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**PATIENTS VIEWS REGARDING CARE RECEIVED IN AN EMERGENCY
DEPARTMENT IN THE LIMPOPO PROVINCE**

by

TW Pataki

20265884

Magister Curationis (M Cur: Clinical)

Faculty of Health Science
School of Health Care Sciences
Department of Nursing Science
University of Pretoria

Supervisor: Dr T Heyns
Co-supervisor: Dr IM Coetzee

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Declaration

Student number: 20265884

I, **Tlou Witness Pataki**, hereby declare that this research study entitled **Patients' view regarding care received in an emergency department in the Limpopo province** is my own work and that all sources consulted or quoted have been indicated and acknowledged by means of complete references and that this work has not been submitted for any other degree at any other institution.

T. W. Pataki

Date

DEDICATION

This thesis is dedicated to my two lovely daughters Rebone, Tlou and my late uncle Makwena Ephraim who motivated me to further my studies.

Lastly to all the emergency nurses for their strength and passion on service delivery they provide to the patients, despite the encountered challenges on daily basis.



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"Call upon me on the day of trouble I will deliver thee, and thou shalt glorify me"

-PSALM 50:15-

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Abstract

Delivery of quality patient care is of a paramount in the emergency department to all the healthcare professionals to improve patient satisfaction. The aim of the study is to explore patients' views of the care they receive in the emergency department in the Limpopo province by means of Appreciative Inquiry. The Appreciative Inquiry process was utilized as the framework for the study to inquire about aspects of care received by the patients in the emergency department who voluntarily signed an informed consent.

A qualitative approach was utilized since the researcher wanted to explore their views the patients related to care they receive. The research design used was descriptive and explorative whereby the researcher could describe the real situation in the emergency department as experienced by the patients. The identified participants were all patients visited the emergency department on the day of data collection.

The findings of the study revealed that, the patients identified the positive and negative views from the healthcare professionals that influences the care received in the emergency department. The recommendations were for all the healthcare professionals to improve the quality of care received by the patients to ensure patients satisfaction.

Key words: Appreciative Inquiry, patients, healthcare professionals, and emergency department.

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List of Abbreviations

AI	Appreciative Inquiry
SOAR	Strengths, opportunities, aspiration, results
SWOT	Strengths, weakness, opportunities, treats

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1 ORIENTATION TO THE STUDY

1.1 INTRODUCTION AND BACKGROUND

Patient satisfaction is a global issue that affects patients irrespective of the country of origin. Patients of all ages entering emergency departments with urgent and/or non-urgent medical illnesses and/or injuries expect to receive quality care. Faced with the increasing population in the Limpopo Province in South Africa, healthcare professionals in a tertiary hospital are challenged to provide quality care on a daily basis to the community. Despite the efforts of the healthcare professionals, some patients say that they are dissatisfied with the quality care received.

Views of patients regarding the care received in an emergency department may originate from various contributing factors. The increased number of patients admitted to the emergency department daily, leads to overcrowding and increased waiting times and consequently dissatisfaction with care received. This situation is supported by a study conducted by Chan, Lo, Lee, Lo, Yu, Wu, Ho, Yeung and Chan (2014:27) in China. Overcrowding, furthermore, leads to a reduction in efficiency and increases the risk of medical errors that may lead to adverse events, affecting patient outcomes (Nugus, Forero, McCarthy McDonnell, Travaglia, Hilman & Braithwaite 2014:3). In addition, Berben, Meijs, van Grunsven, Schoonhoven and van Achterberg (2012:1397) stated that increased waiting times due to overcrowding results in patients' pain not being managed timeously and/or effectively resulting in an increase in dissatisfaction with the care received. Bornemann-Sherpherd, Le-Lazar, Makic, DeVine, McDevitt and Paul (2014:6) are further of the opinion that patients' views are affected by the availability of medical supplies and equipment.

A key parameter that is believed to measure quality of care in the hospital setting is patient satisfaction as suggested by (Sack, Lütkes, Günter, Erbel, Jöckel, & Holtmann 2010:1; Jiang, Gan, Kao, Zhang, Zhang & Cai 2009:223). The South African National Health Act No 63 of 2003 supports the viewpoint that patient satisfaction reflects patients' views regarding the quality of care they received and should

be evaluated. Organisations should therefore involve patients to evaluate the care received and learn from their experiences in order to improve the quality of health care delivered (Luxford 2010:10).

