EXPERIENCES OF HEALTHCARE WORKERS AS PATIENTS DURING THE COVID-19 PANDEMIC, AT A PRIVATE HEALTH FACILITY IN THE UMGUNGUNDLOVU DISTRICT, KWAZULU-NATAL

Reshnee Beekrum (22175266)

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Supervisor : Dr Shanaz Ghuman

Co-supervisor : Dr Vasanthrie Naidoo

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DECLARATION

This is to certify that the work is entirely my own and not of any other person, unless explicitly acknowledged (including citation of published and unpublished sources). The work has not previously been submitted in any form to the Durban University of Technology or to any other institution for assessment or for any other purpose.

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Signature of student Date

Approved for final submission

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Dr S. Ghuman Date

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Dr V. Naidoo Date

ABSTRACT

Background

By understanding patient experiences of healthcare workers during the COVID-19 pandemic, can help the healthcare delivery system prepare and educate healthcare workers on the needs of patients both physical and psychological. Also how to deal with the stresses and reactions to a global pandemic. The effectiveness of care is dependent on the quality of the care delivered by the care providers. Healthcare workers influence the outcome of the treatment not only through their technical expertise, but also the psychosocial support. A patients' experience during the COVID-19 pandemic has a lasting impact on the patient as well as their family. Being a COVID survivor post hospitalization, patients often experienced a "new lease on life". Healthcare workers since the start of the pandemic tried to "dodge the bullet" by taking all precautions not to get infected by the virus. A change in attitude and approach is evident following COVID infection. Feelings are charged with gratitude; which shapes the patients' beliefs. The researcher aims to illustrate that the patients' experiences of healthcare workers will shape the delivery of healthcare and their practices on return to work. Specific measures can be implemented to support patients and their families during the pandemic. Also the researcher hopes that this study will improve the delivery of care and mould the organisations' culture by being proactive agents of change.

Aim of the study

The aim of the study was to explore the experiences of healthcare workers as patients during the COVID-19 pandemic at a private healthcare facility in the UMgungundlovu district, KwaZulu-Natal.

Methodology

The research study employed a qualitative design, which used and exploratory descriptive approach. This allowed the researcher to explore the patient perceptions and experiences of healthcare workers during the COVID-19

pandemic at a private health institution. The explorative descriptive studies are studies that are conducted with the purpose of detailed exploration and describing the topic of inquiry, and addresses the problem that is in need of a solution.
Qualitative research design is an investigation phenomenon. This rich data is obtained through a flexible research design.

The study population included fourteen (14) participants who were admitted at the healthcare facility and who worked at the private hospital. The study participants ranged from clinical to non-clinical staff.
It is noted that a descriptive research approach is used to develop a multi-dimensional picture of the problem, which involves reporting from multiple perspectives.
Data saturation was achieved after interviewing twelve (12) participants.
The method used drew on the theories of Maslow's hierarchy of needs model.

Findings

This study investigated the experiences of healthcare workers, as patients during the COVID-19 pandemic, at a private health facility in the UMgungundlovu District, in KwaZulu-Natal.
The study drew on the theoretical framework of Maslow's hierarchy of needs. This motivation theory related to the basic human needs of man during the wellness continuum. Following the participant interviews the data analysis revealed three (3) major themes and sub-themes for the healthcare workers who were patients.
The study revealed the basic need for physiological and safety needs; and psychological needs for belonging and social security.
While some participants fully recovered from the virus, others still experience long COVID and post-traumatic stress.

Conclusion

A lack of understanding of patient's experiences, influences patient's safety, patient engagement and patient outcomes. Despite the barriers during the COVID pandemic; it appears that going back to basics of care was vital.

By understanding patient experience, a key step in moving toward patient-centred care is possible. By evaluating patient experience along with other components such as effectiveness and safety of care is essential to providing a complete picture of health care quality and delivery.

Key words: patient experience, COVID-19 pandemic, healthcare workers, patient perception, coronavirus, patient journey.

DEDICATION

I dedicate this dissertation to my parents Kartha and Shamila Singh; and my family Kevin, Chirag and Ariya Beekrum. My parents who instilled in me the thirst for life-long learning; and my family for their encouragement, patience and love.

“Om bhur bhuvah swah.

Tatsavitur varenyam bhargo devasya dhimahi.

Dhiyo yo nah pracodayat.”

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To my husband Kevin, and children Chirag and Ariya, for believing in me and understanding my quest for wanting it all: wife, mum, career-woman, home-maker and student. Thank you for supporting my aspirations.

My parents Kartha and Shamila Singh who taught me to be humble and kind; to always respect the power of books and to be a life-long learner. To my Dad whom we lost to COVID – you sparked and guided this study.

And finally to Bhagwan, for keeping me grounded and for the spiritual guidance.

Om Santih, Santih, Santih.

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GLOSSARY OF TERMS

Coronavirus: Coronavirus disease (COVID-19) is an infectious disease caused by the SARS-CoV-2 virus. The virus can spread from an infected person's mouth or nose in small liquid particles when they cough, sneeze, speak, sing or breathe. These particles range from larger respiratory droplets to smaller aerosols (World Health Organisation: 2020).

Healthcare worker: A healthcare worker is one who delivers care and services to the sick and ailing either directly as doctors and nurses or indirectly as aides, helpers, laboratory technicians, or even medical waste handlers (Joseph, B. and Joseph, M. 2016: 71-72).

Pandemic: A widespread disease prevalent over the whole country or the world. An outbreak of such a disease (Oxford dictionary: 2002).

Patient experience: Patient experience is defined as the sum of all interactions, shaped by an organisation's culture that influences patient perceptions across the continuum of care (The Beryl Institute: Jason, *et al.* 2014: 8)

ACRONYMS

Acronym	Full word/sentence
CDC	Centre for Disease Control and Prevention
COVID-19	Coronavirus 2019
H1N1	Type of influenza virus - called “swine flu”
HCAHPS	Hospital Consumer Assessment of Healthcare Providers and Systems
ICU	Intensive Care Unit
IREC	Institutional Research Ethics Committee
KZN	KwaZulu-Natal
OCD	Obsessive Compulsive Disorder
PPE	Personal Protective Equipment
PTSD	Post-traumatic Stress Disorder
SARS-COV-2	Coronavirus – is a member of a large family of viruses
WHO	World Health Organisation

CHAPTER 1

ORIENTATION TO THE STUDY

1.1 INTRODUCTION AND BACKGROUND TO THE STUDY

Healthcare is identified as the most difficult, chaotic and complex industry to manage (Figueroa, *et a*l., 2021:239). Notably, a hospital organisation, is the most complex human organization ever conceived (Drucker 2002:74). Patient experience has become the most talked about concept in modern day healthcare. The patient is central to healthcare service delivery and patient outcomes can be positively influenced by the quality of care delivered. . A positive patient experience is the interplay between safety, quality of care and experience. Patient experience describes the healthcare workers experience of illness and how the health service delivery treats them. The patients' experience with hospitalisation, is part of the change towards patient-centred care. Patient experience in essence, is the human experience of healthcare services and patient safety in healthcare, aims to limit the risks, harm to patients and errors during the provision of healthcare (Doyle, Lennox and Bell, 2012:3).This study has found that there is a link between patient experience and clinical safety and effectiveness.

1.2 THE COVID-19 PANDEMIC

The COVID-19 pandemic is also known as the coronavirus pandemic. This global pandemic is caused by severe acute respiratory syndrome (SARS-CoV-2). The pandemic declared 11 March 2020 by the World Health Organisation (WHO: 2020); has since seen variants emerge in various countries. The symptoms range from mild to severe illness. Healthcare adapted rapidly in order to meet the increased healthcare risks and demands. Droplet transmission is the main recognized route, although aerosols may represent another important route. Since the outbreak of SARS-CoV-2, the use of face masks has

become universal. The fear of being infected has caused everyone to wear a face mask and to sanitise frequently.

The severe acute respiratory syndrome coronavirus (SARS-CoV-2) attacked healthcare systems globally, bringing with it challenges for patients and healthcare workers, never encountered before (Holmes *et al.,* 2020: 547) .Thus, the experiences of healthcare workers or health professionals, as patients during the pandemic, shows the need to fully investigate their customer service experience and the health service delivery. The COVID-19 pandemic has had an impact on healthcare workers as the patient care experience. This pandemic has affected health care workers as patients, physically and mentally with increased levels of depression, distress, anxiety, insomnia or Obsessive Compulsive Disorder (OCD) symptoms in affected persons (De Kock *et al*., 2021: 104).

This humanitarian disaster has affected the globe for years to come. During these unprecedented times, patients' fear of dying alone, gripped the world. Healthcare workers who once were on the other end of decision-making with regard to medical decisions such as patients' level of care: whether to escalate level of care or do not resuscitate; were fearful of their personal outcomes. Medical decisions that once affected their morality and values now affected them. Studies show the psychological effects on healthcare workers during the COVID-19 pandemic, suggesting that nurses may be at higher risk of adverse mental health outcomes (De Kock *et al*., 2021: 104).

This was a painfully lonely time, and the sick role was compounded by the lack of compassion, care and most importantly, contact. The patients drew on their colleagues to fill the gap of emotional and psychological support. On the other end the healthcare workers were also affected by taking care of their colleagues. In an emotionally charged environment, nurses' and doctors behaviours were affected by the existing relations with their colleagues. They now had to provide vigilant expert care and deal with family updates on a daily basis. Caring for colleagues added to the stress and impacted on their ethical codes of conduct. The patients' own experiences influenced the nurse-patient

relationship. In the intensive care setting, the care revolved around keeping the patient or in some cases, the colleague alive. Faced with grief, death and dying, the personal relationships added pressure to deliver quality medical care and psychosocial care. Long stay critical care patients most often developed intensive care syndrome, which added to the experiences, fears and outcomes of both staff and patients. The stigma of being medically knowledgeable and yet still falling victim to this virus was difficult for health care workers to comprehend, resulting in a profound psychological impact on the patient as a healthcare worker.

Additionally, personal family experiences, such as having other COVID positive family members or even losing family to the virus has had a devastating effect on the person as healthcare worker and patient. The emotional trauma of loss and not being there to support and care for their own family has had far reaching effects. Personal tragedies, feelings of grief, and loss of hope for both the patient and care provider creates a stressful situation this sense of hopelessness affects the patients' motivation and recovery. As a patient the healthcare worker now sees the care from a different perspective and assesses the care from their colleagues critically (Roman, Adebiyi and Chinyakata, 2021: 233).

1.3 HEALTHCARE WORKERS AND HEALTH CARE PROFESSIONALS

Healthcare workers and health care professionals deliver care and services to those who are sick or unwell. They may be nurses, doctors, helpers, laboratory technicians, paramedics, radiologists, phlebotomist, medical waste handlers, and allied health professionals such as dieticians, therapists and medical administrators. Health professionals play a vital role as healthcare workers in what is now a hazardous environment, due to the pandemic (Joseph and Joseph, 2016:71-72). Healthcare workers felt the emotional impact of the coronavirus; as they had to adapt their working environment and conditions. Whilst the risk of exposure and being infected affected the mental health of healthcare workers, evidence showed that these individuals may be at

risk of experiencing poor mental health as a direct result of the COVID-19 pandemic. (De Kock, *et a*l. 2021:104).

1.4 HEALTHCARE WORKERS / HEALTH CARE PROFESSIONALS AND THE SICK ROLE

Healthcare refers to the provision of medical services to prevent, diagnose, and treat health problems. Healthcare workers also succumb to ill health and assume the sick role. This criticism of care is often related to a healthcare worker as a patient. Healthcare workers must still face illness and death and death is part of the life cycle (Fang and Comery, 2021: 6). Healthcare workers at times become desensitised to death and dying, but the reality is that its' effects are intense when it is a personal experience. The move towards patient-centred care includes all interactions across the continuum of care, until death

1.5 HEALTH SERVICE DELIVERY

Health service delivery provides the services to be delivered to the people to contribute to their health. The health system includes service delivery where patients receive supplies and treatment. Health institutions need resources such as finances, workforce, procurement and supplies in order to deliver the health service. Without health personnel or the workforce there will not be delivery of the patient service in hospitals. Processes and systems need to be in place and managed, in order for the delivery of the health service to be efficient and profitable. The effects of the COVID-19 pandemic on healthcare delivery and patient experience was felt almost immediately, as emergency centre visits declined; in-person consultations were postponed or cancelled, or changed to telehealth visits, elective procedures were cancelled or delayed; in order to accommodate social distancing. The scale of the pandemic according to the number of cases and deaths; as well as the number of countries affected has left all with an impression that "no-one is safe".

1.6 CUSTOMER AND PATIENT EXPERIENCE

A patient journey or healthcare customer journey map includes all the touch points a patient goes through during their care at a healthcare facility such as the admission process on arrival, history taking on initial assessment, planned care following investigations and procedures; up to the point of discharge. Family and visitors, and personal needs is also part of the patient journey. The patient journey or the sequence of events that the healthcare workers experience as patients is referred to as the patients' experience. By getting an overview of the patient experience of healthcare worker as patients, allows healthcare providers to reassess their approach to the care and treatment as seen from a patients' point of view. In the healthcare space patients should be included in the decisions about their care. Solutions to problems can be identified and provides an opportunity to discover innovation. The patient is the customer, and should be treated with respect. The amount of interaction and the assessment of care received influences the patients' readiness to be discharged. Patient expectations like waiting time or delays for tests and treatment can result in a dissatisfied patient. Furthermore the lack of psychosocial support and the inclusion of family in the care process, shows a disconnect in the holistic patients' experience. Despite the advances in medical technology, there remains a focus for basic human needs; from physiological to safety to relationships, as per Maslow's hierarchy of needs. Maslow's pyramid or hierarchy of needs is a five-tier model of human needs; ascending from the base as follows physiological needs, safety needs, belongingness and love needs, esteem needs and self-actualization needs. Maslow initially stated in 1943 that individuals will progress to meet higher level growth needs after satisfying lower level needs; however it is not an "all-or-none" phenomenon; clarifying that a need, need not be satisfied 100 percent before the next need emerges (Maslow, 1987:69). Not everyone will progress in a uni-directional manner, as they may move back and forth between the different needs. The most basic need is the need for physical survival, and this will be the first thing that motivates behaviour.

1.7 RESEARCH PROBLEM

Healthcare organizations normally monitor patient experiences in order to evaluate and improve the quality of care. The pandemic saw patient experiences being altered drastically across the globe. This forced Healthcare systems worldwide to adapt to new ways of delivering this care. The focus being on patient safety and quality of care. (Sterling, *et al*., 2021:57-59). This forced innovation in healthcare, brought about a new patient experience as well as the interaction between the patient and caregiver. The unforeseen catastrophic effect of the pandemic put patient management and patient outcomes under scrutiny, whilst patient perceptions and expectations were severely challenged. (Wynne *et a*l., 2021:2).

Whilst, the physical, physiological and psychological effects of the virus on patients will be felt for years to come, the manifestation of post-traumatic stress disorders is rife amongst patients and healthcare workers. Research findings has yielded a vast amount of data on healthcare workers caring for patients affected by the COVID-19 disease. However experiences of these healthcare workers as patients themselves remains an under researched area. This has prompted the exploration of the patient experiences as viewed and experienced by healthcare workers themselves. Exploring patient experiences from the “eyes” of healthcare workers themselves not only examined the quality of care that was rendered ,but provided information about the actual experiences and also revealed which quality aspects patients regard as most important as part of hospitalization, care and patient management.

1.8. AIM

The aim of the study was to explore the experiences of healthcare workers as patients during the COVID-19 pandemic at a private healthcare facility in the UMgungundlovu district, KwaZulu-Natal.

1.9 OBJECTIVES

The following objectives guided the study

1. Explore healthcare workers' experiences whilst being a patient in hospital during the COVID-19 pandemic.
2. Describe factors in the professional practice environment such as the healthcare facility that promotes a negative patient care experience and leading to poor patient outcomes.
3. Determine factors in the professional practice environment such as the healthcare facility that supports a positive patient care experience and an overall improvement in patient outcomes.

1.10 RESEARCH QUESTIONS

The following research questions, aligned to the above-mentioned objectives guided the study:

1. How did the COVID-19 pandemic effect healthcare workers or health care professionals as patients?
2. What were the long term effects of the pandemic on healthcare workers health care professionals?
3. What influenced the outcomes of healthcare workers health care professionals as patients?
4. How can service delivery be improved on related to customer satisfaction from the perspective of health care workers or health care professionals?

1.11 SIGNIFICANCE OF THE STUDY

By understanding patient experiences of healthcare workers during the COVID-19 pandemic, can help the healthcare delivery system prepare and educate healthcare workers on the needs of patients both physical and psychological. Also how to deal with the stresses and reactions to a global pandemic. The effectiveness of care is dependent on the quality of the care delivered by the care providers. Healthcare workers influence the outcome of the treatment not only through their technical expertise, but also the psychosocial support. (Hay and Oken 1972:109). A patients' experience during the COVID-19 pandemic has a lasting impact on the patient as well as their family. Being a COVID survivor post hospitalization, patients often experience a "new lease on life". Healthcare workers since the start of the pandemic tried to "dodge the bullet" by taking all precautions not to get infected by the virus. A change in attitude and approach is evident following COVID infection. Feelings are charged with gratitude; which shapes the patients' beliefs. The researcher aimed to illustrate that the patients' experiences of healthcare workers will shape the delivery of healthcare and their practices on return to work. Specific measures can be implemented to support patients and their families during the pandemic. Also the researcher hoped that this study will improve the delivery of care and mould the organisations' culture by being proactive agents of change.

1.12 OPERATIONAL DEFINITIONS

PATIENT EXPERIENCE

Patient experience includes the range of interactions that patient have within a healthcare system. It encompasses care received from doctors, nurses, contracted staff in hospital, allied health professionals and supporting health facilities like pathology and radiology (Wolf, et al., 2021: 7)

HEALTHCARE WORKER / HEALTH CARE PROFESSIONAL

Health workers or health care professionals is defined as all people trained and involved in the provision of health services to a user namely like doctors, nurses, or any other person within the multidisciplinary team (Joseph and Joseph, 2016:71).

COVID-19 PANDEMIC

An acute respiratory illness in humans caused by the coronavirus, capable of producing severe symptoms and in some cases death, initially in older people and those with underlying conditions / co-morbidities (Morens, Folkers and Fauci, 2009:109).

HEALTHCARE FACILITY / HEALTH CARE SERVICE DELIVERY

The Centre for Disease Control (CDC) in South Africa (SA) defines a healthcare facility as a hospital, long-term care facility, or clinic. Other healthcare facilities include associated sites such as pharmacies and outpatient laboratories. A health facility is where healthcare is provided. A healthcare institution provides care or treatment of diseases, such as physical, mental emotional or physiological conditions (Pina *et al*., 2015:670)

1.13 STRUCTURE OF THE DISSERTATION

Table 1.1 Structure of the dissertation

Chapter	Title	Outline
1	Background and overview of the study	This chapter gave an overview of the study. It addressed the problem statement, key objectives and significance of the study.
2	Literature review	This chapter provided literature review from an international and national perspective and from sources that are relevant to the topic of inquiry.
3	Theoretical model / framework	This chapter provided an overview of the theoretical underpinnings behind the theorizing related to the model under study. The components of the model underpinned the objectives and research questions of the study.
4	Research methodology and design	This chapter discussed the research methodology and design and outlined the strategy used to address the main context of the study.
5	Presentation of results / findings	This chapter presented a qualitative analysis and the results of the study findings using themes as the guidelines from the interviews related to the topic of inquiry.
6	Discussions of findings	This chapter provided literature sources that either supported or refuted the findings of the study and related the theoretical framework to the findings of the study.
7	Conclusions, limitations and recommendations	This chapter presented the conclusion, limitations and recommendations of the study.

1.14 SUMMARY OF THE CHAPTER

The researcher aspired to highlight the experiences of healthcare workers as patients, and how their experiences were affected by the care received. An overview of the study was presented in this chapter and the objectives of the study together with its problem statement and rationale were presented. Chapter Two further details information from extensive research findings and articles on the research topic.

CHAPTER 2

LITERATURE REVIEW

"Pandemic is not a word to use lightly or carelessly. It is a word that, if misused, can cause unreasonable fear, or unjustified acceptance that the fight is over, leading to unnecessary suffering and death. First, prepare and be ready. Second, detect, protect and treat. Third, reduce transmission. Fourth, innovate and learn. I remind all countries that we are calling on you to activate and scale up your emergency response mechanisms; Communicate with your people about the risks and how they can protect themselves – this is everybody's business; Find, isolate, test and treat every case and trace every contact; Ready your hospitals; Protect and train your health workers. And let's all look out for each other, because we need each other. Prevention. Preparedness. Public health. Political leadership. And most of all, people. We're in this together, to do the right things with calm and protect the citizens of the world. It's do-able." WHO Director-General, Dr Tedros Adhanom Ghebreyesus. Opening remarks / media briefing: COVID-19. 11 March 2020

2.1 INTRODUCTION

The COVID-19 pandemic is referred to as a once-in-a-century health emergency (Park and Quising 2020: 1). This virus took over the globe and spread anxiety and fear through the population especially healthcare workers as front line workers (Lee 2020: 420). When healthcare workers become patients, they do not handle being in bed as opposed to being at the bedside. Health care workers behaviours are altered and present as dysfunctional coping mechanisms. The anxiety associated with being the patient and knowing all possible outcomes, makes it difficult for colleagues to deliver the expected care. Being in the state of vulnerability, makes the healthcare worker as a patient hypersensitive and critical of colleague's delivery of care. The mind shift of healthcare workers as a patient, makes it difficult to accept the sick role. The patient

healthcare worker often lose their patience. Medical manipulation happens when they feel they may not be getting the care and compassion they deserve. Feelings of despair, anxiety, fear and grief can be overwhelming. (Lee 2020: 421). With the flood of emotions, the healthcare worker may feel like they are not coping. Besides the treatment of the disease, the care practitioner had to treat the relationships and interactions in order to have a positive influence on the patient experience. The corona virus further affected the patient experience, more so of healthcare workers that became patients.

