, 2013:2223).

5.3.6 Recommendation 6: Establish patient biological variation with regard to patient diet whilst adhering to prescribed diet

The following actions could be implemented by operational managers regarding Recommendation 6:

- Order patient's diets as prescribed. It is important to order the diet as prescribed as it ultimately aids in the healing of the patient. This should be explained to the patient who might not want to eat certain foods. The importance of 'high-salt', or 'low protein diets should be explained to the patient.

5.3.7 Recommendation 7: Ensure adequate packaging of food and beverages and assist in feeding where needed

The following actions could be implemented by operational managers regarding Recommendation 7:

- Determine the condition of the patient and order the food which comes in packaging accordingly.
- Offer assistance to patients who need help consuming meals.

5.3.8 Recommendation 8: Provide adequate fluid

The following actions could be implemented by operational managers regarding Recommendation 8:

- Ensure water jugs and a glass per patient within reach. Adequate amounts of fluids should be provided to patients to ensure effective practice. It will also enable changes in the clinical condition of patients to be identified in time (McGloin, 2015:18).

5.3.9 Recommendation 9: Administer oxygen as required and within reach

The following actions could be implemented by operational managers regarding Recommendation 9:

- Ensure that adequate oxygen is administered to the patient. Prevent oxygen toxicity. Goal directed care, which includes the administration of oxygen during the perioperative period, decreases consequent mortality and morbidity associated with surgical procedures (Rhodes, Ceconni, Hamilton, Poloniecki, Woods, Boyd, Bennett & Grounds, 2010:1). Also bear in mind that a common anxiety symptom is a feeling of having a lack of air. Patients may thus experience shortness of breathes by which providing them with oxygen might alleviate these anxiety levels.

Guidelines for operational nurse managers to fulfill the patients' basic needs during the delivery of nursing care in a surgical emergency department with regard to relatedness needs are addressed in recommendation 10,11,12,13 and 14

5.3.10 Recommendation 10: Encourage communication between patient and family and friends with approval of patient when appropriate

The following actions could be implemented by operational managers regarding Recommendation 10:

- Allow visits as per hospital policy and encourage communication between the patient and the family. Provide a chair at the patient's bedside, to enhance hospitality. Facilitate the family of the patient. to support the physical and emotional needs of the patient (Zani *et al.*, 2014:143). Support from family members and friends have a positive effect on the patient's mood and lessens family members' psychological distress (Galway, Black, Cantwell, Mills & Donnelly, 2012:1).
- Document visits and communication between patient and family and friends.

5.3.11 Recommendation 11: Facilitate and encourage family and friends involvement on decision-making on treatment with permission of the patient. Do not disclose information to individuals without patient consent

The following actions could be implemented by operational managers regarding Recommendation 11:

- Involve the patient's family in decision-making on treatment as far as permission is obtained from the patient to do so. Family members play an important role as supportive structures in decision-making and they also possess valuable information about the patient that can promote patient safety (Manias, 2013:850). Family and friend involvement maximizes the effectiveness of treatment as well as the treatment of side-effects (Manias, 2013:865). The family may also actively participate in the patient care process (Zani *et al.*, 2014:143).
- Document involvement of friends and family at all times.

5.3.12 Recommendation 12: Calm patient and clarify information

The following actions could be implemented by operational managers regarding Recommendation 12:

- Alleviate anxiety levels. Clarify all uncertainties the patient might have. Patients expect that health professionals are always ready to provide them with information that may alleviate anxiety (Zani *et al.*, 2014:142). Providing the patient with information is a supportive measure (Mattilla *et al.*, 2013:311).