In addition, Chenail (2011:1173) states, “All research is local” and emphasises the importance of listening to the voice of the patient to inform practice and, in turn produce improvements and enhancements (Welsh 2010:64).

Several complaints regarding the quality of care received in an emergency department have been reported to middle and top management at a tertiary hospital in Limpopo. The extent of the challenges based on the voice of patients who received care in the emergency department is unclear. This study will focus on the views of patients pertaining to the care received in an emergency department.

1.2 PROBLEM STATEMENT

The emergency department at a tertiary hospital in the Limpopo Province is regarded as the “*front door*” to the hospital. Approximately 70 patients of all ages presenting with different emergencies including minor or major medical illnesses and/or injuries receive care in the emergency department daily. Patients admitted to the emergency department experience challenges regarding the quality of emergency care they receive. Despite measures that were implemented to address patient satisfaction in the emergency department, such as the patients’ advantages of effective communication being assisted by a courtesy nurse who regularly updated them about service delivery, some patients remained dissatisfied with the quality of care received. The patients often complained to the unit manager and/or chief executive officer of the hospital about the emergency care provided and indicated that their health needs were not met.

The researcher observed that some patients signed a ‘refuse hospital treatment’ form and discharged themselves without being assisted due to the overcrowding that resulted in prolonged waiting times. The negative publicity revealed in the media, the continued complaints received by middle and top management, and incidents observed by the researcher support a need to explore the views of patients regarding the care they receive. To date, this has not been done formally. Should this be done, the views of patients could be incorporated in recommendations to improve the quality of care delivered in the emergency department.

1.3 RESEARCH QUESTION

The formulated research question for this study is:

What are the views of patients regarding the care they received in an emergency department in the Limpopo Province?

1.4 AIM

The overall aim of this research was to explore the views of patients about the care they received in the emergency department in the Limpopo Province. Appreciative Inquiry was utilised to evaluate the views of patient regarding the emergency care they received at an emergency department in the Limpopo Province.

1.5 SIGNIFICANCE

Exploring the satisfaction of patients with the care they received in the emergency department will assist the emergency nurses and other healthcare professionals to enhance their practice and quality care delivered, which in turn may increase patient satisfaction. This study may raise the awareness of the healthcare professionals regarding the views of patients relating to aspects of emergency care delivered that contribute to dissatisfaction. Based on the research findings, the emergency nurses and healthcare professionals will be able to use the identified recommendations, benchmark service delivery against other similar organisations and prioritise quality improvement strategies to improve practice.

1.6 Paradigm

According to Roux and Barry (2009:2), the paradigm provides a fundamental link between the different research activities in a disciplinary field. A paradigm is a particular way of viewing a phenomenon in the world (Burns & Grove 2009:712) and is also defined as “a typical example, pattern or model of something” (Oxford Dictionary 2007). The paradigm that will be used in this research study is social

constructivism, as Appreciative Inquiry will be used as an approach to collect the data (view Section 1.10). Reason and Bradbury (2011:160) are of the opinion that working from a constructivism (naturalistic) paradigm, the research views the individual's mind as a process to be inherited, but is opposed to human relationships because of the people's original construction of the world. In addition, Polit and Beck (2008:759), as supported by Cherry and Jacobs (2014:88) define constructivism as "*an alternative paradigm to the traditional positivist paradigm that holds that there are multiple interpretations of reality, and that the goal of research is to understand how individuals construct reality within their context; often associated with qualitative research*".

Constructivism is derived from the assumption that learning takes place when a person is able to attach meaning to experiences in the real world, and that learning is an active process aimed at deriving understanding from interactions with the environment (Polit & Beck 2008: 15). In other words, it is a process of understanding the relationship between new information and a person's existing knowledge. The patients will be provided with an opportunity to voice their views on the care they received based on their experiences in the emergency department. In turn, through interaction with the patients, healthcare professionals will learn from and understand how patients viewed the care received.