2.2 BACKGROUND

In this study the literature review investigated the experiences of healthcare workers as patients during the COVID-19 pandemic. During the research process the study aimed to review and determine what is known and unknown about the subject. Many recent studies have focused on the virus origin, its spread, treatment and the race for the vaccine. An in depth study of the healthcare workers experience as patients during the COVID-19 pandemic, extracted valuable information on the patient care process. The focus on the patient experience during the pandemic brought to the fore valuable lessons learnt. Research shows that evidence based learning comes from story-telling. By understanding a patients' experience, insights can be used to improve services.

2.3 DEFINITION OF PATIENT EXPERIENCE IN THE PANDEMIC

Ironically a patient is the person receiving medical care; and should be *patient* by being able to accept and tolerate delays or problems without being anxious or annoyed. Experience is the knowledge acquired by a period of practical experience of something and includes feelings and emotions. A patients' experience is based on the individuals' expectations, perceptions and interactions with the healthcare team. Individualized care during a pandemic seems impossible, however this can be

achieved by ensuring that every interaction makes a difference. The goal: that a patient is treated with care, compassion and respect (The Beryl Institute: Jason, *et al.* 2014: 8).

2.4 THE PATIENT JOURNEY

The patient journey starts from the time a patient is admitted until discharge. This journey includes the patient, family member and visitor. As the clients they deserve care, attention and consideration. The patient journey focuses on the needs of patients by ensuring a positive experience throughout the journey. Secondly, by also focussing on every person that interacts with the healthcare community: visitors and family. The journey is the process that patients go through when they undergo treatment; which includes several steps (pre-, during, and post-visit), where each stage consists of one or more touchpoints. By putting the patients' needs at the centre; the result of this team approach is to ensure a positive patient experience. There is a strive to constantly exceed patient expectations and improve on patient experiences and enrich the experience. Patient journey mapping gives insights into the patient experiences during their patient journey at a healthcare facility. Care providers and their insights can help create strategies to improve the quality of care, increase efficiency, and improve overall patient satisfaction. Patient journey mapping is important to improve the patient experience, as patients benefit from the clear communication, reduced anxieties, and knowing what to expect next. By anticipating the patient needs, the care provider can create the wow experience (Thamrin, 2020: 2-3).

2.5 FACTORS THAT INFLUENCE PATIENT PERCEPTION / EXPECTATIONS

Brooks *et a*l. (2020: 912) reported on the earlier pandemics – the effects which included stigma, confusion, anger, fear of catching the infection and post-traumatic

stress symptoms. The psychological manifestations of anxiety and depression may be long-lasting. The focus on patient and healthcare worker safety was a priority. Healthcare delivery's adherence to the strictest infection prevention and control appeared clinical and lacked the compassion that the patient was expecting. Patient perception and expectations became emotional challenges.

The following graphic (Figure 1) shows the broader detail of the patient experience elements:

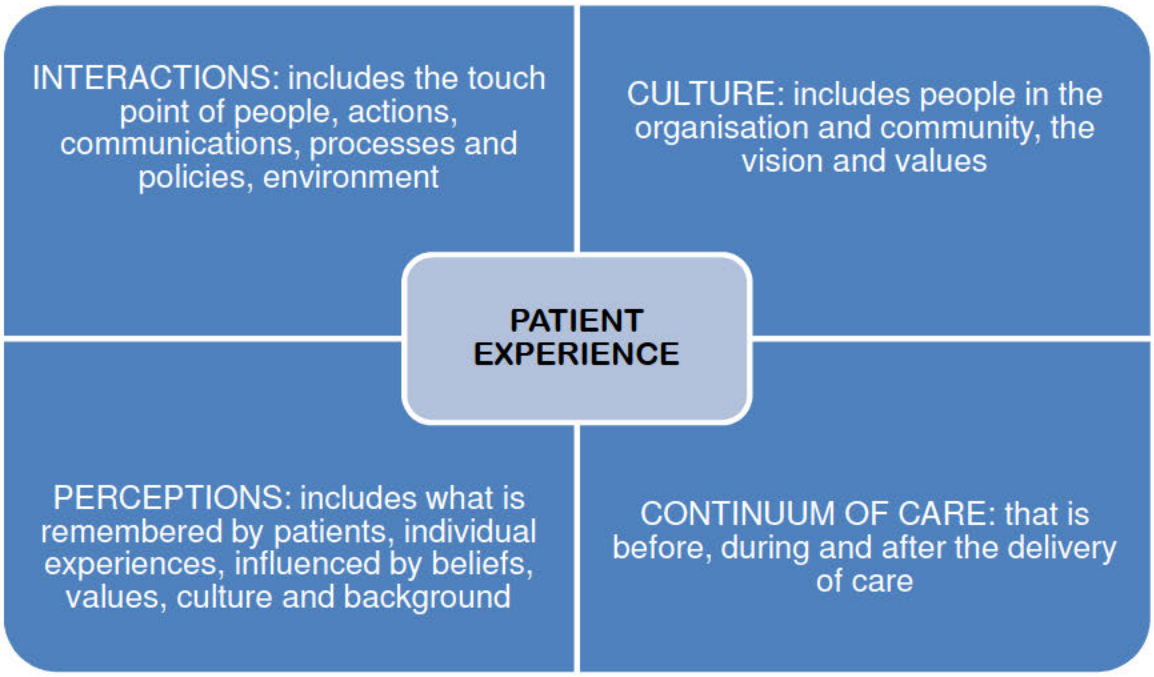

Figure 2.1: Defining Patient Experience, The Beryl Institute (Jason, *et al.* 2014: 8)

The summary of the key elements above, shows that a holistic approach of interactions, culture, perceptions and care is necessary to fully understand the patients' experience. Unfortunately, during the pandemic, various elements were affected – like the lack of touch, change in processes, and adaptation of the

environment, challenged culture, heightened perceptions and care delivery. By putting the patient first and at the centre of every business process – the patients' feedback influences the patient experience and outcomes. By listening to the patients, clinicians can design care specific to the patients' needs. By driving the culture of "patients first" this creates the enabling environment to improve on service delivery during a fearful time like a pandemic.

2.6 WHAT / WHO IS A PATIENT?

A patient is someone who is ill or unwell, or injured and whose health suffers. They need medical and / or nursing care. All patients, even healthcare workers as patients need support, expertise and empathy. All patients have the right to be treated with respect, dignity and compassion. Patients do not want to be in hospital – they are often scared, in pain, lose their control and their dignity; often feeling exposed and lonely. These feelings were further exacerbated during the pandemic.

Healthcare workers reactions to the sick role is uncertain; nobody knows how they will react when they are sick. No two people react in the same way. Religion, culture, past experiences, age, level of pain and discomfort, gender and fear all have an impact on how a patient will act in hospital.

2.7 THE INFLUENCE OF VALUES

Values are principles by which we live our lives. Values are visible in behaviour. Values for a healthcare worker are elements which they find personally important. Core beliefs guide how they conduct their life in a meaningful way. A patient experiences emotions when their values are violated. For example a patient who is a healthcare worker who values honesty, may feel hurt or disappointed or angry when they do not get information on their condition/illness. The healthcare worker as a

patient has needs – and their values are related to their needs. The patient, family and visitor brings their own value system into the healthcare setting.

2.8 THE PATIENTS' EMOTIONS

Emotion and feelings is part of being human. Emotions often influence view points and how you interact with other people. In order to understand patients and their experiences, it is important to understand their emotions, feelings and behaviour. Empathy and compassion is necessary. Emotions are brought on by circumstances. Healthcare workers as patients may experience a broad variety of emotions such as negative emotions like: anxiety/fear, dissatisfaction, embarrassment, frustration, sadness or worry; or positive emotions like: cheerfulness, excitement, gratitude, happiness, optimism.

Maslow's hierarchy referred to needs. Needs are necessities / things that we require as human beings to live and to be healthy, balanced and happy individuals. All patients feel the need to be safe, be loved and respected, and be successful. When a need is not met negative emotions will arise. Instead the healthcare worker will experience fear when their safety need is threatened. By understanding the patients' emotions, the healthcare practitioner can build harmonious and effective relations during the delivery of care. By understanding the emotions of patients during the pandemic, the care practitioner can create the best possible experiences for the patients. Patients and their families experience many emotions during hospitalisation. During the COVID-19 pandemic, emotions of despair, confusion, fear, anger, disappointment, safety, loneliness, anxiety and depression came to the fore. By making emotional connections with patients by showing compassion, the care giver will meet the patients' emotional needs and basic requirements for good healthcare. By optimising the patient experience, health will be promoted. Healthcare workers feared dying during the COVID-19 pandemic. The five stages of grief as referred to by the Kubler-Ross' model (Figure 2) highlights emotions that healthcare workers experienced as

patients: denial, anger, bargaining, depression and acceptance. Going through the Coronavirus grief cycle is likened to the Kubler-Ross grief cycle as seen below.

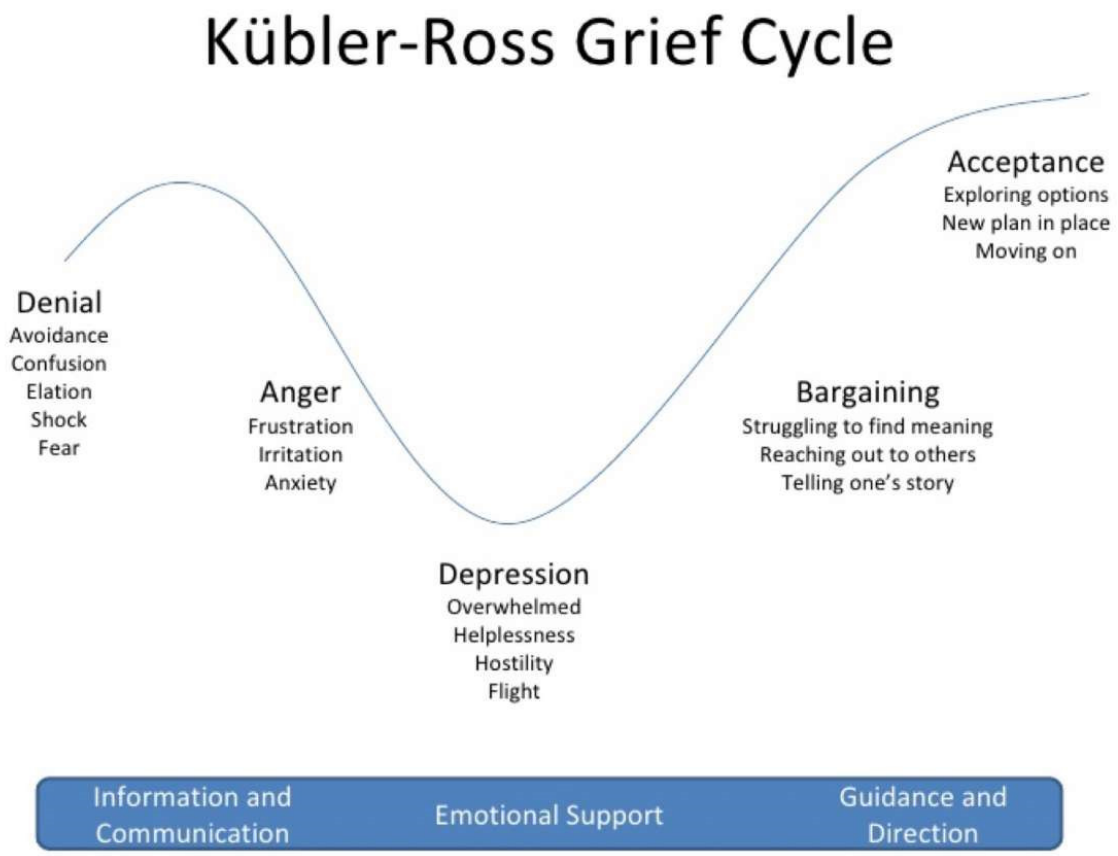

Figure 2.2: The Kubler-Ross Model – 5 stages of the Grief Cycle (Kubler-Ross and Kessler, 2005)

2.9 EMPATHY AND COMPASSION

Empathy is the ability to see and feel what another person is feeling or experiencing. By showing empathy, care givers build trust with the patient. With empathy, the care practitioner can connect with their patient, they can understand what it is the patient is going through, and by acknowledging their emotional state and listening attentively,

they can engage with the patients. Without compassion, empathy is not possible. Compassion is empathy in action. The presence or absence of compassion leaves a lasting impression about the overall experience of care in hospital. The basic and powerful way to connect with another person, is to listen. Effective communication skills are essential for building and maintain good relationships with patients and their families. By listening to healthcare workers who were patients during the pandemic, this will help determine essential needs of patients (Gilbert, P. *et al* 2017:4).

2.10 BUILDING RAPPORT WITH PATIENTS

By understanding patients will help health institutions gain insight into how the care delivery can enrich the patient experience. Rapport is a state of harmonious understanding with the patient that enables easier communication. In other words rapport is connecting with the patient, as well as their family or visitors, by having things in common; this makes the communication process easier and more effective. Connecting with patients is a complex combination of gestures, body language, words and actions. Unfortunately during the pandemic some of these were compromised.

2.11 HEALTHCARE WORKERS ROLE IN PATIENT CARE EXPERIENCE

Healthcare workers attempt to achieve wellness in their patients. Wellness varies as many factors influence the state of wellbeing. WHO's statement says that wellness does not just focus on disease; but includes physical, social and mental aspects. (Petrillo *et al*. 2015:299) Healthcare workers play a critical role in the wellness of their patients, and communities; having an overall impact on society. Research shows that 41% of respondents of a survey felt pressured as their lives were altered by COVID-19. The potential loss of jobs and loss of life affected the healthcare workers wellness, social distancing and quarantining had a negative psychological effect, with reports of loneliness, anxiety and stress (Dimitriou, Drakontaides and Haadjicharalambous, 2020: 20). Healthcare workers had to adapt to rapid change; and the forced innovation

brought about a new patient experience. The patients who know the healthcare protocols and procedures were often questioning the care during the pandemic. The focus on patient experience during the pandemic brought to the fore valuable lessons learnt.

2.12 CORONAVIRUS PRESENTATION

According to the Centre of Disease Control and Prevention, coronavirus can symptoms range from mild to severe. A portion of the population being asymptomatic carriers. Fever, cough and shortness of breath, being the common symptoms. Gastrointestinal symptoms include diarrhoea, nausea, vomiting and abdominal cramps. Cardiovascular, kidney, liver, central nervous system and ocular damage is documented. Complications include myocardial injury, myocarditis and heart failure. Patients with acute respiratory distress syndrome worsen rapidly and die of multiple organ failure, induced by the cytokine storm.

2.13 PSYCHOSOCIAL IMPACT ON HEALTHCARE WORKERS AS PATIENTS DURING THE PANDEMIC

By minimising movement through lockdown and limiting contact through social distancing; psychological stress increased. The COVID-19 pandemic has impacted on healthcare workers and added to stress and severe anxiety. Ten key dimensions make up wellness: environment, psychological, spiritual, social, physical, career, economic/financial, intellectual, climate and culture (Oliver et al, 2019: 42-44). There is a connection between the dimensions like the physical, social and psychological, which may be influenced by other dimensions for healthcare workers such as the environment. These effects and relationships on healthcare workers as patients showed that wellness is a holistic, multidimensional concept. Theses encompass the various aspects of human life which complement one another. As the world watched the daily numbers of the rise of infections and deaths, healthcare workers were dealing

with death and dying; or themselves infected and being admitted as patients. Dokov, Milkova and Stamenkov (2020: 4-7) refer to factors such as wellness and the mental state of being neglected or overlooked. The effects of the COVID-19 pandemic had effects on the well-being of healthcare workers – from the anxiety of getting infected with the virus, fears of losing a loved one, taking the virus home and the psychological distress of death.

Brooks, Webster, Smith, et al. reported on earlier pandemics and their negative effects: including fear, stigma, anger, confusion and post-traumatic stress symptoms. As did the recent 2009 H1N1 influenza virus outbreak, the Ebola outbreak in West Africa and SARS (Severe acute respiratory syndrome). The resultant psychological effects such as suicidality, depression and anxiety have been reported (Kamara, 2017:28). The psychological and psychosocial effects will be felt for years to come, manifesting as post-traumatic stress disorder in both the patient and healthcare workers. Evidence suggest that the overall wellness and the effects on mental health will be long-lasting (Park and Quising 2020: 69-88). By reviewing previous pandemics, we can gain valuable knowledge on wellness strategies. On the positive side, patients respected their colleagues as frontline workers. The on-going COVID-19 pandemic will have an effect on the human race (Brooks et al. 2020: 912-920). Emerging literature regarding the COVID-19 pandemic suggests that the human race was affected and will be affected for some time to come.

2.14 LONG TERM EFFECTS OF THE COVID-19 PANDEMIC / POST-TRAUMATIC STRESS DISORDER (PTSD)

Terms like the “new norm”, lockdown, social distancing, universal masking, working from home, video chats, swabbing and air hugs; found its ways into daily conversations. Adults and children alike were conditioned to sanitise and have a temperature taken with a thermal scanner. Healthcare workers need a stress outlet; and with social distancing and lockdown rules this became difficult. They were found

to be between work shifts and home and back again; often for additional shifts as colleagues succumbed to the virus. This disruption of social interaction and outlet left them battling to handle the loneliness and mental stresses. The cycle of long working hours, bad nutrition, inadequate rest, lack of exercise and stress affected their work outputs. Post-COVID-19 care will emerge as top priority due to the long term psychological effects on patients and healthcare workers. Patients had to adopt life style changes during the recovery period – this timeline is yet to be determined. Healthcare providers would also have to go through a recovery process as they are physically, mentally and emotionally drained. The discrimination and stigma associated with people who were infected is an additional social issue (Simon, Helter and White 2021: 314; Lee 2020: 11-12). The healthcare worker had to fill the gap of emotional and psychological support, patient visits were prohibited; and the resultant lack of support and contact made this a sad and lonely time for the patient. Lastly the reality of pandemic-induced burnout compounds the patient and healthcare workers experience.

2.15 PATIENT OUTCOMES DURING THE PANDEMIC

The pandemic has highlighted the need for skilled workforce, especially nurses and doctors as healthcare workers. In 2020, the International Year of the Nurse on the 200th birthday of Florence Nightingale; during the COVID-19 pandemic; there has never been a better time for nurses to lead. At the frontline of the pandemic, nurses' concerns lacked acknowledgement (Daly et al., 2020:15). Thousands of healthcare workers were infected with the virus; thousands have died. Nurses have an important role to play in achieving necessary change in care delivery. Healthcare decisions made in the ICU ultimately impact the entire healthcare system, the healthcare workforce, patients, carers and families. The focus on patient-centred care, a focus on patients' and relatives needs for supportive or complementary care is imperative. Indirect care is essential in providing holistic care.

2.16 GLOBAL IMPACT OF THE COVID-19 PANDEMIC ON HEALTHCARE AND WORKERS

Evidence on a study conducted in China shows that due to economic distress resulting from the pandemic lockdown restrictions, family violence increased. Imposed curfews, closure of schools and businesses, working from home, inter-provincial and inter-continent travelling slowed down the transmission of the virus in order to prepare healthcare systems to prepare. The resultant availability of healthcare resources was also affected. Healthcare workers are an integral member of the healthcare fraternity, community and society. Literature shows that the quest for virus containment and prevention of spread, as well as treatment and the discovery of vaccines was top priority; however, the patient experience of those infected and healthcare workers who themselves were affected had not been fully explored. Continuous improvements lead the strategy in healthcare for patients with tested and practical clinical ideas, such as telehealth or tele-medicine. The aim of the virtual consultations was to reduce direct physical consultations with COVID positive patients during the pandemic.

At the start of the pandemic, enquiries and calls increased as persons fear of having being infected rose too. Telephonic consultations to emergency care units increased – on the advice that quarantine for suspicious or potential COVID contact, and strict isolation with symptoms with self-care monitoring in order to reduce the pressure on medical practitioners and healthcare facilities. The increased demand for virtual care was complicated. So as not to over burden the testing sites, patients with COVID-19 symptoms were presumed to be infected. The instruction to self-quarantine necessitated frequent updates and reassurance, when to seek medical care; also not to over burden the emergency units. Remote patient monitoring (RPM) provided temporary relief to managing COVID positive patients. However little is known about

RPM; especially patient outcomes, acceptability and lessons around implementation (Tucker, et al., 2020: 1326-1330).

2.17 CONTEXT IN KWAZULU-NATAL

Locally patients with chronic conditions had concerns about their treatment, more-so during the pandemic. The fear of being admitted to hospital and the fear of dying alone, lead to delays in seeking medical care; by not keeping to routine follow up appointments or postponing appointments. Behavioural changes show that there was a need to for hospitals to better understand the need of their patients. Through patient experience surveys hospitals will be able to assess how the patient community manages during the pandemic (Sirotich, Dillingham, Grainger and Haumann, 2020: 871-872). The family is a micro-unit of society and families are responsible for maintaining stability in society. Therefore when families are impacted by crisis, societies are affected. During the pandemic, the effect of the coronavirus had a negative impact on families and thus society. Society was affected at all levels: financial, nutritional, safety, education and healthcare.

2.18 IMPACT OF COVID-19 ON SOUTH AFRICAN HEALTHCARE WORKERS

With the declaration of a state of national disaster on 15th March 2020, following the first recorded case on 5th March 2021; South Africans were suddenly forced to comply with the COVID-19 containment measures. In an attempt to contain the virus and measures to minimize the spread of the virus, the South African population were affected by the lockdown restrictions, which would yield short- and long-term impacts on human functioning.