5.3.13 Recommendation 13: Communicate with patient

The following actions could be implemented by operational managers regarding Recommendation 13:

- Have conversations with patients regarding their health by listening, helping, supporting and comforting the patient. Nursing care is an act of interaction which involves dialogue, listening, helping, returning, supporting and comforting the patient. It also clarifies doubt, cultivates sensitivity, discovery, appreciation and understanding of others. Communication not only heals the body but also heals the spirit (Zani *et al.*, 2014:141). By implementing afore mentioned, the nursing staff will be able to reflect and authentically observe the patient's life by improving the quality for those who are physically or emotionally dependent on it enhancing balance and well- being (Zani *et al.*, 2014:142). This emphasizes treating the patient holistically.
- Document all communication and report and/or report accordingly.

5.4.14 Recommendation 14: Provide adequate attention to patient

The following actions could be implemented by operational managers regarding Recommendation 14:

- Ensure routine rounds whereby the nursing staff 'checks up' on patients. During this time the nursing staff can provide basic nursing care like seeing to it that bandages are in place, to empty catheters, that documents are in order, that new prescriptions or commands from the rest of the multidisciplinary team have been implemented. Also, implement further re-assurance to the patient.

- Assess whether the patient has pain and provide prescribed medication. A patient who experiences increases in their pain also increases attention to this pain experienced. Patients who have fear of pain occurrence are also more likely to experience pain (Crombez, Viane, Eccleston, Devulder & Goubert, 2013:375). Paying attention to a patient makes the patient feel good and when patients feel good, they tend to experience less pain (Crombez *et al.*, 2013:375).

Guidelines for operational nurse managers to fulfill the patients' basic needs during the delivery of nursing care in a surgical emergency department with regard to growth needs are addressed in recommendation 15, 16, 17, 18, 19

5.3.15 Recommendation 15: Include patients in decision-making and problem – solving regarding their own care

The following actions could be implemented by operational managers regarding Recommendation 15:

- Provide the patient with the different management strategies to treat his/her illness. The patient should be informed about the different treatment methods to heal the patient's illness. The benefits and complications of all interventions should be explained to the patient. It establishes a trusting relationship and shows the patient that the health professional has respect towards him/her. Following this recommendation will result in patients having more confidence in their decisions; it will increase patient participation and increases the occurrence of patients choosing more conservative treatment (Elwyn, Frosch, Thomson, Joseph-Williams, Lloyd, Kinnersley, Cording, Tomson, Dodd, Rollnick, Edwards & Barry, 2012:1362).
- Prompt the patient to ask questions on his/her illness. Encourage inquisitive behavior from the patient. Encouraging the patient to ask questions will allow the patient to feel in control, it pays attention from the nursing personnel, it shows interest and a sense of caring and allows for critical thinking. Patient question asking is also considered to be a foundational component of patient- centered communication (Venitis, Robinson & Kearney, 2013:953).

5.3.16 Recommendation 16: Keep patient informed on health status

The following actions could be implemented by operational managers regarding

Recommendation 21:

- Keep patients updated on diagnostic tests, procedures, doctors and or consultants' referrals. It will lessen their anxiety levels and make them feel that the nursing staff knows what is going on concerning their care. Patients should be informed without them asking for this information. The nursing staff should however, be certain about the information that they convey to the patient.

5.3.17 Recommendation 17: Ensure in-service training/ training schedule for personnel

The following actions could be implemented by operational managers regarding Recommendation 17:

- Allow further training of nursing staff and have educational sessions with staff regularly. Patients expect health professionals to provide them with accurate information on their condition/diseases (Zani *et al.*, 2014:142).
- Staff should be encouraged to ask co-health care professionals or members from the multi-disciplinary team for information regarding the patient and his/her illness. It enhances teaching skills of health care professionals (Mattilla *et al.*, 2013:311) and will allow for more accurate information to be given to patients. It is important to realize that nursing is a medical field and ongoing research always takes place. Nurses should be encouraged to keep themselves informed on current medical/nursing practices.

5.3.18 Recommendation 18: Provide patient with oral and written information on further management on illness

The following actions could be implemented by operational managers regarding Recommendation 18:

- Provide post-discharge health education to the patient. Providing health education to the patient who is discharged orally has the benefits of; they can sometimes recall what has been said, they can ask for clarity from the health care professional and proper pronunciations of words are heard. Receiving written information has a great advantage as patients can read through the information at any time if they have forgotten what has been said. A combination of oral and written information would be easy to understand. Information received will increase the patient's knowledge and

also give the patient an opportunity to take part in their own post-operative care treatment.