According to Reed (2007:139), social constructivism is identified as a significant worldview. It is informed about the ways in which Appreciative Inquiry could be used as an approach to develop a focus of exploration, with a group of people to develop or construct ideas about their world, which in this case are the views of patients about the care received in an emergency department. Cooperrider, Whitney and Stavros (2008:14) argue that a central premise of Appreciative Inquiry is that the appreciative process of the knowing is socially constructed. In other words, knowing takes place through interaction with and within a social system. The researcher will aim to learn from and understand patients views about the care received in the emergency department.

1.6.1 Assumptions

Polit and Beck (2008:748) and Brink, van der Walt and van Rensburg (2012:208) define an assumption as a principle that is accepted as being true based on logic or reason, without proof. The assumptions used in this study were based on constructivism described by Polit and Beck (2010:15) and social constructivism as it applies to Appreciative Inquiry as described by Hammond (1998:20-21).

- In every organisation (emergency department) something good is working.
- Reality is created in a moment, and there are several realities (patient views).
- Patients' views are important in order to make recommendations that can be implemented to enhance quality of care.
- Type of questions asked influences the response of the individual/group.
- Different views should be valued.
- Our reality is created by the language we speak.

1.7 ROLE OF THE RESEARCHER

According to Creswell (2007:118), qualitative research takes place in the natural setting. The qualitative researcher often goes to the site of the participants to conduct research. This enables the researcher to develop a level of detail about the individual or place and to be highly involved in the actual experiences of the participants. Gaining entry to a research site and the ethical issues that might arise are also elements of the researcher's role. It is the view of Creswell (2003:184) that qualitative research is interpretive, where the researcher is typically involved in a sustained and intensive experience with stakeholders as a research participant.

Qualitative researchers should explicitly identify their biases, values and personal interests about their research topic process. The researcher is a professional nurse with 13 years' experience as a nurse. She obtained an additional post-graduate diploma in emergency nursing in 2005, and has been working for approximately 13 years in the emergency department where the study will be conducted. Creswell (2007:125) identified the following five elements of the researcher's role that were applied in the study:

- The statement should include the past experience that provides background data through which the audience can better understand the topic, the setting and the participants (see Section 1.1).
- Comments on the connection between the researcher, participants and the setting. The data collection site should be without interruptions and therefore the researcher chose the unit manager's office, as it was quiet and without interruptions. Patients were able to share and disclose their views regarding the care received without being coerced or influenced based on power issues (see Section 1.8).
- Ethical considerations were deliberated during the research (see Section 1:12).

- The human rights of participants were protected (see Section 1.12).
- A letter for permission to conduct the study was written to the gatekeeper (tertiary hospital management) to access the setting (see Annexure A.3).

1.8 THE SETTING

The research setting refers to the surroundings in which the research was conducted (Burns & Grove 2009:35; Polit & Beck 2010:62). The study was conducted in an emergency department of a tertiary hospital in the Limpopo Province (see Figure 1.1). The hospital has a bed capacity of approximately 450 beds and serves the entire community of the Limpopo Province in the management of ill/injured patients. Patients are admitted to the emergency department via direct admission, ambulance transport, referrals from surrounding district hospitals and primary healthcare facilities for specialised emergency care. Emergency department has 13 examination beds.



Figure 1.1: Map of South Africa and its provinces (Adapted from the South African Government Information [n.d.]

Patients of all ages are admitted, including newborns, infants, children, adults and geriatrics presenting with a variety of mild, moderate and severe injuries or illnesses. The major injuries and illnesses (but not limited to them) admitted to the emergency department are patients presenting with chest pain, hyperglycaemia, hypertension, gynaecological emergencies, poisonings, head injuries and fractures. Approximately 70 patients are admitted and managed daily in the emergency department.

1.8.1 Gaining access

The researcher pursued a rigorous process in order to gain access to the participants, who were regarded as a vulnerable population. First, the researcher obtained approval from the Student Research Ethics Committee of the Faculty of Health Sciences at the University of Pretoria (see Annexure A.1), second the Department of Health of Limpopo Province (see Annexure A.2) and third the tertiary hospital management (see Annexure A.3). Based on the fact that the researcher is a professional nurse who had worked for approximately 13 years in the emergency department and who was a clinical facilitator involved in the clinical accompaniment of student nurses in the emergency department, the researcher was known to all the emergency nurses, which enhanced access. Once ethical approval was obtained, a formal meeting was scheduled with the emergency department nurses to discuss the proposed research.