Healthcare workers as breadwinners had to work in COVID units and this had an impact on their safety and mental wellbeing. The stress of being exposed and being infected with the virus affected their overall health – working long shifts, the mental

strain, poor nutrition due to being in full PPE (personal protective wear), inadequate rest and lack of outdoor exercise – led some to succumb to the virus. The overall cascading impact on essential workers was tremendous (Roman N. V., 2021: 233).

2.19 MORAL AND ETHICAL DILEMMAS FOR HEALTHCARE WORKERS

Tucker, Pleasants, Hullma, Lindemann, et al (2020: 1326-1330) refers to rapid prioritisation and decision-making: converting to a hospital command centre, cancelling elective surgeries, delaying or shifting other routine care and converting in-person care to virtual options. The challenged healthcare systems needed to adapt at an alarming rate during the unprecedented time, to protect both patients and staff in preparation for the surges. Intensivists had to prioritise care and triage patients' level of care based on clinical outcomes. This put a huge burden and strain on the treating specialist physicians especially when it came to the care of colleagues and fellow healthcare professionals.

2.20 CONCEPTUAL FRAMEWORK THAT GUIDED THIS STUDY

According to Marnewick and Labuschagne (2010), a conceptual framework is used in research. By visualising and demonstrating the correlation among themes or concepts, such as COVID-19 and the relationship with the various dimensions of health. The dependent and independent variables identified in this study are as follows: COVID-19 pandemic being the independent variable, and the experiences of the healthcare workers as patients being the dependent variables. These dimensions were empirically explored through a qualitative process. Kim, Sefcik and Bradway (2017:30) says rather than merely interpreting the data; a comprehensive summary of events based on the responses of healthcare participants will be the study's basic model. Healthcare workers who were patients and affected by the COVID-19 pandemic were interviewed on the model survey (Figure 3). The approach was

experiential. The healthcare workers interpretations, experiences and meanings were prioritised over the theoretical framework or the researcher's interpretations of events.

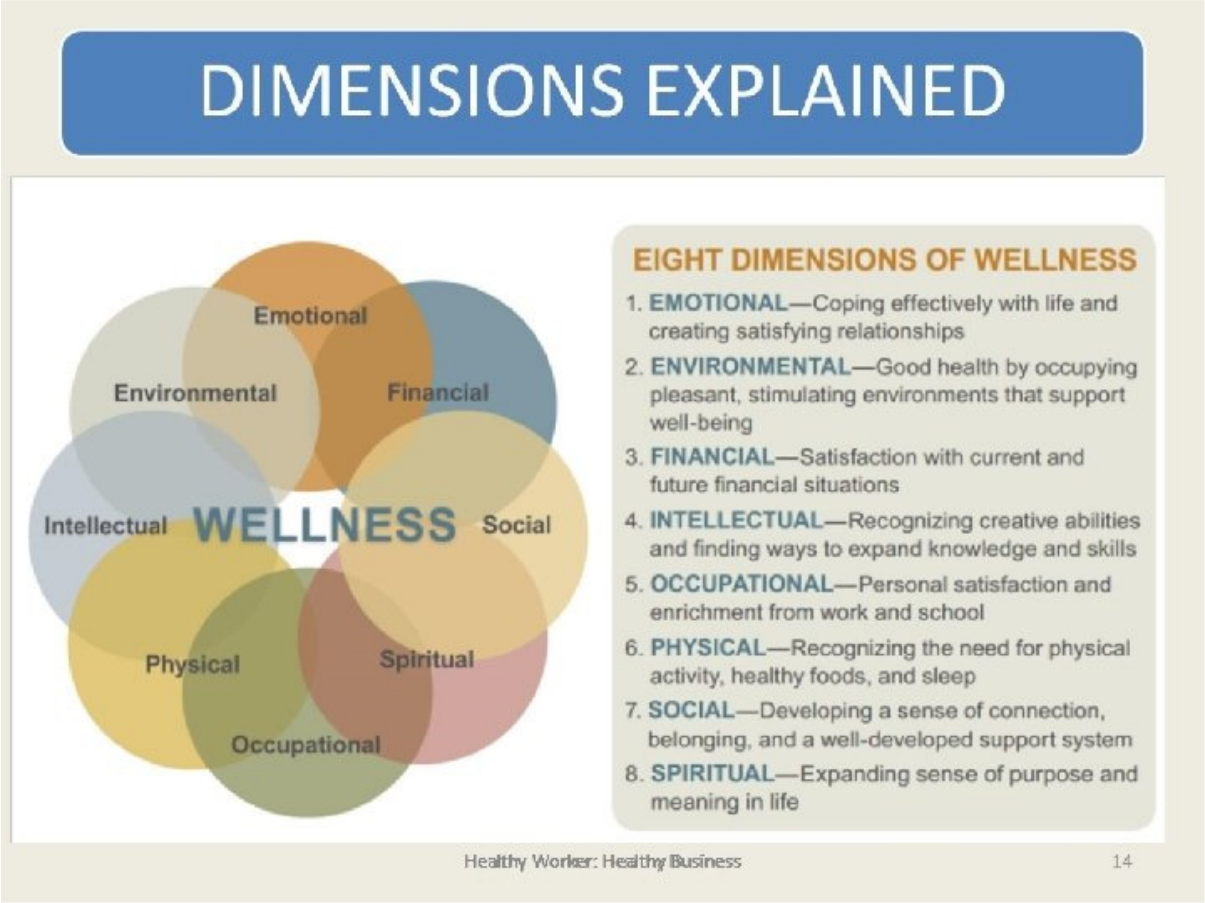

Figure 2.3: The eight dimensions of wellness. (Workplace Wellness Lab, 2016:2)

2.21 EMOTIONAL WELLNESS

Emotional wellness has a significant role in maintaining mental health. By expressing feelings and coping with stress and trauma in life experiences, healthcare workers adjust to emotional challenges. Emotional wellness controls health-seeking behaviours, affects decision-making skills, influences interpersonal communication and aids in recovery from stressful situations and illness. Thimmapuram et al (2017)

says that emotional wellness plays a role in the overall wellness of an individual. COVID-19 has been associated with psychological stress and symptoms of mental illness such as depression (Bao et al. 2020: 37-38). During the pandemic the emotional state of the healthcare workers as patients were affected, and this in turn had an effect on their experiences as patients. Feelings of sadness, loneliness, disappointment, hopelessness, fear, anxiety, panic, stress, anger and depression that surfaced was explored.

2.22 SOCIAL WELLNESS

Social wellness includes relationships with family, friends, colleagues and community. During the COVID-19 pandemic, during the global outbreak, these relationships were affected as lockdowns limited interactions. Social media and digital interaction grew rapidly. Kim, Sin and Tsai (2014: 23-42) refer to social media and social wellbeing parities, which were investigated to show how social media behaviour and its potential impact on psychological wellbeing during the pandemic. The importance of family, friends, colleagues and community highlighted how the pandemic affects social wellness.

2.23 PHYSICAL WELLNESS

Physical wellness includes a healthy body and mind. By maintaining a healthy body through good physical habits, exercise and nutrition. This in turn influences a healthy mind. Access to healthcare is a necessity. Poor physical wellness makes one susceptible to diseases. During the covid-19 pandemic these aspects of wellness were impacted. The individual purpose is to have a good sense of balance of mental and physical health. Corporates, organisations and health care institutions assessed employee wellbeing. Health and wellness programs were an essential factor for healthcare workers (Strout et al. 2018: 21-39). The World Health Organisation

established a holistic definition of health as: “state of complete physical, mental and social well-being and not merely the absence of disease and infirmity”.

2.24 HCAHPS (HOSPITAL CONSUMER ASSESSMENT OF HEALTHCARE PROVIDERS AND SYSTEMS) AND MASLOW’S HIERARCHY

Patient feedback of their experiences has been highlighted to improve on healthcare delivery. HCAHPS surveys include questions through a quantitative section – rating the service and hospital on a scale of 1 to 5, from worst hospital possible to best hospital possible. In some countries, positive survey results have a direct impact on hospitals finances. The HCAHPS survey provides information on the delivery of excellent patient care, which points to the patients’ experience. By applying Maslow’s hierarchy of needs to patient-centred designs, better insight of support to improve care delivery was investigated (Maslow, 1943). Maslow’s theory of human motivation shows that that a strong foundation enables people to lead fulfilling lives. By delving into the patient’s detailed feedback through a qualitative approach – meaningful contributions can be made on patient service delivery; rather than just a rating score. This approach is a means of conceptualising a patient’s experience during hospitalization to highlight ways in which the healthcare facility can support a more responsive delivery of patient care (Miller et al. 2012: 118).

2.25 HCAHPS QUESTIONS USED TO ASSESS PATIENTS’ PERSPECTIVES ON KEY ELEMENTS

1. Communication with doctors
2. Communication of hospital staff
3. Responsiveness of hospital staff
4. Pain management
5. Communication about medications
6. Discharge information

7. Cleanliness
8. Quietness
9. Transition of care

By assessing the quality of care received, the institution can facilitate improvements in healthcare delivery. Maslow's hierarchy of needs can conceptualize the hospitalization and illuminate ways in which the health facility can support more responsive healthcare delivery. For example hospital routine and processes are centred around what works for the facility; rather than what works for the patient; like meal times may be timed to what works for the catering staff shifts or to accommodate planned tests or procedures. The patient does not control aspects of his life, but is at the mercy of care givers.

2.26 SUMMARY OF THE CHAPTER

The health facility makes a crucial first impression on patients. The facility sets the tone for the patient care experience. The health impacts of the coronavirus have affected physical, mental, social, emotional, and the spiritual wellbeing of healthcare workers. By applying Maslow's hierarchy of needs to human-centred design and investigating the research results – supported improved care delivery during the pandemic. Chapter three, the theoretical framework further detailed information based on Maslow's theory model to illustrate a link between the topic and objectives.

CHAPTER 3

THEORETICAL FRAMEWORK

3.1 INTRODUCTION

The theoretical framework is used to justify the researcher's information and intent. It helps the researcher answer the problem question. The framework further defines and formalises a dissertation topic or research investigation.

3.2 THEORETICAL FRAMEWORK

Theories are used to explain and challenge existing knowledge. The theoretical framework is the structure that holds or supports a theory of a research study. It introduces and describes the theory that explains why the research problem under study exists (Abend, 2008:173). A theoretical framework consists of concepts and definitions that are related to the study.

The researcher adopted Maslow's hierarchy of needs to draw a link between the topic of inquiry and the study objectives.

3.3 THEORETICAL FRAMEWORK USED TO GUIDE THE STUDY

Maslow's hierarchy of needs is a theory of motivation. The five categories or tiers of human needs dictate an individuals' behaviour. The hierarchy presents as a pyramid, from the base / bottom up as follows: physiological needs, safety needs, love and belonging needs, esteem needs and self-actualization needs. Maslow's pyramid of human needs of 1943

listed the basic human needs at the bottom and the higher level needs at the top (McLeod, 2020:1)

3.4 MOTIVATION THEORY: MASLOW'S HIERARCHY OF NEEDS

The basic human need is survival. Maslow's theory is that human beings aim to have their most basic needs met. Illness can affect and interfere with a person's development. He further explains that if a need is not met in one area, a person might have their needs from another area met. For example a person who is unwell or in poor health may have the support of and maintain close relationships with family and friends. The person may thus not have their safety needs met, but community and belonging needs are. The needs higher up on the pyramid: esteem and self-actualization are not important at this stage until the safety needs are met (Maslow 1943: 371).

Figure 1 illustrates Maslow's pyramid and hierarchy of needs. The basic needs at the base and the social needs higher up.

3.5 MASLOW'S THEORY MODEL

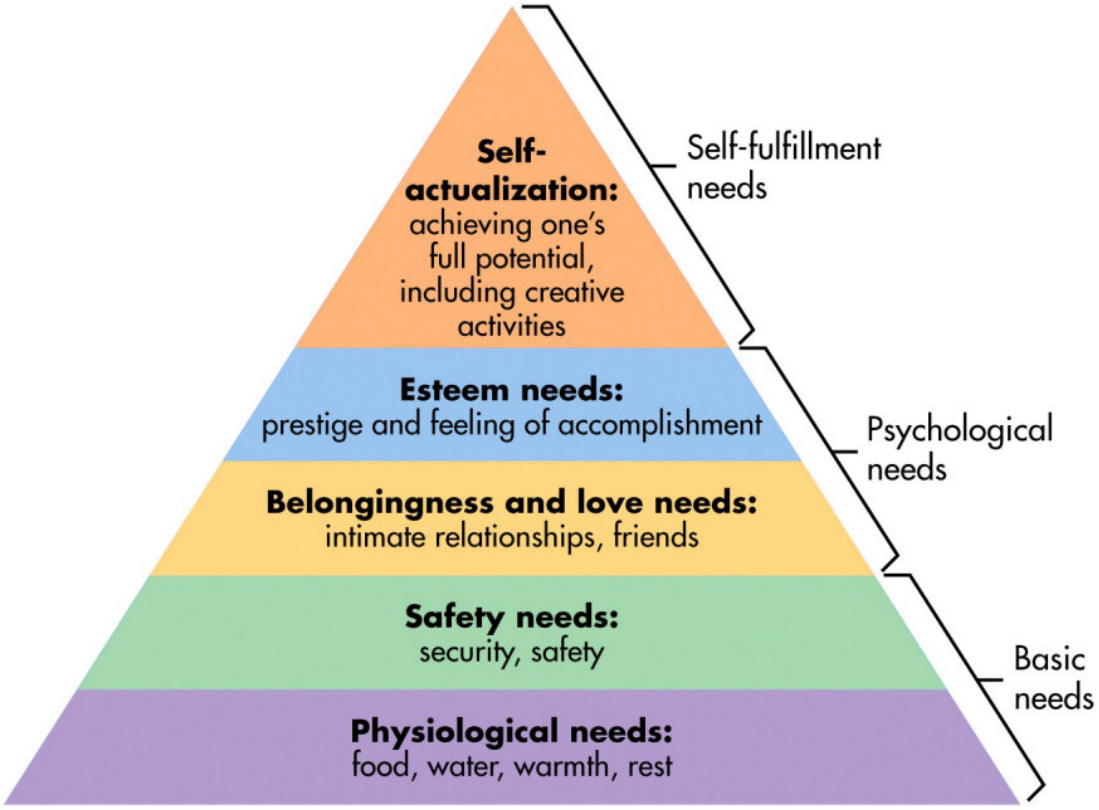

Figure 3.1: Maslow's hierarchy of needs (Maslow 1943: 372)

3.5.1 Components of the Theoretical Framework

TIER 1: The COVID-19 pandemic also known as the coronavirus pandemic caused severe acute respiratory syndrome (SARS-CoV-2). The symptoms affected the patients' physiological status. Biological needs such as the need for air is necessary for human survival. By not having air to breathe, the human body cannot function optimally.

TIER 2: The health service delivery was affected and new ways of adaptation of healthcare delivery showed that healthcare workers both as caregivers and patients reassessed patient safety needs. Protection, security and freedom from fear is part of the human safety need.

TIER 3: Healthcare workers were at risk during the pandemic. The fear of infection and transmission of the virus affected the emotional needs of the patients. The social human needs includes feelings of belongingness and interpersonal relationships, such as friendship, intimacy, trust and love. These strong emotions are as important as being part of a group like family, work and friends.

TIER 4: The patient journey and overall sick role illustrates that the move towards patient-centred care includes all interactions across the continuum of care, until death. According to Maslow (1987:69), the most basic need is the need for physical survival, and this will be the first thing that motivates behaviour. The esteem needs of achievement, independence, respect, reputation and dignity is just as important for human growth.

TIER 5: Patient experience or customer satisfaction: customer satisfaction is referred to as a measurement of experiences, related to the service provided by the healthcare institution. These experiences affect the persons' self-fulfilment, who are seeking personal growth and ultimately self-actualization.

3.6 APPLICATION OF THE THEORETICAL FRAMEWORK TO THE STUDY

By applying Maslow's hierarchy of needs theory, a contribution can be made to teaching and learning in the healthcare setting. Maslow (1971:195) argued that a humanistic approach would develop stronger and healthier patients who would take ownership of their own lives.

TIER 1 – COVID-19 pandemic

The coronavirus affected the patients' respiratory system – the basic need for air. Healthcare workers saw the importance of oxygen administration via mask, nasal cannula, CPAP or full ventilation and oxygen concentrators until discharge. The patients' physiological processes of breathing impacted their overall health.

TIER 2 – Health service delivery

In this study the rapid adaptation of healthcare service delivery was highlighted. For example, the suspension of visitors had an impact on the patients love and belonging needs. The hospital environment of bed spacing, "co-horting" (placing of patients together) of patients, demarcation of red and green zones and installation of "bubbles", changed the "normal" hospital stay. Availability of resources and medical supplies like personal protective equipment and medication, impacted on the patients' safety.

TIER 3 – Patient journey and the sick role

The patients' journey is the patients' experience throughout a period of care – from the time of admission until discharge. Patient experience is influenced by what actually happens to the patient and patient perceptions. Parsons (1951: 13) explanation of the sick role talks to Maslow's hierarchy of needs that an ill persons' behaviour changes according to their need at the time.

TIER 4 – Healthcare workers / Healthcare professionals

Healthcare workers also succumb to ill health and assume the sick role. Healthcare workers had to face illness and death during the pandemic – which was severely traumatising; especially more so when it was a personal experience. The emotions and fears impacted the healthcare workers' sense of accomplishment.

TIER 5 – Patient experience

Maslow refers to the need for security and safety. The basic needs during the delivery of health service was focused on patient safety during the COVID-19 pandemic. Principles of social distancing, wearing of masks and frequent hand sanitizing is indicative of this primary need. The patients' desire for self-actualization was halted as other basic needs were affected.

3.6.1 Tier Grouping

Maslow further explained that not everyone will move through the hierarchy in a uni-directional way, but they may move back and forth between the different needs. Major life experiences like loss of employment or divorce, may cause the person to fluctuate between the levels of the pyramid. The order of human needs are not rigid; instead they may be flexible based on external circumstances.

Growth needs stem from the desire to grow as a person, and not from the lack of something (Maslow, 1987:69). Maslow later further expanded on the model of hierarchy of needs; to include cognitive, aesthetic and transcendence needs. The goal to self-actualize shows the human need to find a meaning to life that is important to them. Self-actualization involves achieving ones' potential and is not equated with perfection. "There are no perfect human beings" (Maslow, 1970: 176).

3.7 MASLOW'S HIERARCHY OF NEEDS ALIGNED TO THE IMPACT OF COVID-19

Table 3.1: Adapted from Ryan, Coppla and Canyon, 2020:21

BASIC NEED	REQUIREMENTS	IMPACT OF COVID-19
1. Physiological needs	Breathing, mobility, sleep, food, homeostasis. Basic needs for survival.	Respiratory effects - lack of oxygen, tiredness and immobility, exhaustion and difficulty sleeping, loss of taste and appetite, imbalance in body function. Need to explain possible outcomes.
2. Safety needs	Health, security, trust, resources, employment. Concerns if the healthcare team can prevent their condition from worsening.	Decline of health state, feeling unsafe, unable to trust, scarcity of resources, uncertain future, loss of employment. Providing care and active emotional support.
3. Social needs	Feelings of love, family, relationships and belonging. The need for visitors.	Lack of affection and support, cessation of visiting, restricted and limited contact, feeling lonely. Strategy to assist survivors to manage with new boundaries and limitations.
4. Esteem needs	Need for respect, recognition, achievement, self-worth and independence. Return to work.	Dependency on others, loss of independence and status, lack of acknowledgement. Cognitive rehabilitation accelerates recovery.
5. Self-actualization	Creativity, ability to problem solve. Able to embrace a new identity.	Judgement affected, loss of desire and drive. Formal counselling or support groups.

3.8 SUMMARY OF THE CHAPTER

The framework discussed in this chapter was used to guide the study and aid the researcher to explain and link the theoretical framework to the research problem, objectives and significance as outlined in chapter 1 and 2. The application of the framework allowed the exploration of the link between the components and needs; and how this impacted on the patients' experience. Chapter 4 deals with the detail and research methodology of the study.

CHAPTER 4

DESIGN AND RESEARCH METHODOLOGY

4.1 INTRODUCTION

This Chapter provided the description of the research design. The target population, sampling, collection tools, data processing, analysis of data, ethical considerations and data management was described. This chapter presented an overview of the exploratory-descriptive qualitative research approach. This study explored experiences of healthcare workers as patients, during the COVID-19 pandemic at a private healthcare facility, in the UMgungundlovu district in KwaZulu-Natal, South Africa. The method used drew on the theories of Maslow's hierarchy of needs model.

The following objectives guided the study

1. Explore healthcare workers' experiences whilst being a patient in hospital during the COVID-19 pandemic.
2. Describe factors in the professional practice environment such as the healthcare facility that promotes a negative patient care experience and leading to poor patient outcomes.
3. Determine factors in the professional practice environment such as the healthcare facility that supports a positive patient care experience and an overall improvement in patient outcomes.

4.2 RESEARCH / STUDY DESIGN

The study utilised a qualitative research design, using an exploratory descriptive approach. This design is appropriate to extract the required information from the research participants. The explorative descriptive studies are studies that are

conducted with the purpose of detailed exploration and describing the topic of inquiry, and addresses the problem that is in need of a solution (Gray, Grove and Sutherland 2017: 70. The researcher chose this approach in order to explore the experiences of healthcare workers as patients.