5.3.19 Recommendation 19: Telephonic/sms's. follow- ups

The following actions could be implemented by operational managers regarding Recommendation 19:

- Telephonic reminders and follow-up dates for procedures and pre-surgical procedures should be done at least 24 hours prior to patients being admitted. As the information provided at discharge may be insufficient, a follow-up phone call a week after discharge is also important for patients. Many patients tend to forget the information received (orally and written) on preparation for procedures like taking bowel preparation to clean the intestines before a colonoscopy. This usually results in patients being sent home or new appointments having to be scheduled as procedures like colonoscopies are unsuccessful. This causes a delay in the flow of the hospital and influences and causes bed management issues which results in overcrowding of the wards which ends up causing patients' needs not being met. Many patients cannot be discharged to go home as they come from far and cannot afford to travel back home and return to the hospital on another date.

5.3.20 Recommendation 20: Acknowledge patient on achievements regarding illness management

The following actions could be implemented by operational managers regarding Recommendation 20:

- Praise patient on recovery.
- Compliment patient on achievements.
- Boost patient self-esteem.

Above are linked to attention and positive emotions which broaden the scope of cognition, enabling flexibility and creative thinking. Increases in positive effects causes less attention to be paid to pain and fearful thoughts (Crombez *et al.*, 2013:376). Self-esteem is an important factor that aids in the maintenance of life satisfaction despite the negative impact of health difficulties thus increasing self-esteem of patients may be an important component of increasing a patient's satisfaction with life (Cox, Loughranb, Adamsa & Navarroc, 2012:656)

and is an important predictor of outcomes following medical illness (McDonnell, Riley, Blanchard, Reid, Pipe, Morrin & D'Angelo, 2011:192).

5.3.21 Recommendation 21: Encourage spirituality if necessary

The following actions could be implemented by operational managers regarding Recommendation 21:

- Ascertain whether the patient has spirituality and or whether the patient is religious.
- Introduce/encourage the patient to spirituality and or religion.
- Provide spiritual advice, teaching and prayer.

Spiritual existence of an ill patient influences a patient's quality of life and the ability to cope or accept an illness or disease. Nurses also exhibit a nature which provides spiritual care which is welcomed by patients. It is important that an attitude of willingness by the nursing staff is maintained in order to incorporate spiritual care. It should thus be done willingly by the nursing staff. Patients should also be allowed to practice their religion if possible- like praying and visitation from church leaders, priests etc.

5.4 LIMITATIONS OF THE STUDY

The study was conducted in one academic hospital in the Western Cape thus limiting generalizing the findings to other institutions and is thus only representative of the patients admitted in the surgical emergency department of this tertiary hospital.

5.5 IMPLICATIONS FOR RESEARCH

Further research is recommended on whether why only certain needs are attended to by nurses towards patients admitted in the surgical emergency departments. Another recommendation for further study is to investigate the importance of the fulfillment of certain needs to certain age groups.

5.6 CONCLUSION

Based on the perceptions of patients on the fulfillment of their basic needs in a surgical emergency department in an academic hospital in the Western Cape, the patient's needs varied and shortcomings were identified. These shortcomings were highlighted in the reviewed literature and research findings. The shortcomings were addressed by providing recommendations that may enhance fulfillment of patient basic needs.

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ANNEXURE A: INFORMATION SHEET



UNIVERSITY OF THE WESTERN CAPE

Private Bag X 17, Bellville 7535, South Africa

Tel:+27 21-9592274, Fax:27 21-9592271

E-mail:c.settley@gmail.com

INFORMATION SHEET

Project Title: Perceptions of patients on the fulfilment of their basic needs while receiving surgical emergency care

What is this study about?