Qualitative design

Qualitative research design is an investigation phenomenon. It uses an in-depth and holistic method, through the collection of narrative material. This rich data is obtained through a flexible research design (Polit and Beck 2017:741). This study was qualitative in nature, as it aims to understand the experiences of healthcare workers as patients at a private hospital.

Exploratory design

Polit and Beck (2017:15) states that the full nature of the phenomenon is investigated in an explorative study. This design sheds light on the different ways the phenomenon presents and manifests, and other factors to which it is related. Background information was gained by the researcher, as well as a better understanding of the experiences of healthcare workers as patients.

Descriptive design

It is noted that a descriptive research approach is used to develop a multi-dimensional picture of the problem, which involves reporting from multiple perspectives (Creswell 2014:176). The author further explains that this approach helps to identify the many factors involved in a situation, and allows for a bigger picture to emerge. The researcher obtained information from participants who themselves are healthcare workers admitted to a healthcare facility. The experiences of the patients as healthcare

workers, provided valuable insight to the study as they better understand the healthcare environment.

4.3 STUDY SETTING

A study setting is the specific place where data collection occurs. It can range from totally naturalistic environments to formal laboratories (Polit and Beck 2017: 65). The researcher proposed to use a private healthcare facility in the KwaZulu-Natal region. State run hospitals will be excluded from the study as private hospitals are run differently and independently in the district. State hospitals work on a referral basis within the district. Public run hospitals operational management differ from management in a private facility.

4.4 STUDY POPULATION

According to Polit and Beck (2017:491) the population is a group of people or a type of element that is the focus of the study; whilst the target population is the entire set of individuals or elements that meet the sampling criteria. The aim of the qualitative study was to discover meaning and to uncover multiple realities of a target population. The target population for this research study included healthcare workers who were COVID patients admitted to a private healthcare facility during the pandemic.

4.5 SAMPLING PROCESS / TECHNIQUE AND SIZE

Sampling is a process of selecting a portion of the population to represent the entire population. Sample size refers to the number of people who participate in the study (Polit and Beck 2017:743). The authors add that sampling designs are classified as probability sampling or non-probability sampling. The researcher used non-probability purposive sampling method for the proposed study. This is frequently used in qualitative research to select the research sample. Samples are small in qualitative

studies; probability sampling is not used, and final sampling decisions usually take place during data collection (Polit and Beck 2017:498). This is done so that the participants can provide insightful information in order to answer the research questions that are based on the topic of interest. This study therefore aimed to interview possibly 10 healthcare workers from the sample healthcare facility. By using a non-probability purposive sampling method, the researcher did not know in advance how many participants were required. The study was guided by data saturation, which was achieved when there was no new information from the participants about the experiences of healthcare workers as patients during the COVID-19 pandemic. Data was obtained through voluntary participation and was guided by data saturation. According to Polit and Beck (2017: 493-497), data saturation is a guiding principle in a sample size in a qualitative approach. Hence sampling was conducted to the point at which no new information was obtained and redundancy was achieved. Data analysis occurred concurrently with data collection, thus monitoring data saturation.

Inclusion criteria:

- Healthcare workers infected with the coronavirus,
- Admitted staff at the private facility during the COVID-19 pandemic.

Exclusion criteria:

- Healthcare worker who was infected with the SARS coronavirus;
- Those not admitted to a private health institution.

RECRUITMENT PROCEDURE

In this qualitative research process, the approach was to describe life experiences from the healthcare workers perspective, to gain insight and therefore improve the comprehension from the views of the people experiencing the phenomenon. The researcher was able to explore the complexity. The qualitative researcher has the

flexibility to adapt during data collection an analysis. The research questions can be adjusted during data collection depending on emergent patterns and themes. Qualitative researchers in health professions use semi-structured methods to gather health related experiences from research participants. These open-ended include observations, focus groups, interviews and analysis of documents. Audio or video recordings will be used for oral methods, so that transcripts can be prepared for analysis, (Gray, Grove and Sutherland 2017: 124).

APPROACHES TO QUALITATIVE RESEARCH

Five commonly conducted approaches to qualitative research (Figure 1) are:

- Phenomenological research
- Grounded theory research
- Ethnographic research
- Exploratory-descriptive research
- Historical research

The five approaches share commonalities, however they differ as they have been developed by different discipline researchers. The common purpose amongst the above approaches is to interpret the meaning of human experiences. Exploratory-descriptive research is used by the disciplines of nursing and medicine. The exploratory-descriptive research approach has a problem-solving approach. Phenomenological research captures the “lived experience”, by listening to the participants. The analysis of the verbal and nonverbal communication of the research participants was done in order to gain a comprehensive understanding of their experiences.

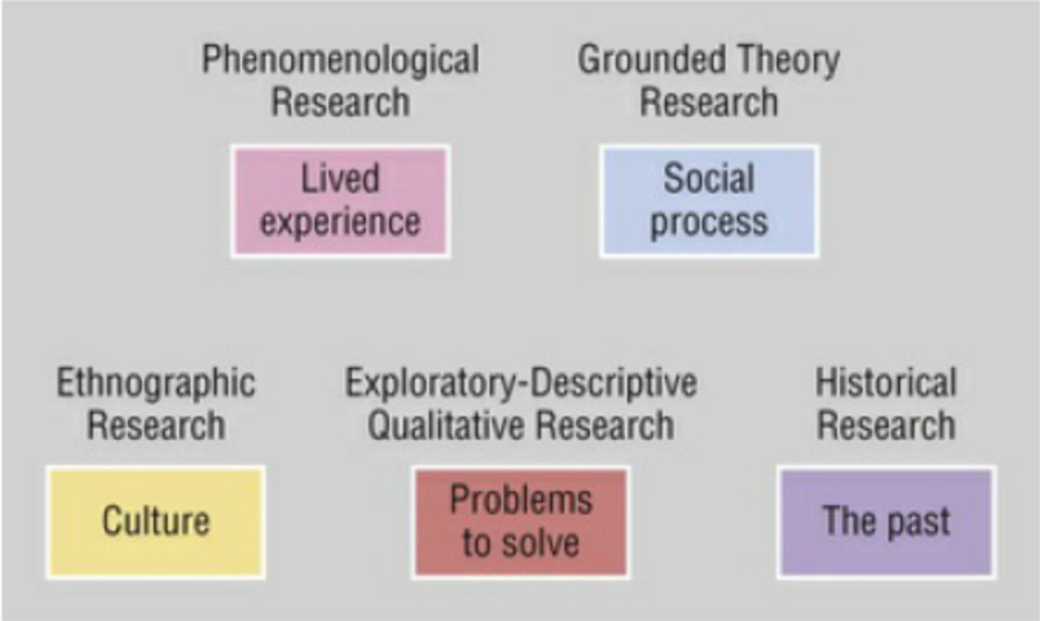

Figure 4.1: Approaches to Qualitative research (Gray, Grove and Sutherland 2017: 127)

EXPLORATORY-DESCRIPTIVE QUALITATIVE RESEARCH

This method of research is a specified method with a comprehensive summary of an event. This approach is frequently used to address a problem in need of a solution. In the study process there is an attempt to understand patient's perceptions; by identifying the lack of knowledge. By seeking the experiences and viewpoints of people most affected. The perceiver is the person living the experience and is the source of the information.

According to Gray, Grove and Sutherland (2017: 137), the experiences of those living with illness or disease changed over time; as the disease or treatments changed. It is therefore important to listen to patients stories. Other methods of research includes narrative inquiry and case studies; in which experiences are also elicited. Hence the

qualitative research approach is a scholarly approach and can be used in the description of life's experiences from in this study the patient's perspective.

EXPLORATORY-DESCRIPTIVE QUALITATIVE METHODOLOGY AND ITS APPLICATION TO THE CURRENT STUDY

The specific research question in this study used Maslow's theoretical framework to structure the study design. By exploring the problem or issue with the use of qualitative techniques and by describing the topic in detail; this promotes understanding of the study. With the use of Maslow's hierarchy as a framework; a step-by-step approach was used to elicit and record participant's perspectives on their experiences. Exploratory-descriptive qualitative studies may use a theoretical perspective like Maslow's theory that is relevant to the research topic, as an organizing structure for data analysis.

4.6 DATA COLLECTION

The researcher needs to build rapport with the subject. The individual needs to know that the information shared will be used discreetly. Trust is important in participant sampling. Because of its nature, this kind technique may consume more time than anticipated. Participant's experiences during the pandemic was therefore recorded having sought permission. A demographic questionnaire with regard to gender, age, race, marital status, level of education, current employment and place of employment (refer appendices) was handed to each participant prior to collection of data. The researcher ensured that the data is stored confidentially and is password protected in the Cloud.

Delimitations

Healthcare professionals included a range of disciplines: from managers of healthcare institutions, nurses, technicians, administration support staff and physicians. They may work directly or indirectly with COVID patients. The participants were informed of the study and followed COVID-19 protocols of social distancing. They were given the letter of information (refer appendices) which explained the study and gave the prospective participants an opportunity to clarify any ethical issues relating to the study, and purpose of the study and the data collection method to be used. When the prospective participant verbally agreed to participate in the study, they then, were provided with the consent form to participate in the research study.

Data collection strategy

The data collection strategy in the proposed study was face to face, telephonic and online interviews. The researcher hereby proposed online interviews as an alternate option to face to face interviews dependent on the state of the COVID-19 situation and the level of the country lockdown at the time of data collection. Should the option of online interviews be exercised it would have taken the form of Skype, Zoom, WhatsApp video calling or Microsoft TEAMS programmes. In the case of face-face interviews, strict COVID-19 protocol such as maintaining a social distancing of 1, 5 metres between interviewer and interviewee, hand sanitising and wearing of masks was followed. This study sought to use an exploratory-descriptive approach to interview specifically health care workers. The researcher proposed a maximum sample size of 20 and minimum sample size of 10 health care workers who were hospitalized with COVID -19.

The researcher should give careful thought to the wording of the questions, which should be easy to understand and make sense to the participants (Polit and Beck 2017: 515). The use of semi-structured interviews for the healthcare workers provided the researcher an opportunity to further explore themes or responses, as well as encourage the participants to express freely. The authors further state that the semi-

structured interviews are used as the researcher knows what she wants to ask, but cannot predict the answers from the healthcare participants. By probing this enhances the rapport and shows the participant that the researcher is interested in understanding the participant's experiences. The interviewer also had an opportunity to clarify and expand responses. The researcher needed audio recording equipment, a charger, notebook and pens, and the consent forms as data collection tools. The timeframe for the planned interview was a minimum of twenty to thirty (20-30) minutes to a maximum of one hour. Participants were re assured about the confidentiality of the interview and were told that they can withdraw at any time.

4.7 DATA ANALYSIS

The purpose of data analysis is to organise, provide structure to, and generate meaning from data (Polit and Beck 2017: 530). The authors' further state that in qualitative study, data collection and analysis often occur concurrently, rather than after all the data has been collected. This increases the validity and trustworthiness of the study.

a) **Description phase**

   In this phase the qualitative research method relies on linguistic rather than numerical data. It employs meaning-based data rather than statistical forms of data. Open exploratory research questions were used rather than predetermined choices or rating scales. An important feature of this initial phase is that the researcher should become aware of the possible nature of their pre-understandings, as these are likely to shape the data collection, analysis and interpretation.

b) **Analysis phase**

   Qualitative research also requires flexibility during the analysis phase. All steps of the analysis phase includes reflection. The analysis needs to be systematic and organised. The data preparation includes notes and recordings.

Recordings are transcribed verbatim. The whole picture was collated by combining the notes and transcribed recordings. Redundancies, digressions and repetitions are omitted.

c) Interpretation

The data is then divided into distinctive meaning units. These units communicated meaningful information to the reader. A code can be assigned to the meaning units so that the information can be traced back for clarity in the context. By sorting the data into domains the researcher provided a conceptual framework for the research development. Identification of important themes began from the start of data collection. The recordings were carefully listened to, immediately following data collection; so that the transcription is accurate. The researcher will be able to assess whether or not improvements in the interviews to follow, are required (Polit and Beck 2017: 516). According to the authors verbatim transcription of audio data is critical in preparation for data analysis because its accuracy validly reflects the interview experience.

Creswell's (2014:198) reference to Tesch's eight steps was used to code and analyse the content of the narrative data, in order to identify prominent themes and patterns.

Tesch's eight steps:

Step 1: Reading transcriptions carefully to get a general sense of the whole.

Step 2: Read one document at a time, note thoughts about underlying meanings in the margin.

Step 3: List all topics and cluster together similar topics under column headings of Major, Unique and Leftover topics.

Step 4: Write codes by abbreviating these topics, next to the appropriate segments of the text data. This will serve as a preliminary organising scheme to assess if new categories and codes emerge.

Step 5: Convert these topics into categories. Use descriptive words, and group topics related to each other – the list of topics will be reduced.

Step 6: Alphabetise the codes after finalising the abbreviations for each category.

Step 7: Perform a preliminary analysis by assembling the data material belonging to each category.

Step 8: If necessary, recode existing data.

4.8 TRUSTWORTHINESS / RELIABILITY AND VALIDITY

Trustworthiness is an alternative construct for validity and reliability in qualitative research. According to Polit and Beck (2017:559) Lincoln and Guba (1994) suggested that trustworthiness encompassed several dimensions, which include the following:

a) Credibility

Polit and Beck (2017:559) states that credibility refers to confidence in truth of the data and their interpretations. The researcher ensured clear and open channels of communication throughout the process of data collection. The researcher ensured credibility by building trust and establishing rapport between the researcher and participants, at the outset of data collection. This will assist with obtaining rich data.

b) Dependability

Dependability refers to the stability or reliability of the data obtained over time (Polit and Beck, 2017: 559). Credibility cannot be attained without dependability. The researcher had to reflect on one's own behaviour to maintain dependability – to avoid their behaviour from affecting the data that is obtained. This includes guarding against getting emotionally involved with the participants. Supervisors will maintain dependability by reviewing data.

c) Confirmability

To ensure confirmability, the researcher's bias and perceptions should not be reflected in the study. The data representation is provided by the participants and not the researcher's interpretation (Polit and Beck 2017:560). Audio recording of the interviews were done to ensure that the information provided by the participants were documented accurately and truthfully.

d) Transferability

Transferability is defined as the ability to apply the findings in other contexts or to other participants (Brink *et al.* 2012:173). Polit and Beck (2017:164) add that thick description of research settings and the sample of participants support transferability. This qualitative research showed through its methodology and analysis, why the research can be clearly transferred to other studies with the same or similar context.

4.9 ETHICAL CONSIDERATIONS

Polit and Beck (2017:727) state that ethics refers to a system of moral values that is concerned with the degree to which research procedures adhere to professional, social and legal obligations in interacting with participants. The research study commenced once DUT Institutional Research Ethics Committee (IREC) grants ethics clearance.

The following principles were adhered to, to ensure the rights of participants are upheld:

a) Beneficence

This important ethical principle in research, outlines the obligations of the researcher to avoid, minimise or prevent harm and discomfort to participants; such as physical, psychological, emotional, legal or social (Polit and Beck 2017: 139). During the research study, the researcher maintained beneficence by protecting and respecting the participants and organisations culture and reputation by ensuring their identities does not appear in the report.

b) Respect for human dignity

The Belmont report, as cited in Polit and Beck (2017:140), is the second ethical principle which includes the right to full disclosure. Coercion was avoided; there were not any sort of monetary incentive for participants. Self-determination of the participants was promoted and they decided whether to be part of the study, to refuse or withdraw, without prejudice from others or the researcher.

c) Justice

The third broad principle refers to participants' right to fair treatment and the right to privacy (Polit and Beck 2017:141). Participant selection was based on the requirements for the study and not on the groups' vulnerability; ensuring the right to fair treatment. The participants' privacy were maintained, especially during the compilation of the report. The research was also not intrusive.

4.10 SUMMARY OF THE CHAPTER

The COVID-19 pandemic caused crucial changes in work and personal life of healthcare workers. Working in a pandemic era is a unique experience and the impact on healthcare workers was unknown. The study attempted to show how the COVID-19 pandemic had a far-reaching negative impact on healthcare providers and had placed healthcare workers under physiological and psychological pressures, by undertaking an in-depth exploration of the experiences of healthcare personnel during the COVID-19 crisis.

CHAPTER 5

PRESENTATION OF RESULTS

5.1 INTRODUCTION

Chapter 4 outlined the research methodology that was used to conduct the study. In this chapter the results of the data obtained during the individual interviews is presented. The qualitative research design used an exploratory descriptive approach. The experiences of healthcare workers as patients, were explored and an overview of the 14 healthcare workers that were interviewed at a private hospital, is presented.

The demographic data shows variation of healthcare workers: gender, age, category / discipline / position, race and length of service. The experiences of healthcare workers as patients during the COVID-19 pandemic were explored. The data collection relied on in-depth interviews using an interview guide.

The themes and sub-themes that emerged from the interviews conducted, are highlighted in this chapter. The theoretical framework of Maslow's Hierarchy of Needs Theory, was the method base to explore the topic of inquiry and study objectives. The phenomenological approach was used to explore the lived experiences of the healthcare workers.

The following research objectives:

1. Explore healthcare workers' experiences whilst being a patient in hospital during the COVID-19 pandemic
2. Describe factors in the professional practice environment such as the healthcare facility that promotes a negative patient care experience and leading to poor patient outcomes
3. Determine actors in the professional practice environment such as the healthcare facility that supports a positive patient care experience and an overall improvement in patient outcomes

supported the purpose of this study, to explore the experiences of healthcare workers as patients during the COVID-19 pandemic at a private healthcare facility.

5.2 SAMPLE REALISATION

Data was collected through scheduled interviews with healthcare workers; following distribution of the letter of information and agreement to participate. The demographic form was completed prior the semi-structured interview commenced and received with the consent document.

The participant list was extracted from the hospitals data warehouse specific to healthcare workers who were admitted during the COVID-19 pandemic, between April 2020 and May 2022. Twenty five (25) letters of information were distributed by the human resources department in an attempt to elicit a minimum of 10 random participants. Interested participants contacted the researcher and consented to participate in the research study.

All participants were scheduled for interviews subject to shift availability for a minimum of 20-30 minutes. The interviews were conducted personally by the researcher with a set question guide, either telephonically, via video call or in person / face-to-face. The interviews showed data saturation after twelve (12) interviews were conducted. A further two (2) interviews were conducted to further confirm data saturation. A total of fourteen (14) participants were interviewed. The interviews were conducted over a period of six (6) weeks.

5.3. DEMOGRAPHIC DATA

Demographic data was collected from 14 participants at the healthcare facility; which is a medium sized private hospital of 222 beds. During the hours of interviews the researcher explored the experiences of healthcare workers as patients.

5.3.1 Table of participants interviewed for this study. Demographic data.

PARTICIPANT NUMBER	GENDER	AGE	RACE	LENGTH OF SERVICE IN YEARS	POSITION / TITLE	ADMIT / DISCHARGE DATE: DD/MM/YYYY
P1	Female	29	Indian	9	Enrolled Nurse	19/12/2021 21/12/2021
P2	Female	49	Indian	28	Senior Professional Nurse	09/07/2020 20/07/2020
P3	Female	47	Black	11	Enrolled Nurse	10/05/2022 18/05/2022
P4	Female	41	Indian	13	Unit Administrative Assistant	29/10/2020 04/11/2020
P5	Female	57	Indian	34	Unit Administrative Assistant	06/10/2020 06/11/2020
P6	Female	34	Indian	10	Care Worker	18/07/2020 27/07/2020
P7	Female	42	Black	19	Clinical Facilitator	01/10/2020 20/10/2020
P8	Female	51	Black	20	Senior Professional Nurse	03/03/2021 06/03/2021
P9	Male	58	Black	35	Doctor	27/01/2021 31/01/2021
P10	Female	39	Black	15	Senior Professional Nurse	28/12/2020 30/12/2020

P11	Female	56	Indian	20	Accounts Controller	26/08/2021 04/09/2021
P12	Male	40	Indian	16	Professional Nurse	11/07/2021 14/07/2021
P13	Female	35	Coloured	12	Enrolled Nurse	01/09/2020 09/09/2020
P14	Female	28	Black	6	Professional Nurse	28/07/2020 04/08/2020

5.4 PARTICIPANTS OVERVIEW

Participants' age range from 28 to 58 years; showing a diverse level of maturity.

All married with a family orientation, except one that is engaged to be married. Of the fourteen participants 2 were males with the majority of 12 being female. Race groups included: black, Indian and coloured. The minimum length of service as a healthcare worker was 6 years, with the longest being 35 years.

Categories / titles of healthcare workers included both clinical and non-clinical: enrolled nurses (3), professional nurses (2), senior professional nurses (3), clinical facilitator (1), unit administration assistants (2), care worker (1), accounts controller (1) and doctor (1).Most of the participants were admitted in 2020 (8), with five admitted in 2021 and one in 2022.

The variety of participants explored different experiences of the healthcare workers.

Saturation of data was reached after twelve (12) interviews; however a further two (2) interviews were conducted to confirm saturation.

5.5 OVERVIEW OF FINDINGS

The findings of the study is provided in this Chapter. The researcher used a qualitative research methodology with an explorative descriptive approach to explore the experiences of healthcare workers as patients during the COVID-19 pandemic. Semi-structured interviews were conducted to understand the participants lived experiences (phenomenological research), through sharing and expression of feelings, perceptions and experiences.

A positive patient experience of the participants highlighted the interplay between quality of care, safety and personal experience. The effect of the COVID-19 pandemic affected the healthcare workers physiologically and psychologically and speaks to the research aim and the following research questions of this study:

1. How did the COVID-19 pandemic affect healthcare workers or healthcare professionals as patients?
2. What are the long term effects of the pandemic on healthcare workers or healthcare professionals?
3. What influenced the outcomes of health care workers or healthcare professionals' health, as patients?

5.6 THEMES THAT EMERGED FROM THE PARTICIPANTS INTERVIEWS

Three (3) major themes emerged during analysis of the findings.
Sub-themes are presented with each major theme.

Patient experience of the interviewed participants exposed the following themes:

- Physiological needs – The treatment of signs and symptoms and the management of care during the infectious phase; as well as the continuity of care. Nutritional needs, difficulty in breathing and the need for rest and sleep was notable.
- Safety needs – The hospital environment and need for safety and security during hospitalization was highlighted; as well as interaction with healthcare colleagues and access to information and protection of family and colleagues.
- Psychological needs – The personal experience and sharing of emotions occurred; with a need for inclusion in treatment and decision-making; the need for support and family also emerged. The patients' perception of care was influenced by these emotions.

Based on Maslow's Hierarchy of Needs Theory, it emerged that the basic human need of survival was highlighted from the participant interviews. Maslow's Hierarchy of Needs Theory model illustrates that a human beings' aim to have their most basic needs met is vital, and that illness or disease can interfere with a person's recovery and growth (Maslow 1943: 372).

5.6.1 Table of themes and related sub-themes

THEMES	SUB-THEMES
THEME 1	SUB-THEMES
1. Physiological needs	1.1 The declining basic nutritional need for food and water
	1.2 The fear of experiencing difficulty with breathing
	1.3 The increased need for warmth, rest and sleep
THEME 2	SUB-THEMES
2. Safety needs	2.1 The need for personal security, protection of family and colleagues
	2.2 The need for a safe and non-threatening environment
	2.3 The need for adequate resources to ensure safety and security.
THEME 3	SUB-THEMES
3 Psychological needs	3.1 Building of relations with healthcare workers as colleagues and care workers
	3.2 The increased need for family contact and support
	3.3 The need to strengthen spiritual needs and connections

5.7 PRESENTATION OF FINDINGS

In the presentation of findings that follows, themes and sub-themes are supported by statements from the participant interviews. Excerpts from the transcripts are included, as quotes, related to the themes and sub-themes. To maintain the integrity of the data a brief background to explain the context is included; as well as punctuation to ensure that the quotations are logical and understood.

5.7.1 THEME 1: PHYSIOLOGICAL NEEDS

The interviewed participants shared their experiences and signs and symptoms. The common emergence was that they felt worse / sick with the coronavirus around day nine. The first few days was spent in isolation with self-care, medication and treatment.

The common symptoms were headaches, breathing changes or difficulty in breathing, sudden loss of appetite and taste, vomiting. Due to the lack of energy, participants were unable to do the basics of hygiene needs like showering and use the bath room unassisted. The lack of sleep and rest due to the inability to breathe "normally" delayed their healing and recovery.

These basic needs or biological component of human survival is necessary as per the physiological needs of Maslow's hierarchy of needs theory. From the interviews the basic physiological needs had to be met in order for the patient to recover and progress to the next stage of recovery.

The participants described their physiological symptoms specifically as follows:

"The headaches was my first symptom. The headaches were something else … My head was getting numbed from the headaches. I knew then, that something was not right." (Participant 1)

"I had severe pain. I went for physiotherapy which did not help. The shoulder pain was a different kind of pain. It was in my shoulder blades. I couldn't take the pain. I think I was going to die with the pain." (Participant 2)

"The first three days I had severe diarrhoea and that was embarrassing to me because I had messed myself numerous times. I was ashamed and felt very dirty …it worried me." (Participant 11)

5.7.1.1 Sub-theme 1.1 The declining basic nutritional need for food and water

The interviews revealed the declining nutritional state of the patients. The healthcare workers mentioned a loss of appetite and a sudden loss of taste as well as vomiting.

Further to the signs and symptoms of fever and rigors, the healthcare workers were dehydrating. This necessitated a need for hydration fluids in the form of intravenous therapy. Participants reported as follows:

"I had lost my taste. I started vomiting, so I did not eat much, because I was scared of vomiting." (Participant 3)

The onset of diarrhoea further added to the dehydration.

"Then I had diarrhoea. I couldn't manage to wipe myself… I was feeling so embarrassed… Because of my colleagues; it was too much for them to see me like this, with loss of control. Because they were trying by all means to help me." (Participant 3)

Other complications that added to the participant's physiological need of eating:

"I developed sores in my mouth which was very painful and it took a long time to heal. It restricted my talking and eating habits. The medication impacted me as well. I lost weight and was very weak" (Participant 11)

5.7.1.2 Sub-theme 1.2 The fear of experiencing difficulty with breathing

Most participants expressed concerns of breathing. The virus affected their lungs as confirmed with chest x-rays. A feeling of a "tight" or "heavy" chest was described. Oxygen therapy was needed with constant monitoring of oxygen saturation levels to determine a deterioration in condition. Nebulization was required to assist with the clearing of the lungs and mucous accumulation in order to alleviate the wheeze.

Participants expressed the discomfort with having to “prone” (lie on their stomach) to avoid the mucus build up at the base of the lungs. The participants expressed that “proning” to assist lung healing and prevention of deterioration, was a challenge.

They also noted that the demand for and usage of oxygen was high. This was evident by the following excerpts:

“The patients struggled to breathe. You could hear the oxygen roaring the moment you walked into the COVID unit. And patients were just dying in front of you.” (Participant 14)

“Breathing was a difficult thing. It is very, very difficult to describe how it feels like to have to battle for each breath that you take day and night. In fact that’s what eventually lead to me being hospitalised. Initially I treated myself at home and that didn’t work.” (Participant 9)

“I had a panic attack. My mum was visiting family who were COVID-positive, and I panicked and really went hysterical. I had shortness of breath and I was uncontrollable. I could not breathe and the ambulance was called.” (Participant 11)

5.7.1.3 Sub-theme 1.3 The increased need for warmth, rest and sleep

The COVID-19 pandemic affected patients physically and mentally with increased levels of distress and insomnia, as they were afraid to rest and sleep due to the breathing difficulty.

Basic comfort and healing needs of warmth, rest and sleep was highlighted as a challenge. Most participants desired these basic needs, however fears of sleep settled in due to difficulty in breathing. Participants were unable to rest due to care and

treatment – like difficulty to sleep with an oxygen mask on; not comfortable with "proning" and fear of sleeping as they may not wake up or die.

The need for warmth was affected during the fever and rigors phase of the viral infection. The basic physiological need of rest was interrupted due to breathing and care interruptions day and night as noted by participants below.

"To be woken up at 3am to have your bloods taken by the lab (laboratory) people, was irritating. Especially being woken up from a deep sleep and struggling to sleep while "proning" (sleeping on your stomach) with oxygen therapy. So when you do get a couple of hours of sleep and someone comes in and says they are here for the bloods; it is irritating." (Participant 9)

"I was so cold, uncontrollable shivers during the fever. I felt nothing could warm me as I was constantly cold. I told the nurse. And I think I had 4 or 5 duvets on. I cried and the night sister rubbed me and tucked me in. I will never forget her." (Participant 2)

"The last time I was admitted to hospital was about 15-19 years ago, when I had my wisdom removed. That was a day case, so this was new to me; trying to adjust… My sleeping habits were way off; I couldn't fall asleep… The doctor's strict instructions were for me to lie on my stomach, which I found very difficult." (Participant 11)

5.7.2 THEME 2: SAFETY NEEDS

The need for safety and security was evident with the interviewed participants. The healthcare workers expressed feelings of being safe in a familiar environment, where safe patient care was practiced; especially knowing the effects of the coronavirus.

The support of fellow colleagues / healthcare workers was reassuring that they were in a patient centred environment. The healthcare workers had to offer their colleague patients health security, personal security and emotional security.

The participants felt confident in the care that was delivered by their healthcare colleagues, and trusted them with their care and stated the following:

"I came out with a new sense of appreciation of what it actually means to be an in - patient. What it means to be on the receiving end of medical care." (Participant 9)

"I was trying every avenue to avoid being admitted. I needed to go home to sort things out. The doctor said I was not in a state to go home because you have come with a heavy heart and if you go home you will not worry about yourself. Let us take care of you and this is not going to be hard. This is familiar territory. You will be fine. There was a lot of people advising me that the best was to be admitted." (Participant 11)

5.7.2.1 Sub-theme 2.1 The need for personal security, protection of family and colleagues

The treating healthcare workers had to offer their colleague patients health security, personal security and emotional security.

During hospitalization the healthcare worker patient expressed concerns about their family and colleagues safety. The main concern was who was taking care of their children, spouses or partners and parents.

Being in a COVID unit with carers taking care of other COVID positive patients was not a concern for the participants as they were aware that their colleagues were trained on safe patient care. It was reassuring to some as they knew that the staff were trained, sometimes by themselves and upskilled to nurse high care patients during the COVID-19 pandemic.

One of the participants was affected to the extent that she had to change her role and move to another unit. Memory loss and shortness of breath – long COVID, affected her work output. So the decision to move positions from a senior professional nurse to a professional nurse from a trauma / emergency unit to the after-hours dispensary,

with reduced nursing hours has affected her financial situation / financial security as expressed by the participant below:

"I came back and I asked to be demoted to a professional nurse so that I could do lighter duties. Working there [After hour's medication cupboard as the night nurse] is nice and relaxed, but it is not nice because you get a huge drop in your salary. It was quite a big impact." (Participant 8)

The concern for family protection was high.

"I almost fainted when I got my results. I was with my family that weekend. And I thought I had given COVID to them. I thought I was about to kill my kids." (Participant 14)

"My baby was with me the entire weekend. I was scared. That was my fear. My kid's safety. I was worried about my baby." (Participant 1)

Emotional safety needs and support, were evident as follows:

"The thoughts were very pronounced… There was a cupboard and I would stand behind the cupboard and the doctor would look for me. There was a feeling in the room I did not like… The corner by the cupboard was my safe place. And my doctor referred me to Dr Sacoor [neurologist]. They did a brain function test and asked me to take it easy and if there's anything bothering me to speak about it." (Participant 11)

5.7.2.2 Sub-theme 2.2 The need for a safe and non-threatening environment

Institutional environment and structures were appreciated by the interviewed participants. For example the emergency centre used containers to received patients

when the unit was at capacity. Patients were triaged and attended to accordingly – based on severity of illness and oxygen saturation.

The patients were nursed in isolation rooms or “bubbles” (plastic structures around their bed which was pressurized) in the emergency centre and intensive care units. Patients in semi- or 3 and 4 bedded cubicles were “co-horted” (had to share the room) and were nursed together, based on stage of infection.

Environmental cleaning was strictly adhered to and as patients were discharged or demised, terminal cleaning protocol was implemented as per infection control procedures and protocol; thus ensuring a safe environment by preventing the spread of infection.

A participant was admitted during the unrest and looting; when the supply chain had stopped and resources like oxygen was scarce.

“It was strange being nursed by your colleagues; but I was safe. During the looting, I felt safer in the hospital as I was able to get a hospital bed, medication, the care and treatment. Doctors and pharmacies were closed.” Participant 12)

The patient’s perception of the disease process varied, and the participant below was conscious of the environmental effects.

“I was in an isolation room. I did not feel an increased state of “COVID-ness”. The doctor informed me that I need to take it serious. The results were saying otherwise. Doctor felt that my saturations levels were bad, my lungs and breathing capacity and my weight loss, my hair loss and my appetite… Everything had deteriorated.” (Participant 11)

“The environment was conducive to me getting good treatment. The familiarity of the sounds and layout. I had a lovely window room that I could look out and enjoy nature.

The environment was not too closed; yes it was sealed but the visual aspect carried me through." (Participant 11)

"The hospital is not built for situations like this…if there was more visibility. The isolation room has its pros and cons; it's there for you to heal and not infect everyone." (Participant 11)

5.7.2.3 Sub-theme 2.3 The need for adequate resources to ensure safety and security.

Social wellness and support was lacking due to the non-visitation rule during the COVID-19 pandemic. The aim was to reduce the transmission of the virus and during that time video calling (digital devices example mobile phones and tablets) was the only contact that patients had with their family outside of the hospital. These limited interactions increased the patients' feelings of anxiety and worry which did affect their recovery.

Personal protective equipment (PPE) was available for the staff and patient example surgical masks, face-shields, goggles, aprons, gloves. With sanitisers available at every touch point. Staff in personal protective equipment ensured the patients safety as well as that of the healthcare colleague delivering the care.

The isolation rooms in the COVID unit ensured that the transmission of the coronavirus did not occur, however some participants expressed the feeling of loneliness during their hospitalisation and need for family presence, and resources as evident below:

"It is important to involve the family. The patients needed their support. So we covered our cell phones with the plastic and did the video calls. The patients felt happy." (Participant 3)

"The medical staff treated their patients with support and empathy. They were given their own mobile probes to monitor their COVID patients, which I feel they were well equipped." (Participant 13)

"I think we were more at risk (in the green zone or non-infectious zone), because we were not given N95 masks. We were given the general surgical masks and our patients were asymptomatic at first, then they turned positive. So we were exposed." (Participant 13)

5.7.3 THEME 3: PSYCHOLOGICAL NEEDS

Patient experience is affected by a patients' emotions. The circumstances around the COVID-19 pandemic affected patients' emotions as expressed by the participants below:

"I cried because I was scared and I had fears of ventilation. Then I was relieved that I had a positive result. So I knew what it was, not something else. It was an emotional roller coaster!" (Participant 1)

"What surprised me first was again the rapidity with which I was overwhelmed by the symptoms. First there was a feeling of denial; that this will pass after a few days." (Participant 9)

The common emotions expressed by the participants were fear, anxiousness, worry and embarrassment. The patients' self-esteem was affected.

*"… when the diarrhoea started, a male nurse was looking after me. He came to help me on the bed pan; and I chased him away. He said that's my job and I said no! And to be put on diapers; that I will never ever forget." (*Participant 5)

Initial feelings of shock after being tested for the coronavirus lead to feelings of denial, bargaining, being overwhelmed and acceptance.

"I think I was more in shock that I had COVID, more than anything. And fear of the unknown. It was more the anxiety than the signs and symptoms that affected me…I felt fearful to be admitted. Fear of the unknown, COVID wasn't something that we were all used to…we were still learning in the first wave." (Participant 13)

The healthcare workers as patients were drawing on the empathy and compassion from fellow colleagues and family support was not possible at the time of hospitalisation.

5.7.3.1 Sub-theme 3.1 Building of relations with healthcare workers as colleagues and care workers

The support of fellow colleagues / healthcare workers was reassuring in that the participants were in a patient centred environment. The participants relied on the carers for encouragement and positive feedback on progress.

The healthcare colleagues delivering care were the ones to provide the psychosocial support. Which ultimately drained them emotionally and physically.

The patient had to trust the care delivery by their colleagues; it was reassuring to know the standard of care was at a high level as participants expressed below:

"The nurse who took care of me was up-skilled nurse from the ward… It was full circle for me… I was very relaxed about it, because I knew what I taught them, and I evaluated them; so I knew that they were good to nurse in ICU." (Participant 7)

"I was really impressed. I had a new outlook and respect for the nursing staff. Because they were there for the patients 24 hours in a day. And the degree of care that they gave me and their adherence to the principles of patient care and instructions from the doctor and the way they carried out their procedures with empathy; it was a very sobering and humbling time." (Participant 9)

"The nurses did not treat me differently; they treated me well; however I had my own stigma." (Participant 10)

"I was taken care of by the ICU team, because my stats (oxygen saturation levels) were dropping. I was on continuous oxygen. They were very helpful because the doctors always explained when they examined you." (Participant 13)

5.7.3.2 Sub-theme 3.2 The increased need for family contact and support

The inability to attend to themselves – basic needs of elimination caused embarrassment for the healthcare worker patient. This loss of control and dignity had a profound emotional effect. And in that time of need family were not near.

The emotional security was not available from family due to the cessation of visiting during the COVID-19 pandemic. This lack of human connection affected the patients' emotional state and recovery. Mental health plays a huge role in a patients' healing and progress as is evident in the following excerpts:

To be faced with personal fears was evident with the participants.

"My hospital stay was very frightening; absolutely frightening. Because initially I was making a video will because I thought that I was going to die." (Participant 6)

It was a scary time for healthcare workers – as care givers and as patients. Participants reported as follows:

"That was a challenging moment. My husband was allowed only for the day, for the few hours of my delivery. I needed help and the nurses took too long to don PPE (put

on the personal protective equipment). The baby is far away from me and the baby is crying. I was in pain and emotional and had to ring the call bell for help. It would have been nice if my husband was near to support or hold the baby." (Participant 10)

"Being a nurse in uniform was the scariest – you were a dead person walking. (Because you can contract the virus and pass it on)…People stared at healthcare professionals. You were the COVID virus walking in the streets." (Participant 14)

"Even the visits by my physician colleagues who were checking on me every day. I now understood why patients are so keen on seeing the doctors who are looking after them and if you miss a day out, why it has such a profound effect on the patients." (Participant 9)

"The challenges were within myself, within me. I was trying to restore my faith, to put away all negative thoughts and to forge forward and make up my mind and think positive... In your quiet times you'll be surprised the amount of memories that flood back." (Participant 11)

5.7.3.3 Sub-theme 3.3 The need to strengthen spiritual needs and connections

Humans are social beings, which is clear in the healthcare setting. The patients needed compassion, empathy, love, comfort and support. The participants interviewed expressed gratitude for their colleagues support, prayers, and often hope during their recovery.

It was evident during the interviews that the participants carry a lot of emotions post their COVID admission to hospital. The long term effect of the coronavirus referred to as "long COVID" has affected some participants.

The experience of traumatic grief, faced with death and dying; has had a profound effect and psychological impact on the patient and healthcare worker. The following excerpts from participant interviews:

"I had pulmonary emboli… I told him (the doctor) if you put me there (intensive care unit), I am going to die. Because that's what happens to people who go to ICU." (Participant 4)

"I was overwhelmed. First a feeling of denial. I must confess that I hardly let emotions dictate the way I respond to various things… The word I can use to describe my emotional feeling was one of extreme vulnerability; I had to face my potential demise or mortality. That was a very sobering instant... I didn't panic. Vulnerability was my main emotion. I wasn't angry, I wasn't depressed." (Participant 9)

"God sustained me, because throughout my working period I didn't have COVID.I went on maternity leave, only then I had COVID. Did my random check and found out I was positive. But I didn't have any symptoms. I needed to test before admission. Because I was going to theatre for a caesarean." (Participant 10)

"I was happy (post-delivery), but I was praying at the same time. The baby was fine." (Participant 10)

"The loneliness got to me more than anything else. I had not seen my husband since I got admitted…I got despondent... If we had an isolation unit that was conducive to visitors then the loneliness and my stay could have been better; it could have impacted positive on my length of stay. If we had a glass cubicle that we could see our loved ones…" (Participant 11)

"My mind was busy. I needed to read and I didn't have my Bible. So went onto my phone on the App (application) to read." (Participant 11)

5.8 SUMMARY OF THE CHAPTER

In this chapter the researcher presented the findings according to the themes that emerged from the data analysis of the semi-structured one-on-one interviews with actual excerpts from the participants. The experiences of the healthcare workers as patients highlighted the need for physiological, security and psychological support.

In Chapter 6, the researcher will discuss the findings, recommendations and limitations of the study and conclude the study report.

CHAPTER 6

DISCUSSION OF FINDINGS

6.1. INTRODUCTION

The findings of the qualitative study were presented in Chapter 5 as themes and sub-themes. In chapter 6, the researcher will discuss the results from the findings of the one-on-one, semi-structured interviews with the healthcare participants. The discussion of results are presented with reference to the research questions and objectives of the study. The analysis of the data collected during the interviews with the participants, are discussed according to the theoretical framework of Maslow's hierarchy of needs theory.

6.2. DISCUSSION OF FINDINGS RELATED TO THE THEORETICAL FRAMEWORK

The data collected was based on the study objective, guided by Maslow's Theoretical Framework (Maslow 1943: 375). The specific research questions used Maslow's hierarchy of needs theory to structure the study design. The step-by-step approach elicited and recorded participant's perspectives on their experiences. The exploratory-descriptive study used the theoretical perspective relevant to the research topic to organise the structure for data analysis. Maslow's theory of needs is a theory of motivation, where the five categories of human needs, states that these needs, influences an individual's behaviour. This psychology of motivation helps to understand patients' behaviour. By understanding patients' needs during the COVID pandemic, will help understand how their behaviour impacts on motivation to recovery. The humanistic needs or three core needs of the patients that emerged in correlation with Maslow's theory, were: basic need for survival, need for relationships and the need for growth. The purpose of the research was to understand the physiological, safety and psychological effects of the pandemic on healthcare workers as patients.

6.3. FINDINGS DISCUSSED IN RELEVANCE TO THE OBJECTIVES OF THE STUDY

The discussion of results is focused on the three research study objectives and according to the aim of the study. The objectives were as follows:

1. Explore healthcare workers' experiences whilst being a patient in hospital during the COVID-19 pandemic.
2. Describe factors in the professional practice environment such as the healthcare facility that promotes a negative patient care experience and leading to poor patient outcomes.
3. Determine factors in the professional practice environment such as the healthcare facility that supports a positive patient care experience and an overall improvement in patient outcomes.

The set objectives ensured that the researcher was able to gain insight relevant to the study. The objectives guided the research questions during the interviews, to understand the experiences of healthcare workers as patients during the COVID-19 pandemic.

6.3.1 Objective 1: Explore healthcare workers' experiences whilst being a patient in hospital during the COVID-19 pandemic

The interviews revealed that the participants experienced similar physiological needs: the basic need for nutrition - food and water, difficulty in breathing, and the need for warmth and rest. Patients expressed the need for family support and presence which was lacking due to the restriction on visitation. These basic needs are related to Maslow's hierarchy of needs theory. Firstly, physiological needs of food and water to are required to maintain the patient's nutritional, hydration status and homeostasis, which is required for their healing (Maslow 1943: 32). Furthermore the need for warmth and rest aids in this recovery.