I am Chantal Settley, registered for a Master's in Nursing Degree at the University of the Western Cape with Prof K Jooste as my supervisor. You are being invited to participate in this research project because you have been making use of the services delivered in the surgical emergency department and meet the criteria for being selected.

What will I be asked to do if I agree to participate?

You will be asked to answer a few questions about the extent to which your basic needs were being met while nursing care was delivered. It will not take more than 30 minutes for you to complete the questionnaire.

Would my participation in the study be kept confidential?

Your participation and personal information will be kept confidential. The study will be undertaken in a private room.

What is the risk of participating in this research?

There is no known risk in participating in this study. However, a counsellor will be available if needed to provide support for any emotional experiences of discomfort.

What are the benefits of this research?

There is no financial gain or other benefits to you personally, but the results may assist the researcher to develop recommendations that could be used by operational managers to take action in addressing the basic needs of patients during the delivery of nursing care.

Do I have to take part in this research and may I terminate my participation at any time?

Your participation in this research is completely voluntary. You may choose not to take part at all. Even if you do decide to participate in this research, you may withdraw at any time. You will not be penalised when you decide to stop participating in the study. However, we urge you to finish the study once you have started, but it would not be held against you if you decide to terminate your participation.

If I have any questions, how would I get them addressed?

This research is being conducted by Chantal Settlely from the University of the Western Cape. Should you have any questions about this study and your rights as a research respondent or if you wish to report any problems you have perceived in relation to the study, please contact:

Chantal Settlely
207 Leipoldt Avenue
Parkersdam
Worcester
Cell Phone:084 489 2450
Email:c.settlely@gmail.com

Should you have any questions with regard to this study and your rights as a research respondent or if you wish to report any problems you have experienced related to the study, please contact:

Head of Department
Prof Yinka Adejumo 021 9593024
Email :oadejumo@uwc.ac.za

Dean of the Faculty of Community and Health Sciences
Prof Hester Klopper 021 9592631 Email:hklopper@uwc.ac.za
University of the Western Cape
Private Bag X17
Bellville 7535
Head of Department

This research project has been approved by the Senate Research Committee and Ethics Committee of the University of the Western Cape.



ANNEXURE B: WRITTEN INFORMED CONSENT



WRITTEN INFORMED CONSENT

Letter of request to participate in the study

Title of Research Project:Perceptions of patients on the fulfilment of their basic needs while receiving surgical emergency care

The study has been described to me in a language that I understand and I freely and voluntarily agree to participate. My questions about the study have been answered. I understand that my identity will not be disclosed and that I may withdraw from the study at any time without giving a reason and it would not negatively affect me in any way.

Respondent's name

Respondent's signature

Should you have any questions about this study or wish to report any problems you have experienced related to the study, please contact the study coordinator:

Study Coordinator's Name:Prof Karien Jooste

University of the Western Cape

Private Bag X17, Belville 7535

Telephone:(021)959-2274

Cell:0828972228

Fax:(021)959-2271

Email:kjooste@uwc.ac.za

ANNEXURE C: LETTER OF REQUEST TO PARTICIPATING HOSPITAL TO CONDUCT THE RESEARCH



UNIVERSITY OF THE WESTERN CAPE

Private Bag X 17, Bellville 7535, South Africa

Tel: +27 21-9592274, Fax: 27 21-9592679

E-mail: c.settley@gmail.com

July 2012

Chief Executive Officer
Dr. Erasmus
Tygerberg Hospital
Franzie Van Zijl Road
Parow
7570



Dear Dr Erasmus

Consent to Conduct Research Investigation

I am a post-graduate student at the University of the Western Cape, and am studying to fulfil the requirements for a Master's Degree in Nursing. My research topic is: Perceptions of patients on the fulfilment of their basic needs while receiving surgical emergency care .

In order to conduct this study; with your permission; patients making use of the surgical emergency services will be requested to complete questionnaires.