6.3.2 Objective 2: Describe factors in the professional practice environment such as the healthcare facility that promotes a negative patient care experience and leading to poor patient outcomes

Negative experiences expressed by the participants showed the influence of the environment during the pandemic. Isolation rooms may have protected the patient and prevented the further spread of the coronavirus; however it affected the social and relationship needs of the patients. Patients needed to be in a safe and secure environment like the isolation rooms, however they also need the safety and security of family and loved ones. This basic need as per Maslow's hierarchy of needs theory shows that safety and security is integrated into the healthcare continuum (Maslow 1943: 372).

Contributing to sleep disturbance was the need for continuous medical care, day and night. For example the laboratory tests of blood gases at 3am in the morning. Physiologically the participants needed the rest and sleep to have a better patient experience and improve the patient outcomes.

6.3.3 Objective 3: Determine factors in the professional practice environment such as the healthcare facility that supports a positive patient care experience and an overall improvement in patient outcomes

The access to and provision of medical resources like oxygen, intravenous fluids and antibiotics, protective wear, medication was vital. The private health facility was able to secure and procure these requirements that was essential to provision of care.

The professional healthcare providers were able to support their patients as the pandemic progressed – by meeting their safety and psychological needs.

According to Maslow's hierarchy of needs theory, basic physiological and psychological needs are the basis of human needs and to function holistically. Access to medical resources like oxygen to improve patient saturation levels, and to assist with breathing difficulties contributed to a positive patient care experience as well an overall improvement in the patient outcomes.

6.4 RESEARCH QUESTIONS

The following research questions, aligned to the above-mentioned objectives guided the study:

1. How did the COVID-19 pandemic effect healthcare workers or health care professionals as patients?
2. What were the long term effects of the pandemic on healthcare worker's health care professionals?
3. What influenced the outcomes of healthcare worker's health care professionals as patients?
4. How can service delivery be improved on related to customer satisfaction from the perspective of health care workers or health care professionals?

The COVID-19 pandemic affected the healthcare workers as patients, both physiologically and psychologically. The basic human need of survival like the need for oxygen to assist with the difficulty in breathing was evident. Physiologically the effects range from fatigue and exhaustion, joint pains, memory loss and lack of concentration.

Psychologically, the patients experienced extreme emotions of fear, anxiety and loneliness. The long term effects or long-COVID affected the healthcare workers in varying degrees. Some felt a renewed sense of life, sleep problems; whilst others dealt with anxiety. Going through the Coronavirus grief cycle is likened to the Kubler-Ross

grief cycle: feelings of denial, anger, depression, bargaining and finally acceptance (Jardine, 2022: 1).

The influences on the healthcare workers experiences as patients were the need for safety and protection as well as emotional support. The participants expressed the need for family support, hope and encouragement. Improvements include the need for family inclusion and contact. Communication by the healthcare provider as well as listening to the patient's needs. There was no one blanket approach to treating this virus. Evidence suggest that the overall wellness and the effects on mental health will be long-lasting (Park and Quising 2020: 69-88).

6.5 RELEVANCE TO THE THEORETICAL FRAMEWORK

By assessing the quality of care received, the institution can facilitate improvements in healthcare delivery. Maslow's theory of needs conceptualized the hospitalization and illuminated ways in which the health facility can support more responsive healthcare delivery. The health impact of the coronavirus have affected physical, mental, social, emotional, and the spiritual wellbeing of healthcare workers. By applying Maslow's hierarchy of needs to human-centred design and investigating the research results – will expose the need for improved care delivery. The basic human need is survival. Maslow's hierarchy of needs theory is that human beings aim to have their most basic needs met. Illness can affect and interfere with a person's development. He further explains that if a need is not met in one area, a person might have their needs from another area met. For example a person who is unwell or in poor health may have the support of and maintain close relationships with family and friends. The person may thus not have their safety needs met, but community and belonging needs may be met. The needs higher up on the pyramid: esteem and self-actualization are not important at this stage until the safety needs are met (Maslow 1943: 371).

6.6 OVERVIEW OF THE RESEARCH DISCUSSION

The presentation of findings following data analysis was done according to themes and sub-themes. The (3) three majors themes and sub-themes for the experiences of healthcare workers as patients during their hospitalizations were as follows:

6.6.1 THEMES AND SUB-THEMES

6.6.1.1 Theme 1: Physiological needs

Theme 1 sub-themes included:

- The basic nutritional need for food and water
- Difficulty with breathing and the fears associated with the lack of oxygen
- The need for warmth, rest and sleep

6.6.1.2 Theme 2: Safety needs

Theme 2 sub-themes included:

- The need for personal security, protection of family and colleagues
- The need for a safe and non-threatening environment; safe from infection
- The need for adequate resources to ensure security: availability of protective wear (PPE), oxygen and ventilator access and availability, digital devices for video calling

6.6.1.3 Theme 3: Psychological needs

Theme 3 sub-themes included:

- Building relationships with healthcare workers as colleagues and care providers: the need for encouragement, trust and positive feedback
- The need for family contact and support: to be able to face fears and express anxiety

- Spiritual needs and the need to strengthen connections: thus creating hope and allowing beliefs, facing death and dying, post-traumatic stress disorder (PTSD)

6.7 PRESENTATION OF THE RESULTS

The themes are discussed, interpreted and supported with literature where appropriate. The eight dimensions of wellness: emotional, environmental, financial, intellectual, occupation, physical, social and spiritual; were affected by COVID-19.

6.7.1 THEMES AND SUB-THEMES DISCUSSION:

According to Maslow's hierarchy of needs theory; a theory of motivation is where basic human needs are ranked according to perceived importance.

MASLOW'S HIERARCHY OF NEEDS MODEL

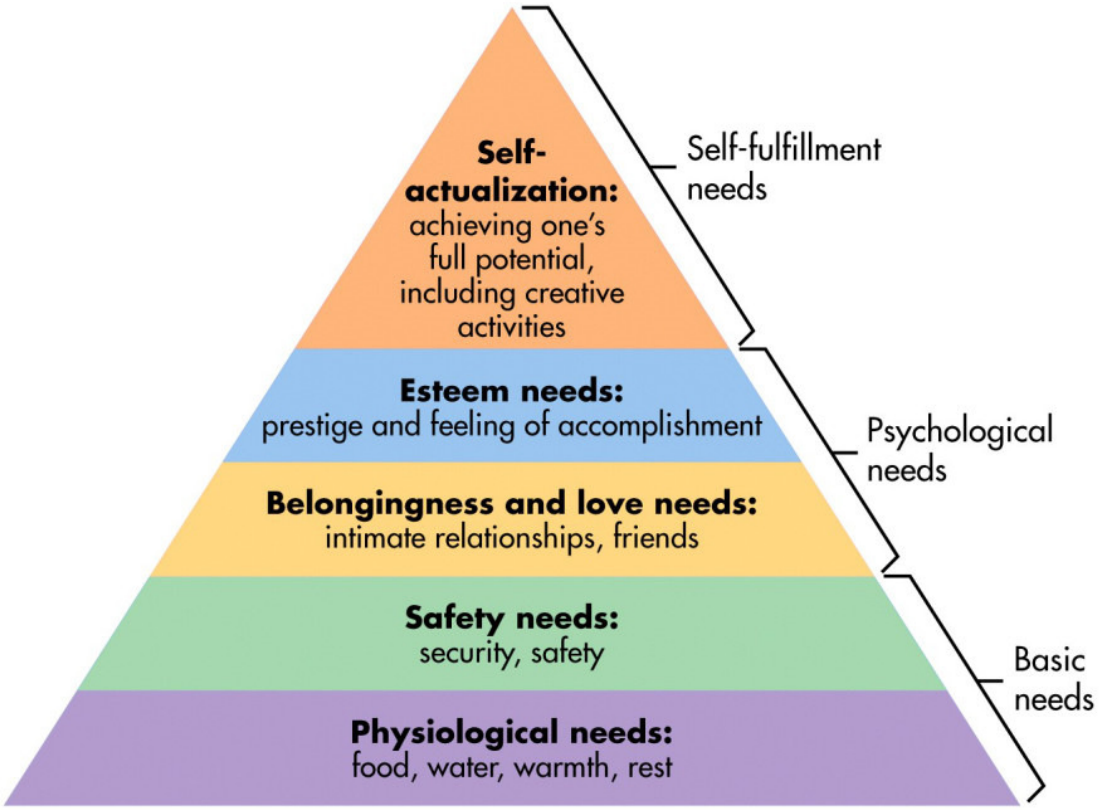

Figure 6.1: Maslow's hierarchy of needs (Maslow 1943: 372)

This pyramid starts at the base or tier 1 with the physiological needs of survival: air (breathing), water, food (nutrition), homeostasis (balance) excretion, warmth, rest, sleep, shelter. It was evident that these basic needs were severely affected by the coronavirus which lead to the participants eventually being admitted to hospital for care and treatment. The physiological needs of nutrition deterioration and the difficulty in breathing were the main needs affected. This imbalance coupled with other signs like pain, affected rest and sleep. The next tier, tier (2) refers to the need for security: personal safety, security of health, resource availability, employment, psychological safety, protection, stability, predictability, freedom from fear.

The patients experienced fears and expressed the need for safety and resources. The healthcare facility was able to provide this environment of protection and healthcare resources.

Tier 3 of psychological needs refer to the need for: relationships, friendships, love and belonging, acceptance, family, sense of connection, tenderness and trust.

The healthcare worker patients showed their mental vulnerability during the expressions of fears – fears of not seeing loved ones, the need for belonging, the need for family connection and support.

Whilst tier 4 refers to esteem needs: competence, positive self-evaluation, dignity, independence, reputation, respect, status, strength, prestige, feelings of accomplishment.

Esteem needs of independence or the loss thereof affected the patient's dignity. The participants expressed feelings of embarrassment and accomplishment during their recovery.

And lastly tier 5 reference to self-actualization: self-fulfilment, growth, understanding, morality, problem-solving, lack of prejudice. Maslow further explained that not everyone will move through the hierarchy in a uni-directional way, but they may move back and forth between the different needs. Maslow later further expanded on the model of hierarchy of needs; to include cognitive, aesthetic and transcendence needs. The goal to self-actualize shows the human need to find a meaning to life that is important to them. Self-actualization involves achieving ones' potential and is not equated with perfection. "There are no perfect human beings" (Maslow, 1970: 176).

6.7.1.1 Theme 1: Physiological needs

The study's findings revealed that the healthcare workers as patients progressed through the stages or tiers of Maslow's hierarchy of needs. The coronavirus attacked the body systems and affected their physiological needs. As the viral infection

progressed participants became weaker as they were unable to maintain their nutritional and hydration state.

This imbalance / not maintaining homeostasis further with vomiting and diarrhoea, led to dehydration, an electrolyte upset and the need for intravenous fluids. The SARS-CoV-2 virus caused acute respiratory syndrome. There was a need for air and oxygen as the virus attacked the lungs / respiratory system. The participants expressed the inability to breathe. Explaining symptoms of tight chest, pain in the chest, breathlessness, and cough. Due to the symptoms above, coupled with fevers and rigors, the participants found it difficult to rest and sleep. These physiological effects contributed to overall weakness and disorientation. These feeling of helplessness and insomnia further exacerbated their feeling of fear, distress, anxiety and depression.

The study highlighted that these fundamental basic needs became a priority for the patients.

6.7.1.2 Theme 2: Safety needs

The progression to the need for safety and security was apparent as the virus consumed the participants. The healthcare workers that were interview at some point realized that they cannot self-treat and needed to seek medical help. The findings of the study show that health safety, security and protection of family necessitated the healthcare workers seeking medical help. The need for a safe healthcare environment with isolation together with medical treatment was sought as the virus overcame the healthcare worker.

Medical resources like oxygen was needed to treat difficulty in breathing and lowering of saturation levels. Fears of the severe viral outcome as known to the healthcare workers prompted them seeking medical care. This psychological security was expressed by the interviewees as they felt secure and safe in the healthcare institution.

The participants contact with family via video calls and social platforms reassured them of their safety, and encouraged their recuperation. These feelings of safety and security gave them hope and belief, and reduced anxiety with a positive psychological

effect. The participants revealed their social need of being connected with loved ones and people who cared, which helped the patients through their difficult time.

6.7.1.3 Theme 3: Psychological needs

The social and human element highlights the participants need to form relationships with their fellow healthcare givers. The study shows that the participants drew on the support and encouragement of their carers / colleagues, as their family and friends were not present due to the cessation of visiting in hospital during the COVID-19 pandemic. Majority of the participants yearned for family contact and support. They expressed fears of being alone and of facing their fears of dying. Some participants expressed their spiritual need of praying and connecting within themselves as a form of hope and peace. The sudden realization of facing their own possible death was intensified as the participants expressed re-evaluation of their values. However not openly expressed, fears of facing one's own death may or may not manifest as post-traumatic stress disorder (PTSD).

The desire for love and belonging through the participants lived experience during the COVID-19 pandemic presented during their grief cycle: of shock, fear and denial, through feelings of anxiety and disbelief, depression – feelings of being overwhelmed and helplessness, reaching out to others and bargaining; and finally acceptance and moving on; in keeping with the Kubler-Ross Model of the 5 stages of Grief Cycle (Jardine, 2022:1).The study highlighted the trust relationship of the healthcare worker as a patient with their healthcare colleagues and care givers.

6.8 SUMMARY OF THE CHAPTER

The study explored the experiences of healthcare workers as patients during the COVID-19 pandemic, at a private health facility in the UMgungundlovu District, KwaZulu-Natal. The researcher drew on the theoretical framework of Maslow's theory of needs. This theoretical framework supported the research study. The researcher's adoption of Maslow's hierarchy of needs drew a link between the topic of inquiry and the study objectives. The current study revealed that the healthcare workers' experiences as patients realized the need for their basic and physiological needs to be met. The COVID-19 pandemic exposed the need for safety and security for patients. The mental health focus on psychological needs of support, with trust and preservation, revealed the call out for help by the healthcare workers.

New ways of delivering healthcare emerged – like staying connected with family through video calls. This accents the need for the family to be involved in patients' health delivery. The findings during the interviews was mostly of fears of the unknown, coming to face ones' own fears, and finding the strength to overcome a virus that changed healthcare delivery models. The study shows that by understanding patient experiences of healthcare workers during the COVID-19 pandemic, it can help the healthcare delivery system prepare and educate healthcare workers on the needs of patients both physical and psychological. The following chapter includes the conclusion of the study, strengths and limitations as well as recommendations for future research on the patient experiences of health care workers.

CHAPTER 7

SUMMARY, LIMITATIONS, RECOMMENDATIONS AND CONCLUSIONS

7.1 INTRODUCTION

The researcher discussed the results from the findings of the participant interviews of the healthcare workers who were patients, in Chapter 6. In Chapter 7 the researcher will discuss the findings and the conclusions that emerged from the one-on-one interviews. Conclusions are based on the results of the study. The aim of the study was to explore the experiences of healthcare workers as patients during the COVID-19 pandemic. Recommendations for future studies and limitations of the study are also discussed.

7.2 OVERVIEW OF THE STUDY FINDINGS

A patients' experience during the COVID-19 pandemic has had a lasting impact on the patient as well as their family. The researcher aimed to illustrate that the patients' experiences of healthcare workers will shape the delivery of healthcare and their practices on return to work. The patient experience has quickly become the most talked about concept in modern day healthcare. By putting the patient central to healthcare service delivery, patient outcomes can be positively influenced. A positive patient experience is the interplay between safety, quality of care and experience. The overall aim was to study the experiences of healthcare workers as patients during the COVID-19 pandemic at a private health facility in the UMgungundlovu District, KwaZulu-Natal. Patient experience describes the healthcare workers experience of illness and how the health service delivery affects them. The patients' experience with hospitalisation, is part of the move towards patient-centred care. The findings of the study exposed the link between patient experience and clinical safety and

effectiveness. There was an overall need for meeting basic physiological needs and psychological support, which influenced the patient experience and patients' recovery.

7.3. LIMITATIONS OF THE STUDY

The study offers useful information on patient experience and patient perception, however it has limited generalisability because of the sample size and the type of statistical analysis conducted. Limitations of the research study includes the methodological approach was at one private institution in the UMgungundlovu District in the province of KwaZulu-Natal. The participants worked at the private hospital facility, which therefore limits the population, and the findings of the study cannot be generalised to the perceptions of other healthcare workers who were patients at other private institutions or government facilities, during the pandemic. Some of the participants appeared anxious prior the interview as concerns of expressing their personal experiences created hesitancy. Emotions also affected a few of the participants which showed the fragile and vulnerable state some were still in. The researcher assured the participants of confidentiality and allowed the expressions of emotions and created a comfortable space. Despite these limitations the following recommendations are made, based on conclusions.

7.4 RECOMMENDATIONS

The COVID-19 pandemic caused healthcare to adapt rapidly in order to meet the increased healthcare risks and demands. The severe acute respiratory syndrome coronavirus (SARS-CoV-2) attacked healthcare systems globally, bringing with it challenges for patients and healthcare workers, never encountered before. Thus, the experiences of healthcare workers or health professionals, as patients during the pandemic, showed the need to fully investigate their customer service experience and the health service delivery. The research study recommendations may be found below.

7.4.1 Patient safety

While patient safety was top of mind for both healthcare giver and recipient, like donning of PPE and handwashing during the pandemic; healthcare delivery was affected with delays. The use of technology which allowed the monitoring of patient's symptoms, reassured the patients of their safe monitoring, nevertheless contributed to the patients' anxiety and stress.

7.4.2 Patient education

Patient education is critical to the compliance with the care received and delivered. The participative approach of patient inclusion in their care plan is important and influences the patients' recovery. A personalised approach to care contributes to co-operative care and mutual trust with patient and care giver.

7.4.3 Patient engagement

By arming patients with key information and educating them, ensures an engaged patient. The assumption that healthcare workers as patients, are aware of health information must not be underestimated. Shared decision-making is a step to improving patient engagement and patient outcomes. This minimizes barriers to care and advocated patient-centred care.

7.4.4 Patient centred care

Patient-provider communication is key. This boosts teamwork and care coordination. Rapid response builds confidence in the patient for the care received. By the care provider using active listening will show that they are focused and committed. Encouraging questions ensures participation. Inclusion of the family in care decisions and sharing knowledge allows mutual belief. For the delivery of continuous care, the power of personal connections should not be underrated.

7.5 FURTHER RESEARCH

To improve on patients' experience, it is essential to conduct more research on healthcare experience. By encouraging feedback more knowledge will be gained on ways to improve. There is a need to acquire understandings of patient perceptions and experiences that will mould the delivery of healthcare.

7.6 ADDITIONAL RECOMMENDATIONS

The research study revealed experiences of healthcare workers as patients, which will provide a better understanding of the need of patients. Studies show the psychological effects on healthcare workers during the COVID-19 pandemic, suggesting that nurses may be at higher risk of adverse mental health outcomes. The patients and health providers were faced with grief, death and dying; and the personal relationships added pressure to deliver quality medical care and psychosocial care. There was a need for care and compassion on both ends of the scale.

7.7 SUMMARY OF THE CHAPTER

The objective of this research study was to understand the experiences of healthcare workers as patients during the COVID-19 pandemic at a private health facility, in the UMgungundlovu District, KwaZulu-Natal. The findings of the study are significant in contributing to shaping healthcare delivery based on patients' perceptions and experiences. The results benefit understanding the experiences of patients in the healthcare setting and offers useful appreciation of patient perspectives. The findings also disclosed the effects and contribution of patient education and engagement. Improved communication was an important aspect of care provision as well as the need for care and compassion. A safe patient environment was not the only need during the pandemic. A patient-centred approach and personal connections became equally paramount, especially as part of crisis intervention and management.

REFERENCES

Abend G. 2008. The Meaning of 'Theory.' *Sociological Theory*, 26(2): 173-199. Available: doi:10.1111/j.1467-9558.2008.00324.x (Accessed 28 August 2021).

Bao, Y., Sun, Y., Meng, S., Shi, J. and Lu, L. 2021. 2019-nCov epidemic*: address mental health care to empower society. The Lancet,* 395(10224): 37-38. Available: https://doi.org/10.1016/S0140-6736(20)30309-3. (Accessed 13 August 2021).

Brink, H., van der Walt, C. and van Rensburg, G. 2012. *Fundamentals of Research Methodology for Healthcare Professionals.* 3rd ed. Cape Town, South Africa Juta and Company.

Brooks, S., Webster, R., Smith, L., Woodland, L., Wessely, S., and Greenberg, N. 2020. The psychological impact of quarantine and how to reduce it: rapid review of the evidence. *The Lancet,* 395: 912-920. Available: DOI: https://doi.org/10.1016/S0140-6736(30)30460-8. (Accessed 23 July 2021).

Creswell, J., 2014. *A concise introduction to mixed methods research*. USA: Sage Publications, Inc.

Daly, J., Jackson, D., Anders, R., & Davidson, P.M. (2020) Who speaks for nursing? COVID-19 highlighting gaps in leadership. *Journal of Clinical Nursing, 29(15-16), 2751-2752. Available:* https://doi.org/10.1111/jocn.15305. (Accessed 1 August 2021).

De Kock, J.H., Latham, H.A., Leslie, S.J., Grindle, M., Munoz, S.A., Ellis, L. Polson, R., and O'Malley, C. 2021. A rapid review of the impact of COVID-19 on the mental health of healthcare workers: implications for supporting psychological well-being. *BMC Public Health.* 21:104. Available: https://doi.org/10.1186/s1 2889-020-10070-3 (Accessed 11 July 2021).

Dimitriou, L., Drakontaidis, M., and Hadjicharalambous, D. 2020. Psychological Resilience, Hope, and Adaptability as Protective Factors in Times of Crisis: *A study in Greek & Cypriot Society during the COVID-19 Pandemic.* Available: https://doi.org/10.37256/ser.20021618. (Accessed 17 July 2021).

Dokov, H., Milkova, K., Stamenkov, I. 2020. Spatial discourses of the COVID-19 multidimensional impacts: *The case of Bulgaria. Working Paper. WP/SU/FGG/20-08. August 2020.* Available: https://doi.org/10.13140/RG.2.2.21905.86889. (Accessed 16 March 2021).

Donga, G.T., Roman, N.V., Adebiya, B.O., Omukunyi, B. and Chinyakata, R. 2021. Lessons Learnt during COVID-19 Lockdown: A Qualitative Study of South African Families. *International Journal of Environmental Research and Public Health.* 18, 12552. Available: https://doi.org/10.3390/ijerph182312552. (Accessed 12 July 2021).

Doyle, C., Lennon, L. and Bell, D. A systematic review of evidence on the links between patient experience and clinical safety and effectiveness. *BMJ Open* 2013; 3:e001570. Available: https://doi/10.1136/bmjopwn-2012-001570. (Accessed 16 July 2021).

Drucker, P.F. 2002. "They're Not Employees, They're People." *Harvard Business Review* 80(2): 70-77. Available: https://hbsp.harvard.edu/product/R0202E-PDF-ENG. (Accessed 16 July 2021).

Fang, C. and Comery, A. 2021. Understanding Grief During the First-Wave of COVID-19 in the United Kingdom – A Hypothetical Approach to Challenges and Support. *Policy and Practice Reviews.* Available: https://doi/10.3389/fsoc.2021.607645. (Accessed 13 July 2021).

Figueroa, C.A., Harrison, R., Chauhan, A. and Meyer, L. 2019. Priorities and challenges for health leadership and workforce management globally: a rapid review. *BMC Health Services Research*, 19:230. Available: http://www.bmchealthservres.biomedccentral.com/articles/10.1186/s12913-019-4080-7. (Accessed 11 July 2021).

Gilbert, P., Catarino, F., Durarte, C., Matos, M., Kolts, R., Stubbs, J., Ceresatto, L., Duarte, J., Pinto-Gouveia, J. and Basran, J. 2017. The development of compassionate engagement and action scales for self and others. *Journal of Compassionate Healthcare, 4.* Available: https://doi.org/10.1186/s40639-017-0033-3. (Accessed 20 October 2021).

Gray, J.R., Grove, S.K. and Sutherland, S. 2017. *The practice of Nursing research. Appraisal, Synthesis and Generartion of Evidence.* Edition 8. Elsevier.

Hay, D. and Oken, D. 1972. The Psychological Stresses of Intensive Care Unit Nursing. *Psychosomatic Medicine:* March 1972-Volume 34- Issue 2- P109-118.

Holmes, E. A., O' Connor, R.C., Perry, V.H., Tracey, I., Wessely, S., Arseneault, L., et al. Multidisciplinary research priorities for the COVID-19 pandemic: a call for action for mental health science. *Lancet Psychiatry* 2020 June, 7 (6): 547-560.

Jason, A.W., Niederhauser, V., Marshburn, D. and LaVela, S. 2014. "Defining Patient Experience". *Patient Experience Journal:* Vol 1. Issue 1. Article 3. Available: https://pxjournal.org/journal/vol 1/iss 1/3. (Accessed: 28 July 2020). P7-19

Joseph, B. and Joseph, M. 2016. The health of healthcare workers. *Indian Journal of Occupational and Environmental Medicine.* May-Aug; 20(2):71-72. Available: https://10.4103/0019-5278.197518. (Accessed 12 July 2021).

Kamara, M.H., Najjemba, R., van Griensven, J., et al. 2017. Increase in acute malnutrition in children following ghr 2014-2015. *Ebola outbreak in rural Sierra Leone. Public Health Action.* 7(1):S27-S33. Available: https://10.5588/pha.16.0084. (Accessed 02 April 2021).

Kim, H., Sefcik, J.S. and Bradway, C., 2017. Characteristics of qualitative descriptive studies: A systematic review. *Research in nursing health,* 40(1), 23-42. Available: https://10.1002/nur.21768. (Accessed 02 April 2021).

Kim, K.S., Sin, S.C.J. and Tsai, T.I., 2014. Individual differences in social media use for information seeking. *The journal of academic librarianship,* 40(2), 171-178. Available: http://hdl.handle.net/10220/20196. (Accessed 20 August 2021).

Kubler-Ross, E. and Kessler, D., 2005. On grief and grieving: Finding the meaning of grief through the five stages of loss. Available: https://www.futurelearn.com/info/courses/dealing-with-loss-covid-19/0/steps/114543. (Accessed 16 May 2021).

Lee, J. 2020. Mental health effects of school closures during COVID-19. *Lancet.* Vol 4. P420-422. Available: https://doi.org/10.1016/s2352-464(20)30109-7. (Accessed 25 July 2021).

Marnewick, C., and Labuschagne, L. 2021. A conceptual framework to improve the delivery capability of an organisation, *Acta Commercii,* Available: http//www.actacommercii.co.za/index.php/acta/article/view/136. (Accessed 12 September 2021).

Maslow, A.H. 1943. A Theory of Human Motivation. *Psychological Review.*

Maslow, A.H. 1987. *Motivation and personality.* 3rd edition. Delhi, India: Pearson Education.

McLeod, S.A. 2018, May 21. *Maslow's hierarchy of needs.* Retrieved from: https://www/simplypsychology.org/maslow.html. (Accessed 15 August 2021).

Miller, R., Swensson, E., and Robinson, T. (2012). *Hospital and Healthcare Facility Design,* Norton (3rd ed., 2012) pp. 25,118.

Morens, D.M. Fullers, G.K. and Fauci, A.S. 2009. What is a Pandemic? *Perspective.* JID 2009:200. Available: https://academic.ouip.com/jid/article/200/7/1078|903237 (Accessed 31 May 2021).

Oliver, M.D., Baldwin, D.R. and Datta, S., 2019. Health to Wellness: A review of Wellness Models and Transitioning Back to health. *International Journal of Health, Wellness & Society, 9(1).* Available: https://scholar.google.com/scholar. (Accessed 08 September 2021).

Oxford South African Dictionary. 2002. 3rd edition. Oxford University Press Southern Africa. ABC Press, Cape Town.

Park, D. and Quising, P. 2020. Why does wellness matter so much in the age of COVID-19? A selective literature review. *Asian Development Outlook 2020 Updates: Wellness in Worrying Times.* P69-88. Available: http//dx.doi.org/10.22617/FLS200256-3. (Accessed 24 July 2021).

Parsons, T. The Sick Role and Chronic Illness. *Body & Society*. 2010; 16(2):72-94. Available: https://10.1177/1357034X10364766. (Accessed 29 August 2021).

Petrillo, G., Capone, V., Caso, D. and Keyes, C.C.C. 2015. The Mental Health Continuum-Short Form (MHC-SF) as a measure of wellbeing in the Italian context. *Social Indicators Research;* 121(1), 291-312. Available: https://doi.org/10.1007/s11205-014-0629-3. (Accessed 28 July 2021).

Pina, I.I., Cohen, P.D., Larson, D.B., Marion, L.N., Sills, M.R., Solberg L.I. and Zerzan, J. 2015. A framework for describing healthcare delivery organizations and systems.

American journal of Public Health. 105, no 4 (April 1, 2015): pp670-679. Available: https//doi.org/10.2105/AJPH. 2014.301926. (Accessed 31 March 2021).

Polit, D., Beck, C. and Polit, D., 2017. *Resource manual for Nursing research, generating and assessing evidence for nursing practice, tenth edition*. 10th ed. Philadelphia, Pa.: Wolters Kluwer, p.741.

Roman, N.V. 2012. Preadolescent psychological well-being: *determining the association with maternal psychological control and family environment*. Available: http://repository.uwc.ac.za/xmlui/handle/10566/2839. (Accessed 8 August 2021).

Ryan, B.J., Coppla, D., and Canyon, D.V. 2020. Disaster Medicine and Public Health Preparedness. COVID-19 Community Stabilization and Sustainability Framework: *An Integration of the Maslow Hierarchy of Needs and Social Determinants of Health.* Available: https://10.1017/dmp202.109. (Accessed 29 August 2021).

Simon, M. 2011. *The role of the researcher.* Available: http//dissertationrecipes.com/wp-content/uploads/2011/04/role-of-the-Researcher. (Accessed 11 May 2021).

Simon, J., Helter, T.M., White, R. G., van de Boor, C., and Laszewska, A. 2021. BMC Public Health. Impacts of the COVID-19 lockdown and relevant vulnerabilities on capability, well-being, mental health and social support: *an Austrian survey study*. Available: https:/doi.org/10.1186/s12889-021-10352-5. (Accessed 16 July 2021).

Sirotich, E., Dillingham, S., Grainger, R., and Hausmann, J.S. 2020. American College of Rheumatology Vol 72, No 7. Capturing Patient-Reported Outcomes During the covid-19 Pandemic: *Development of the COVID-19 Global Rheumatology Alliance Patient Experience Survey*. 871-873. Available: https://DOI/10.1002/acr.24257. (Accessed 7 August 2021).

Sterling, R.S., Berry, S.A., Herzke, C.A. and Haut, C.R. 2021. Patient Safety and Quality Improvement Adaptation During the COVID-19 Pandemic. *American Journal of Medical Quality.* January/February 2021 – Volume 36 – Issue 1 – p57-59. Available: https://doi: 10.1097/01.JMQ.0000733448.50484.98. (Accessed 13 July 2021).

Strout, K., Ahmed, F., Sporer, K., Howard, E.P., Sassatelli, E. and Mcfadden, K., 2018. What are older adult's wellness priorities? A qualitative analysis of priorities within multiple domains of wellness. *Healthy aging research, 7(2),* 21-39. Available: http://dx.doi.org/10.1097/HXR/000000000000021. (Accessed 15 August 2021).

Thamrin, D. 2020.Patient journey mapping: What you need to know. Available: https://www.qmatic.com.blog/patient-journey-mapping. (Accessed 30 July 2021).

Thimmapuram, J., Pargament, R., Sibliss, K., Grim, R., Risques, R. and Toorens, E., 2017. Effect of heartfullness meditation on burnout, emotional wellness and telomere length in health care professionals. *Journal of community hospital internal medicine perspectives, 7(1),* 21-27. Available: https://DOI: 10.1080/20009666.2016. (Accessed 10 August 2021).

Tucker, A., Pleasants, S., Hullman, G., Lindemann, E., Thompson, J.A., Billecke, S., Badlani, S., and Melton, G.B. Rapid implementation of a COVID-19 remote patient monitoring program. *Journal of the American Information Association*. 2020 Jul; 27 (8): 1326-1330. (Accessed 6 August 2021).

Wolf, J.A. Niederhauser, V. Marshburn, D. and Lavela, S.L. 2021. Re-examining "Defining Patient Experience": The human experience in healthcare. Patient Experience Journal. Vol 2 | Issue 1. Article 4. Available: https://DOI:10.35680/0247.1594. (Accessed 30 May 2021).

Wynne, R. Davidson, P.M., Duffield, C. Jackson, D. and Fergusen, C. 2021. Workforce management and patient outcomes in the intensive care unit during the COVID-19 pandemic and beyond: a discursive paper. *Journal of Clinical Nursing.* Available: https://DOI:10.111/jocn.15916. (Accessed 14 July 2021).

APPENDICES

APPENDIX A: UNIVERSITY ETHICS CLEARANCE: IREC 116/22

Institutional Research Ethics Committee
Research and Postgraduate Support Directorate
2nd Floor, Berwyn Court
Gate 1, Steve Biko Campus
Durban University of Technology

P O Box 1334, Durban, South Africa, 4001

Tel: 031 373 2375
Email: lavishad@dut.ac.za
http://www.dut.ac.za/research/institutional_research_ethics

www.dut.ac.za

14 July 2022

Mrs R Beekrum
P.O. Box 202
Pietermaritzburg
3200

Dear Mrs. Beekrum

Experiences of Health Care Workers as patients, during the COVID-19 pandemic at a private health facility in the uMgungundlovu District, KwaZulu-Natal.
Ethical Clearance Number: IREC 116/22

The Institutional Research Ethics Committee acknowledges receipt of your gatekeeper permission letters.

Please note that FULL APPROVAL is granted to your research proposal. You may proceed with data collection.

Any adverse events [serious or minor] which occur in connection with this study and/or which may alter its ethical consideration must be reported to the IREC according to the IREC Standard Operating Procedures (SOP's).

Please note that any deviations from the approved proposal require the approval of the IREC as outlined in the IREC SOP's.

Yours Sincerely

Prof J K Adam
Chairperson: DUT-IREC

APPENDIX B: LETTER OF REQUEST TO MEDICLINIC TO CONDUCT RESEARCH

Appendix B:

LETTER: REQUEST FOR PERMISSION

Dear Mrs Tabitha Lolliot

I am registered for a Master's Degree at the Durban University of Technology, in the Faculty of Health Sciences.

The topic of my research study is: Experiences of healthcare workers as patients, during the COVID-19 pandemic, at a private health facility, in the UMgungundlovu district, KwaZulu-Natal, South Africa.

The aim of this study will be to explore the experiences of healthcare workers as who were admitted as patients during the COVID-19 pandemic, at a private healthcare facility in the UMgungundlovu district in KwaZulu-Natal.

Data collection: The study will be conducted using a qualitative research design. An exploratory, descriptive research design will be used. The target population for the study will be healthcare workers who were infected and admitted as patients during the COVID-19 pandemic. The data will be collected using semi-structured interviews.

Interview process: Interviews will be conducted by the researcher in a private room. COVID-19 protocol will be maintained: sanitizing on entry, wearing of masks and social distancing. Should the direct / in-person interview not be possible, then the interview will be conducted via online medium: Zoom, Teams, Skype or WhatsApp video call.

I hereby request permission to conduct the research study at Mediclinic Pietermaritzburg. Should you require, my research proposal can be forwarded for your perusal. Your permission to conduct this study will be greatly appreciated.

Kind regards,

Reshnee Beekrum

APPENDIX C: SAMPLE OF DEMOGRAPHIC INFORAMTION

Appendix C:

DUT DURBAN UNIVERSITY OF TECHNOLOGY

INSTITUTIONAL RESEARCH ETHICS COMMITTEE

DEMOGRAPHIC INFORMATION

Title: DR

Participant#:

Gender: M

Date of birth: 20TH MARCH 1964

Race: BLACK

How long / years of service as a healthcare worker: 35 YEARS

What position you hold as a healthcare worker: SPECIALIST NEUROSURGEON

Dates you were admitted: 27-31.01.2021.

Email address: shc@vodamail.co.za

Telephone / Mobile number: 0824490245

APPENDIX D: INTERVIEW GUIDE

Appendix D

INTERVIEW GUIDE

Ice breaker>
Greet. My name is Reshnee. Thank you for agreeing to participate in my research.
Tell me a bit about yourself?

Introduction:
My interest has led me into looking at how the COVID-19 pandemic affected patients during their in hospital stay.
What are your thoughts on this?
What was your experience like?

Possible probing questions:
Considering the effect of the pandemic on the healthcare system – do you think there were influences or complications that could have affected your stay?
What do you think could have been done differently?

As a healthcare worker how did you experience your hospital stay?
What challenges did you experience?

How would you rate your overall care? 1-10 scale, 10 being excellent. Give reasons.

Did the healthcare team listen carefully to you / your requests?
Or take the time to include you in the treatment plan?

Any experiences / perceptions of staff attitudes?
Did the team treat you with courtesy and respect? Explain.

Did you feel safe? Why?
Did you receive support / comfort – addressed emotional needs?

APPENDIX E: LETTER OF INFORMATION

Appendix E

LETTER OF INFORMATION

Title of the Research Study: Experiences of healthcare workers as patients, during the COVID-19 pandemic, at a private health facility, in the UMgungundlovu district, KwaZulu-Natal, South Africa.

Principal Investigator/s/researcher: Reshnee Beekrum, BA (Cur)

Co-Investigator/s/supervisor/s:
Main supervisor: Dr Shanaz Ghuman PhD, Masters in Public Health (Senior Lecturer)
Co-supervisor: Dr Vasanthrie Naidoo Doctorate in Nursing (Senior Lecturer)

Brief Introduction and Purpose of the Study:

Good Day.

I am a student at the Durban University of Technology (DUT) doing research for my Master's degree in Health sciences.

I would like to invite you to participate in my qualitative research study on patient experience during the COVID-19 pandemic; a study to investigate your experience as a patient and on how to improve the patients' experience and enhance the quality of care. The COVID-19 pandemic has had far-reaching negative impact on healthcare systems worldwide, and has placed healthcare providers under immense physiological and psychological pressures.

Research shows that through investigation and collaboration, the human experience can be elevated in healthcare. This transformation can influence the patient outcomes and compliance. The relationship between the patient and healthcare providers is crucial in the holistic care of the patient. Therefore the aim of the current study will be to undertake an in-depth exploration of your experiences as a healthcare worker as a patient during the COVID-19 crisis.

Outline of the Procedures:
If you agree to participate in this study, you are required to sign a letter of informed consent.
For research purposes you will complete a form to capture your demographics.
The research process will entail a semi-structured interview.

Aim: The aim of the study will be to explore the experiences of healthcare workers as patients during the COVID-19 pandemic at a private healthcare facility in the UMgungundlovu district, KwaZulu-Natal.

Objectives:

Explore healthcare workers' experiences whilst being a patient in hospital during the COVID-19 pandemic.

Describe factors in the professional practice environment such as the healthcare facility that promotes a negative patient care experience and leading to poor patient outcomes.

Determine factors in the professional practice environment such as the healthcare facility that supports a positive patient care experience and an overall improvement in patient outcomes.

Although your name will be required and used in the interview process it will be replaced by a code and eliminated from all the recorded data. Anonymity will be maintained throughout the rest of the research process. Once you have completed the relevant paperwork (letter of consent, and demographic form,) I, Reshnee Beekrum, the researcher, will contact you and set up an interview date and location.
The interview can be conducted in person or online on Zoom, Skype, MS teams or WhatsApp, at a location convenient to both interviewee and researcher. COVID-19 protocols will be followed. The interview will be approximately 45 minutes / an hour in duration and contain open ended questions around the topic outlined above.
The interviews will be recorded for analysis afterwards. A summary of the results and the final dissertation will be made available to you once they have been compiled. In this qualitative research study the semi-structured interview will be transcribed and deeply analysed to identify themes and look for the meaning within the information obtained.

Risks or Discomforts to the Participant:
There will be no risks to you, if you decide to participate in this study. Due to the nature of a semi structured interview, it is possible for emotional risk or discomfort to incur during the interview process. This will be kept to a minimum by ensuring that only information outlined in the topic above will be addressed during the interview process and you as the participant only have to talk about and share information you wish to share.

Explain to the participant the reasons he/she may be withdraw from the Study:
In order to minimize any discomfort or harm during the research process it is important to note that you, as a potential participant, can withdraw at any time example for reasons such as ill health. Likewise the researcher under certain circumstances may withdraw the participant from the research; however you will be informed accordingly.

Benefits:
Your full cooperation will assist in expanding the knowledge on the subject. Thus, helping others and enhancing the quality of care.

Remuneration:
No remuneration will be given to participants of this study.

Costs of the Study:
There will be no cost to you, in participating in this study. The only cost to consider will be the valuable cost of your time which will be greatly appreciated.

Confidentiality:
All interview recordings and transcripts will be kept in confidence. The interviews will be conducted and transcribed solely by the interviewer who will need your name for practical reasons. All recordings and transcripts following the interview will have no identification details on them to maintain confidentiality.
The transcripts (not containing any identity details) will be analysed by the researcher as well as the supervisors mentioned above therefore confidentiality will be maintained. All personal information is confidential, and the final results of the study will be made available in the Durban University of Technology library in the form of a dissertation.
None of your individual responses will be made available to other patients or the university. The other participating parties will only receive the information regarding this study after all the data has been collectively analysed, meaning that your individual data will not be identifiable.

Results:
All results will be disseminated to the participants via e-mail once it has been compiled. The dissertation will be available in the DUT library for interested parties to read if they would like. An article summarizing the study and its findings will be drafted for possible publication.

Research-related Injury:
There should be no injury incurred in the research process. If any emotional harm is experienced during this process counselling can be arranged to help you process and work through any unforeseen emotional trauma that might have arisen.

Storage of all electronic and hard copies including tape recordings:
All data, recordings and transcripts obtained during the research process will be stored electronically which will be password protected, for a duration of 5 years which is a legal requirement of the ethics board. During which is can be made available if necessary, for litigation purposes. After which point it will be destroyed. During the research process only, the researcher will have access to your information.

Persons to contact in the Event of Any Problems or Queries:
Please contact the researcher: Reshnee Beekrum (082 731 3760) or supervisor: Dr Shanaz Ghuman at: 031 3732807 or shanazg@dut.ac.za or the Institutional Research Ethics Administrator on 0313732375. Complaints can be reported to the Director: Research and Postgraduate Support Dr L Linguino on 031 373 2577 or researchdirector@dut.ac.za.

APPENDIX F: SAMPLE OF CONSENT

Appendix E:

CONSENT

Full Title of the Study: Experiences of healthcare workers as patients, during the COVID-19 pandemic, at a private health facility, in the UMgungundlovu district, KwaZulu-Natal, South Africa.