I hereby request your permission to conduct my research investigation at your institution. Attached is a copy of the respondent consent form. Respondents will participate voluntarily

and may withdraw, without fear or favour, from the study at any time. All information will be handled confidentially and will be transcribed personally. The respondents will remain anonymous and codes be used to protect respondents' identities and the name of the institution.

A private room nearby the emergency unit will be needed to complete the questionnaires with the respondents. A counsellor will be available if needed to provide support for any emotional experiences of discomfort. Completing the questionnaire will take no longer than 30 minutes.

Information acquired during this research project will be shared with all respondents prior to public dissemination. Results of the study will be published in an accredited journal.

Yours sincerely,

Chantal Settley
Student No:2519796

Prof Karien Jooste
Supervisor
0219592274



ANNEXURE D: QUESTIONNAIRE



Instructions:
Mark X in the response box to indicate your answer:

SECTION A: BIOGRAPHICAL AND DEMOGRAPHICAL INFORMATION

This section of the questionnaire refers to your background information.

Mark your answer with an X in the appropriate space.

1. Age group

How old are you?

.....



2. Gender

Male	
Female	

3. Highest academic qualification

What is your highest level of education?

.....

THE NEED FOR EXISTENCE

This section refers to the fulfilment of your individual needs for safety, physiological matters and material needs

		NEVER						ALWAYS
14.	I took in adequate fluids during being cared for in the Department.	1	2	3	4	5	6	7
15.	I was given oxygen during procedures when I needed it.	1	2	3	4	5	6	7
16.	When I had an urge to pass urine or a bowel I was assisted.	1	2	3	4	5	6	7
17.	The surgical emergency department was quiet that contribute to my recovery.	1	2	3	4	5	6	7
18.	My pain was under control during service delivery.	1	2	3	4	5	6	7
19.	I could lie in a comfortable position in my bed.	1	2	3	4	5	6	7
20.	Staff carefully touched or turned me during conducting procedures	1	2	3	4	5	6	7
21.	I felt at ease that my valuables and property were safe in the department, when I e.g. had to go for procedures.	1	2	3	4	5	6	7
22.	I could be visited by family or friends to bring me necessities	1	2	3	4	5	6	7
23.	Family members were allowed to sit next to my bed during my stay in the department.	1	2	3	4	5	6	7
24.	Staff members carried over messages from e.g. telephone calls, directed at me	1	2	3	4	5	6	7
25.	My privacy was respected my nursing staff, e.g. closing the curtains.	1	2	3	4	5	6	7

26. What could be done to assist you in meeting your safety, physiological matters and material needs?

.....

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SECTION C: THE NEED FOR RELATEDNESS

This section refers to you're the fulfilment of your individual needs for relationships with other people

		NEVER						ALWAYS
27.	I could form a relationship with the nurse(s).	1	2	3	4	5	6	7
28.	I formed meaningful relationships with other people e.g. patients during my stay in hospital.	1	2	3	4	5	6	7
29.	Nurses acknowledged me in matters that concerned me and my care.	1	2	3	4	5	6	7
30.	I could feel a sense of caring from the nursing staff.	1	2	3	4	5	6	7
31.	Nurses were kind to me through word or deed.	1	2	3	4	5	6	7
32.	Nursing staff should empathy towards me when I was e.g. in pain.	1	2	3	4	5	6	7
33.	I had noticed that nurses were kind to other people.	1	2	3	4	5	6	7
34.	I was addressed in a professional manner by nursing personnel.	1	2	3	4	5	6	7
35.	Nurses explained matters to me in an understandable manner.	1	2	3	4	5	6	7
36.	I gave permission to nurses for procedures conducted on me.	1	2	3	4	5	6	7
37.	I received spiritual support from the nurses.	1	2	3	4	5	6	7
38.	Support from the nursing personnel, in general, made me feel comfortable.	1	2	3	4	5	6	7
39.	The nursing staff had assisted me to form meaningful relationships with other people.	1	2	3	4	5	6	7
40.	The nurses treated me as if I was important for them.	1	2	3	4	5	6	7
41.	I was allowed to give input in decisions taken about my nursing care.	1	2	3	4	5	6	7

42. What could have been done to assist you in meeting your need for relationships with other people?

.....
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.....
.....
.....