Names of Researcher/s: Reshnee Beekrum, BA (Cur)

Statement of Agreement to Participate in the Research Study:

- I hereby confirm that I have been informed by the researcher, Reshnee Beekrum, about the nature, conduct, benefits and risks of this study - Research Ethics Clearance Number: *IREC 116/22*.
- I have also received, read and understood the above written information (Participant Letter of Information) regarding the study.
- I am aware that the results of the study, including personal details regarding my sex, age, date of birth, initials and diagnosis will be anonymously processed into a study report.
- In view of the requirements of research, I agree that the data collected during this study can be processed in a computerized system by the researcher.
- I may, at any stage, without prejudice, withdraw my consent and participation in the study.
- I have had sufficient opportunity to ask questions and (of my own free will) declare myself prepared to participate in the study.
- I understand that significant new findings developed during the course of this research which may relate to my participation will be made available to me.

STEWART WINTER CHIPO	27.09.2022	12:45
Full Name of Participant	**Date**	**Time**

I, Reshnee Beekrum herewith confirm that the above participant has been fully informed about the nature, conduct and risks of the above study.

6 August 2020

APPENDIX G: APPROVAL TO CONDUCT RESEARCH AT MEDICLINIC

MEDICLINIC

MEDICLINIC CORPORATE OFFICE
25 DU TOIT STREET
STELLENBOSCH
7600

PO BOX 456
STELLENBOSCH
7599

T +27 21 809 6500

www.mediclinic.co.za

Our ref: 20220706-Reshnee Beekrum-DUT
Date: 11 August 2022
Mrs Reshnee Beekrum
E-mail: Reshnee.Beekrum@Mediclinic.co.za
Copies to: Tabitha.Lolliot@Mediclinic.co.za

Dear Mrs Beekrum,

APPROVAL TO CONDUCT RESEARCH AT MEDICLINIC PIETERMARITBURG

Your research study entitled: "**Experiences of Health Care Workers as patients, during the COVID-19 pandemic**" refers:

1. **Degree level**: Masters

2. **Study Aim:** Explore the experiences of healthcare workers as patients during the COVID-19 pandemic at a private healthcare facility in the uMgungundlovu district, KwaZulu-Natal.

3. **Study design and methodology:** Qualitative research and exploratory-descriptive (interviews and demographic questionnaire).

4. **Mediclinic contact person**: Miss Nomfundo Maseko, Research Coordinator.

5. **Access conditions:** A research invite will be sent to the Mediclinic Pietermaritzburg Hospital WhatsApp group by the Hospital General Manager, Tabitha Lolliot. Interested participants will directly contact you.

Kindly submit a written summary/closing report to research@mediclinic.co.za within 30 days of the study end date stipulated in the protocol. Should your research period surpass the initial period indicated in the protocol ending, you will be required to apply for an extension.

DR MELANIE STANDER
Acting Chairperson: Clinical Research Committee

APPENDIX H: SAMPLE LETTER OF INFORMATION / INVITATION TO PARTICIPANT

MEDICLINIC
PIETERMARITZBURG

90 PAYN STREET
PIETERMARITZBURG
3201

PO BOX 3342
PIETERMARITZBURG
3200

T +27 33 845 3700

ETHICS LINE 0800 005 316

www.mediclinic.co.za

Dear Suzan Mntambo,

As a student at DUT [Durban University of Technology] conducting research for a Master's degree in Health Sciences, I invite you to participate in my qualitative research study on Patient experience during the COVID-19 pandemic.

This study is to investigate your experience as a patient, and on how to improve the patients' experience and enhance the quality of care.

The aim of the research will be to undertake and in-depth exploration of your experiences as a healthcare worker, as a patient during the COVID-19 crisis.

Should you agree to participate in the study, you are required to sign a letter of informed consent. For research purposes you will complete a document to capture your demographics. The research process will entail a semi-structured interview.

Although your name will be used in the interview process, it will be replaced by a code and eliminated from all the recorded data. Anonymity will be maintained throughout the rest of the research process.

Please contact **Reshnee Beekrum**, the researcher, on mobile number **0827313760**, via voice, text, or WhatsApp, so that an interview can be arranged.

Your participation will assist in expanding knowledge on the subject. Thus helping others and enhancing the quality of care. Thank you.

Yours in healthcare,

_ 22 August 2022_

Reshnee Beekrum Date

Jane Blackbeard [HRBP]

mohlotli@gmail.com

MEDICLINIC (PTY) LTD
REG. NO. 1969/009218/07

APPENDIX I: SAMPLE OF TRANSCRIPT OF PARTICIPANT INTERVIEW

PARTICIPANT 11 [LILLY V. NARAINSAMY]
03/10/2022 10:13 – 10:47am

RESHNEE BEEKRUM: Good morning Lilly. As you know my name is Reshnee Beekrum. And thank you so much for participating in this research study. Today is Monday, 3rd October 2022, and it is now 10:13am. I appreciate your time to come out to feedback to me. As you have received my letter of information. I am doing a research study on healthcare workers who were admitted patients during the COVID pandemic. At the outset maybe just tell me a little bit about yourself.

LILLY V. NARAINSAMY: *Lilly Narainsamy; working at Mediclinic for 20 years. Married, I have two grown up daughters and I am in the accounts department. And I love working at Mediclinic.*

Ok. Great. Alright.
So, Lilly as you understand, my interest in the COVID pandemic brought me to think about how patients felt during their stay at a hospital. And more so being a HCW and how it affected you. The pandemic changed the world, it changed our hospital, it changed the community. Tell me your thoughts about this.

It was a very difficult situation, being a HCW. And all the precautions that you had taken and all the advice and information that was shared really brought unanswered questions to my mind and that lingered for quite a long time; as to where it happened, how it happened. And was I at fault or was anyone close to me at fault; how can I find this out – so there were a lot of questions that really bugged me and took a lot of my time.

Ok. So you were obviously quite affected by this pandemic. During the start of the pandemic, like you say you work in the accounts department. How did it affect you working in the hospital in the accounts department?

Being already informed that you have COVID and that I had been admitted – I had to get back on my feet and back to work. I found that I did things a bit different. I took longer to understand, longer to interpret and to execute the normal tasks I was given. My case was exceptionally different being that I has a speech problem and that was very strange. Most of them found it very strange including the doctor. I developed sores in my mouth which was very painful and took quite some time to heal. It restricted me with my talking and also with my eating habits. The impact was when I returned to work I had to decide when I need to speak which was important and when I could just be quiet and also I was on medication. So that really impacted me seeing that I'm a person who does like to speak.

OK. And your job entails a lot of speaking?

It does. I have to communicate with various colleagues and with the theatre staff and on the phone as well. And it was not feasible for me to speak because I had to repeat myself a number of times.

Let's go back to the beginning. How did you find out that you had COVID?
It was the high temperature, the coughing and the headaches, which on a Monday morning returning to work. Felt my body not being the same. I felt there was something hindering me from going about my early morning routine. But then I pushed through, through the day and in the afternoon went for a test. And did my test and got the results on my cell phone indicating that I am COVID positive.

How did you feel at that time?

I was at home when the results came – I was in the lounge and I remember my husband and I were busy talking and when I saw the results I just burst our crying. I said have a look at this. He read the results and yes also he was being tested and found out to be positive as well.

OK. So from the time you were crying and came into hospital – tell me about that time. At which point did you realise that you needed to be hospitalised?

We were advised to isolate and practice the COVID protocols at home which was fairly easy for my husband and I, seeing that we are the only two in the house. And we planned things quite you know to the tee and followed that routine for the first three days. And then on the fourth day I was relaxing in the lounge then I got a call from my mum – not my mum; I got a call from my cousin who lives close to my mum. And she said that the whole family is COVID positive. So I got quite surprised at that 'cause that's the house my mum frequents on a daily basis seeing that she's alone. And as I'm being told that my mum enters the house. So my mum went to visit my cousin unknowingly that the entire house is COVID positive. And I'm at my place and this message is being relayed to me that my mum is there, and they don't know what to do. So I panicked at my place which is a good 20ks from Northdale to town. So I panicked and in that I really went hysterical. There was shortness of breath and I was uncontrollable because this was something I felt I needed to sort out but I couldn't in the state that I was in. And that's where I had a panic attack and I couldn't breathe and nothing my husband could do could help me and then the ambulance was called and that's how I ended up coming into casualty at Mediclinic.

OK. Tell me about what happened in the EC.

When I came into the Casualty at Mediclinic I was asked if I had done the test and I said yes. But the paramedic had already relayed the information what transpired when they came to my house and the details were transferred to the sister in charge. And then I was taken to a bed immediately which was available, and it was also isolated. There was protection.

Are you talking about the EC?

Yes.

So you were in a bubble?

Yes. And after the paramedics had transferred the information and did the hand over I was attended to by the EC doctor.

OK. At that time that you came into the EC did you think you were going to get admitted?

The thought never crossed my mind. I thought it was a Casualty visit, and that they would stabilize me and reassure me and give me a script or medication and that I'll be out of Casualty not more than an hour or two. By that time not realizing that the doctor had ordered more tests and that they felt that it was necessary for me to be admitted.

So these tests were done. And then you were told that you are going to be admitted to hospital. How did you feel then?

I was upset. How can I say? I was angry. I was visibly shaken. I was trying every avenue to avoid being admitted. I gave every excuse that I could – and I'll be fine. I reassured the doctor that I would medicate myself. I need to go home, I need to find out what's happening at home. The doctor said that you are not in a state to go home because you've come already – a heavy, heavy heart and if you go home you are not going to worry about yourself; so let us take care of you. And this is not going to be hard, this is familiar terrority – you'll be fine. So there was a lot of people advising me that the best was for me to be admitted.

And then from the EC where did you go?

I was taken to medical ward.

At that time it was the COVID ward?

Yes.
I was taken to an isolation section in the medical ward.

Was there anything… So now you are admitted to hospital getting the treatment and care. At which point you said there were complications that extended your length of stay?

It was… my stay in the hospital was new to me 'cause the last I ever remember staying in hospital was about 15 to 19 years ago when I had my wisdom removed. That was a day case. Even though I work here this was totally new for me. Trying to adjust and me being the patient. So my sleeping habits were way off. I couldn't fall asleep. And my medication was given to me on time. The doctor's strict instruction was for me to lie on my stomach which I found very difficult. And as much as I tried there were times when no one was present I would go back and lie on my back. It was difficult. And

needless to say the first 3 days I had severe diarrhoea so that was very, very – how can I say – embarrassing to me because I had messed myself numerous times. And it's something that I was very aware of and you know ashamed and felt very dirty if you could say. And there was a lot of clothes that had to be sorted out. And my personal belongings had to be sorted out 'cause it worried me. And until I got it sorted out then I was fine.

So you lungs were badly affected?

It was – the doctor…

Were you on oxygen therapy?

Yes.
The doctor had informed me that I need to take it serious. For me I felt that I was fine – I wasn't in any pain. I wasn't feeling any way different than when I did from the first day. I didn't feel and increased state of "COVID-ness" or whatever you could call it. I just felt that I've come into Casualty, and I'm in the ward but I'm still the same; but the results were saying otherwise. The doctor felt that my saturations levels were bad, and my lungs and breathing capacity and weight loss, my hair loss and my appetite – everything had just deteriorated.

Ok – were you afraid at that time?

I'll tell you that the thing I was afraid of was being alone in that room. For some reason or the other, the loneliness got to me more than anything else. The fact of me having COVID didn't bug me that much – but the loneliness – the visitors – I hadn't seen my husband from the time I got admitted. And the sisters of the different shift – they were the most time - the people I would speak to, the cleaners. Obviously the calls, video calls and Skype; those kind of communication methods I used. But after the 4th day or so I got very despondent.

So you feel you had lost control of yourself, and it was embarrassing. It was probably the effect of drugs or the effect of the COVID.
Did you feel safe?

Yes.
I think the environment was conducive to me getting good treatment. And getting back onto the road to recovery. And also the familiarity of the sounds and the layout – and I had a lovely window room that kept me … in the mornings I could see the nature; I could enjoy. Even though I wasn't physically there to touch. I think the whole idea of being in an environment that was not too closed – yes it was sealed. The sounds were out but I think that the visual aspect carried me through.

Was there anything – when you look back now – was there anything we should have done differently?

I think it's that loneliness. That loneliness I think could have been handled differently.

The hospital is not built to cater for situations like this. But the hospital improvised to cater for family members and to cater for visitors. Bit I somehow felt that if we had an isolation unit which was conducive to visitors and family members I think your stay, or my stay could have been dealt with in a better way – I could have worked on it. To see loved ones could have impacted in a positive way on my stay on the length of my stay and the whole healing process. You know if there was a glass cubicle where we could see our loved ones where we don't have these concrete walls and stuff like that. The more visibility… because I think they were people in the same ward. Isolation has its pros and cons. It's there for you to heal and to not infect everyone – for you to be away from the environment from where the infection is bad. I honestly felt being a first time patient for that amount of 10 days – the loneliness was the biggest issue.

And more-so you say you came in the start of your admission was this panic attack. So you were worried about what's happening at home, your mum's status – because she was visiting a home that was COVID positive household. And that your husband was positive. How were they while you were in hospital?

There was constant contact with my husband via the cell and video. He was fine, he was coping, he was medicating. And then my daughters arrived and it was company for him – I think he wouldn't have managed if he was alone. The day I got admitted they immediately came down to KZN. You could see the encouragement and someone there, giving him advice and speaking to him and allowing him to grieve because I'm in hospital. It was good for him. My mum as well – I did hear at a later stage that she was emotional. But she did not get COVID. She went for the test and she did not get COVID, even though she had visited that household. She's doing very well and her time of being alone was a reflection because there was no call from me, there was no messages from me but she was relying on other family members relaying my well-being to her.

So you stayed for those 10 days. How would you rate your care with 1 / 0 being not so good and 10 being excellent?

I would rate it … say 9 the nurses were excellent and they understood because they were also recovering from COVID, so they understood fairly well the needs of the COVID patient.

Did you experience any challenges?

The challenges were within myself – within me. It was not anything to do with the ward or the staffing. It was within myself – it was me trying to restore my faith. To put away all negative thoughts and to forge forward – to make up my mind and think positive. To make up my mind in getting better and moving forward.

So if I'm listening to you carefully – COVID didn't only affect you physically, it also affected you emotionally.

Yes.
It did a lot in that area. In a negative way. In your quiet times you'd be surprised the

amount of memories that flood back. And it's not one-sided – it's everything from negative to positive. From the things you should have done and should have said and the things you hadn't done and promised to do. So in the quiet time you are using your thoughts in your mind – you are using everything that your memory can bring out and you are trying to process this but the advice from everybody and the doctor – and the recommendation is that you should be resting and healing. But you have these thoughts that you are juggling in your mind. And I needed to read – and that was another thing. I didn't have a book to read and I didn't have the Bible so I went onto my phone – went onto the App to read. But then you also have to be careful now I needed to charge that phone. And the first 2 days I didn't have a charger until someone had to get me a charger. So when my personal belongings were brought through I had to ask for a charger from home. So I'd say the initial 2 days was a lot of stumbling blocks there, but after that I was comfortable with what I had and I made it work.

From you colleagues – the healthcare team; did they include you, did they listen to you?
How was their attitude toward you – the fact that they knew you?

I think that it was very easy. From morning till afternoon – with the different shifts. I think that communication flowed seamlessly. It was old friends. I was sitting at the window one morning, and a lady came from the back and blocked my eyes and she said guess who. And I gave every name I could think of and I asked her to carry on speaking so that I can make out her voice. And then I said is it Mavis? And she said it's Mavis. So Mavis and I go a long way – she's here over 20 years.

Mavis Sithole?

Yes.
So I asked what are you doing here. She said she heard I'm admitted, but she's not working here. She came to visit me. So she said what happened and I told her. She said you need to be careful and take it easy. So I was quite surprised – so when they meet in the corridors or on their breaks or on their route home – they probably say did you hear Lilly's admitted. And she remembered and came to visit me that day.

That's very special.
Lilly is there anything that stands out in your mind – when you look back now? Of how this COVID virus changed you / affected you? How do you feel you came out of it?

I'm glad that I got discharged and was given ample advice on the way forward and living a healthy life. But it has done some damage. It's like not doing things as quick as I used to do, as fast as I used to do. And it's not allowing me to be the extrovert that I used to be. It's also made me very aware of cleanliness and hand washing and sanitizing. And the precautions when you cough and sneeze and when you are around. So it's heightened my knowledge on that in areas which I would have never have taken seriously for. And it's also made me very aware to read things that are given and to make notes. It's where I overlooked certain things and brushed certain things – it's brought me to focus on that and to understand what I'm reading. In all spheres – in the group setting in the home and in my work environment.

So you are saying that this virus and experience has changed you?

It has. How can I say – it would be not true. It would not be true if I say that nothing has come out of this or that I'm the same Lilly that used to be or that I used to be before August 2021. It's not the same. It's changed – some may have noticed, some may have not noticed. But I definitely notice a change in me. And I think my husband – because we are together all the time. It would be very hard for someone to say you've changed, unless you are with them for a long period of time. Physically yes – there's the hair loss and the weight loss; but that could happen with any other illness. But with COVID it has really opened my eyes and made me look at life differently.

You mentioned these thoughts you had in you "alone time". When you were discharged from hospital, did you speak to anyone, did you get any help or counselling after discharge? Were you strong enough, were you brave enough?

I did seek help available from the company, because the thoughts were very pronounced. That room made me so scared that I – there was a cupboard and I would like to stand behind the cupboard. And when the doctor came to look for me he couldn't find me because I was behind the cupboard. So for me there was things in that room there was sounds; there was a feeling in that room that I didn't like. So if I went to stand in the side of the cupboard I felt like I was away from where this feeling in this room was presenting. So the doctor asked what is the problem and why I always stand in the corner? So I said I don't want to be here, I don't want to see this… And it was only a bed and a normal cupboard and the drip stand and the curtains and the bin – and that was it and a chair – nothing else. But there was things all over the room – all over the room that I didn't want to see. I cannot describe it, I cannot give you an outline of it. It was just there. It was a feeling. That corner by the cupboard was my safe place.

I understand.
So you did get help from INCON?

And my doctor KT Naidoo referred – asked Dr Sacoor to come and have a look at me. So Dr Sacoor came and he brought his technician and they did a brain function test. He told me that I need to take it easy and he told me that if anything is bothering me I need to speak about it. He asked me how my day is, what do I do, when do these thoughts happen; how does it happen and was it like that before. And I said no. I could be in my house I could be at someone else's house – I'm comfortable I would not see anything, I would not hear anything. I'll be present, everyone in that room will be present. I'll be present just like how they are present. There'll be nothing interfering or any unseen sounds or voices. So I said that there's something in this room that I am just not comfortable with. So he checked me and gave me medication, spoke with Dr KT Naidoo and told me that if I ever went through it again I need to come and see him.

Have you seen him again?

When I got discharged there wasn't a need to see Dr Sacoor. But I did a follow-up with Dr KT Naidoo and he check on how I was doing and I told him I am fine. I can be in a

room and I am not scared of anything. I don't find a safe place. Everything is open to me and I can make use of it fully.

Do you thing that was an effect of COVID? And beside the hair loss and weight loss, do you have any other long term COVID effects?

It would be the shortness of breath when you are rushed. I could be doing something that needs urgent attention and I could do it fine = before COVID. The breathing everything would be there but it would not be so exhausting and overwhelming. Now the very same function if I had to do it and it had to be done and there's a time constraint – then I'm exhausted already. The thought of having a deadline and I've got to do it and I've got limited resources or whatever is already causing me to tense up.

! We didn't realize the effects?

True.

How are you feeling now? How are you doing now?

Way better. I finished all my sessions with INCON and I got over my mum and her ordeal. I had to deal with that. And I do things that I need to do not the things I want to do. And waste time. I've pulled back on a lot of things. So I've really sorted – sorted my time in a day, in a week, in a month. I am fine with that. It works for me. I find that I like doing – going out and enjoying the nature and doing all the things that you need to do. When I sat in that room – it was the last room in that isolation ward, so there was the river there and you could always see the birds and ducks. This ground was there for years and I never used to wonder and I never knew what used to happen. So after I got discharged I went to visit the ground. Looking out the window. You would always see people training.

Yes that stadium is very busy.

Yes at odd times of the day – there will be small groups and big groups. It was just this vast amount greenery that was there. And it was coming into spring. That just gave me a sense of relief as I looked out that window. I was not one to stay in the bed. I preferred to sit there and that was

Connecting with nature.

Yes.
It has a lovely garden there and birds. It is a good mix if you just want to sit and enjoy breakfast and reflect on the day as the day unfolds.

That time was a lot of self-reflection for you.

It was.

Lilly I want to say thank you. That was all my questions. Unless you've got something to add or ask me a question? I can see that this journey you have been through, from not having COVID, from getting COVID and being a patient in this hospital as a healthcare worker – yes I had changed us somewhat. It has changed our outlook on life and most important it has changed us to do better, be better.
Lilly I want to say thank you for your time and most importantly your contribution to this study.

You're welcome.
Thank you so much.

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APPENDIX K: TURNITIN REPORT

EXPERIENCES OF HEALTHCARE WORKERS AS PATIENTS DURING THE COVID-19 PANDEMIC, AT A PRIVATE HEALTH FACILITY IN THE UMGUNGUNDLOVU DISTRICT, KWAZULU-NATAL

ORIGINALITY REPORT

12%	11%	8%	6%
SIMILARITY INDEX	INTERNET SOURCES	PUBLICATIONS	STUDENT PAPERS

PRIMARY SOURCES

1	ir.dut.ac.za Internet Source	1%
2	nurse.mums.ac.ir Internet Source	1%
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6	Rochelle Wynne, Patricia M. Davidson, Christine Duffield, Debra Jackson, Caleb Ferguson. "Workforce management and patient outcomes in the intensive care unit during the COVID - 19 pandemic and beyond:	<1%