SECTION D:THE NEED FOR GROWTH

This section refers to an individual's needs for personal growth and self-actualisation

		NEVER							ALWAYS								
43.	The nursing staff helped me to discover / increase my self-esteem, my e.g. respecting my opinions.	1	2	3	4	5	6	7									
44.	Due to nurses' support, I felt more confident about my future health status.	1	2	3	4	5	6	7									
45.	Nursing staff made me feel that they understood my individual basic needs.	1	2	3	4	5	6	7									
46.	Nursing staff seemed well-informed about my health condition, to treat me adequately towards recovery.	1	2	3	4	5	6	7									
47.	Nursing staff shared information about my health condition with me.	1	2	3	4	5	6	7									
48.	The nursing staff provided me with health education throughout my stay in the department.	1	2	3	4	5	6	7									
49.	I have learned about my health condition from my stay in the department.	1	2	3	4	5	6	7									
50.	The health education given in the department, has lead that I can control situations of acute onset of my condition.	1	2	3	4	5	6	7									
51.	I understood my condition better after nursing personnel had informed me about the reasons for it.	1	2	3	4	5	6	7									
52.	The nursing personnel made me realise my own responsibility in looking after my health.	1	2	3	4	5	6	7									
53.	After treatment, I had a more positive outlook on my condition that I was admitted for.	1	2	3	4	5	6	7									
54.	I felt more confident after engaging in conversation	1	2	3	4	5	6	7									

SECTION D:THE NEED FOR GROWTH

This section refers to an individual’s needs for personal growth and self-actualisation

NEVER ALWAYS

	with the nursing personnel concerning my condition.	
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55. What could have been done to assist you in meeting your goal to become a healthy person?

.....
.....
.....

THANK YOU



ANNEXURE E: APPROVAL DOCUMENT



UNIVERSITY of the
WESTERN CAPE

OFFICE OF THE DEAN DEPARTMENT OF RESEARCH DEVELOPMENT

12 December 2012

To Whom It May Concern

I hereby certify that the Senate Research Committee of the University of the Western Cape has approved the methodology and ethics of the following research project by:
Ms C Settley (School of Nursing)

Research Project: The perceptions of patients about fulfilment of their basic needs during nursing care at a surgical emergency department of the Western Cape.

Registration no: 12/8/15

Any amendments, extension or other modifications to the protocol must be submitted to the Ethics Committee for approval.

The Committee must be informed of any serious adverse event and/or termination of the study.

A handwritten signature in black ink, appearing to read 'Josias'.

*Ms Patricia Josias
Research Ethics Committee Officer
University of the Western Cape*

Private Bag X17, Bellville 7535, South Africa
T: +27 21 959 2988/2948 . F: +27 21 959 3170
E: pjosias@uwc.ac.za
www.uwc.ac.za

A place of quality,
a place to grow, from hope
to action through knowledge

ANNEXURE F: PERMISSION LETTER



Tygerberg Hospital

REFERENCE: Research Projects
ENQUIRIES: Dr M A Mukosi

REGISTRATION NO: 12/8/15 (UNIVERSITY OF THE WESTERN CAPE)

The perception of patients about fulfilment of their basic needs during nursing care at a surgical emergency department in the Western Cape.

Dear Ms Settley

PERMISSION TO CONDUCT YOUR RESEARCH AT TYGERBERG HOSPITAL

In accordance with the Provincial Research Policy and Tygerberg Hospital Notice No. 40/2009, permission is hereby granted for you to conduct the above-mentioned research at Tygerberg Hospital.

The research should be conducted in line with the recommendations made to you by the Head of Nursing.

Yours faithfully

A handwritten signature in black ink, appearing to be "K. Settley", written over a circular stamp.

CHIEF EXECUTIVE OFFICER: TYGERBERG HOSPITAL

Date: 18 July 2013



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