1.9 CLARIFICATION OF KEY CONCEPTS

For accuracy and consistency of the study, the key concepts used in the study are defined below.

1.9.1 Emergency care

According to Dorland and Newman (2007:615), emergency is defined as, '*...an unlooked for or sudden occurrence, often dangerous, such as an accident or urgent or pressing need...*' Emergency is defined as a serious and unexpected situation requiring immediate action (Oxford Dictionary 2009). Care is defined as a special attention or effort made to avoid damage, risk, or error. Care can also be defined as the process of looking after and protecting someone or something (Oxford Dictionary 2009). Dorland and Newman (2007:300) define care as '*...the services rendered by members of the health professions for the benefit of the patient...*'.

For the purpose of the study, emergency care is the immediate care rendered to the ill/injured patient according to their level of condition in the emergency department in order to preserve life, and avoid complications – specifically as viewed by patients.

1.9.2 Healthcare professionals

Healthcare is the service of providing medical care (Oxford advanced learners dictionary 2005). Professional is defined as doing something as a job rather than as a hobby; or relating to or belonging to a profession (Oxford Dictionary 2009). Health professional is defined as a person with “... a special training, licenced when necessary, who works under the supervision of a health professional with responsibilities bearing on patients...” (Dorland & Newman 2007:1545).

For the purpose of the study, healthcare professionals are emergency nurses and medical doctors working in the emergency department of the tertiary hospital in the Limpopo Province in which the study was conducted.

1.9.3 Patients

A patient is a person who is receiving medical treatment, especially in a hospital, or a person who receives treatment from a particular doctor (Oxford advanced learners dictionary 2005). Furthermore, Hinkle and Cheevers (2014:4) define patient as ‘...those who are recipients of care service...’

For the purpose of the study, a patient was regarded as all individuals who have been admitted to and received care in an emergency department of a tertiary hospital in the Limpopo Province.

1.9.4 Patient satisfaction

Patient satisfaction is defined by Zia, Mohsen, Rijji, Abbas and Mostafa (2011:9) as “...when the patients’ own expectations and their relatives for treatment and care are met”

For the purpose of this study, the definition of patient satisfaction related to how satisfied the patient was with the care received in the emergency department of a tertiary hospital in the Limpopo Province.

1.10 RESEARCH MODEL

A model is defined as the section of a research report that describes the overall process of implementing the research study, including who was included in the study and how information (data) was collected and the interventions done (Rebar, Gersch, Macnee, & McCabe 2011:394).

1.10.1 Introduction to Appreciative Inquiry

Appreciative Inquiry was used as an approach to guide the study. Reason and Bradbury (2011:190) argue that Appreciative Inquiry is an art that enables the participants to see anew and to bring something fresh into the world that inspires thoughts and actions that flourish in the individual and organisations. In the view of Watkins and Kelly (2010:259), Appreciative Inquiry can be regarded as a philosophy, process, methodology or approach in research, as it is defined as:

"...A process for engaging people in building the kinds of families, communities, organizations and world they want to live in; and, a practical daily philosophy, that can guide our work with families, communities, and organizations based on the realisation that what we learn from what works and gives life is more effective and sustainable than what we learn from breakdowns and pathologies..."

Furthermore, Watkins and Kelly (2010:259) clarify 'appreciate' and 'inquire' as follows:

*"...**Appreciate:** To value or admire highly; to perceive those things that give life (health, vitality, excellence) to living systems. To increase in value..."*

*"...**Inquire:** To search into, investigate, to seek for information by questioning. It is the act of exploration and discovery. It means to ask questions; to be open to seeing new potentials and possibilities..."*

Appreciative Inquiry can also be regarded as a model was developed by Srivasta, Fry and Cooperrider in 1990. The Appreciative Inquiry model consists of three phases namely: 'Discovery', 'Dream' and 'Destiny' (Watkins & Mohr 2001:18). The model evolved from the 3D to the 4D Cycle (Watkins & Mohr 2001:19; Stefanaik 2007:43). The model was further refined by Watkins and Mohr (2001:25) whereby the fifth 'D' namely 'Define' was introduced (Cooperrider et al. 2008:51). The 5D cycle is composed of five phases, which encompass a positive core and thus is consciously constructed around the positive core strengths of the organisation (Cooperrider, Whitney & Stavros 2008:34).

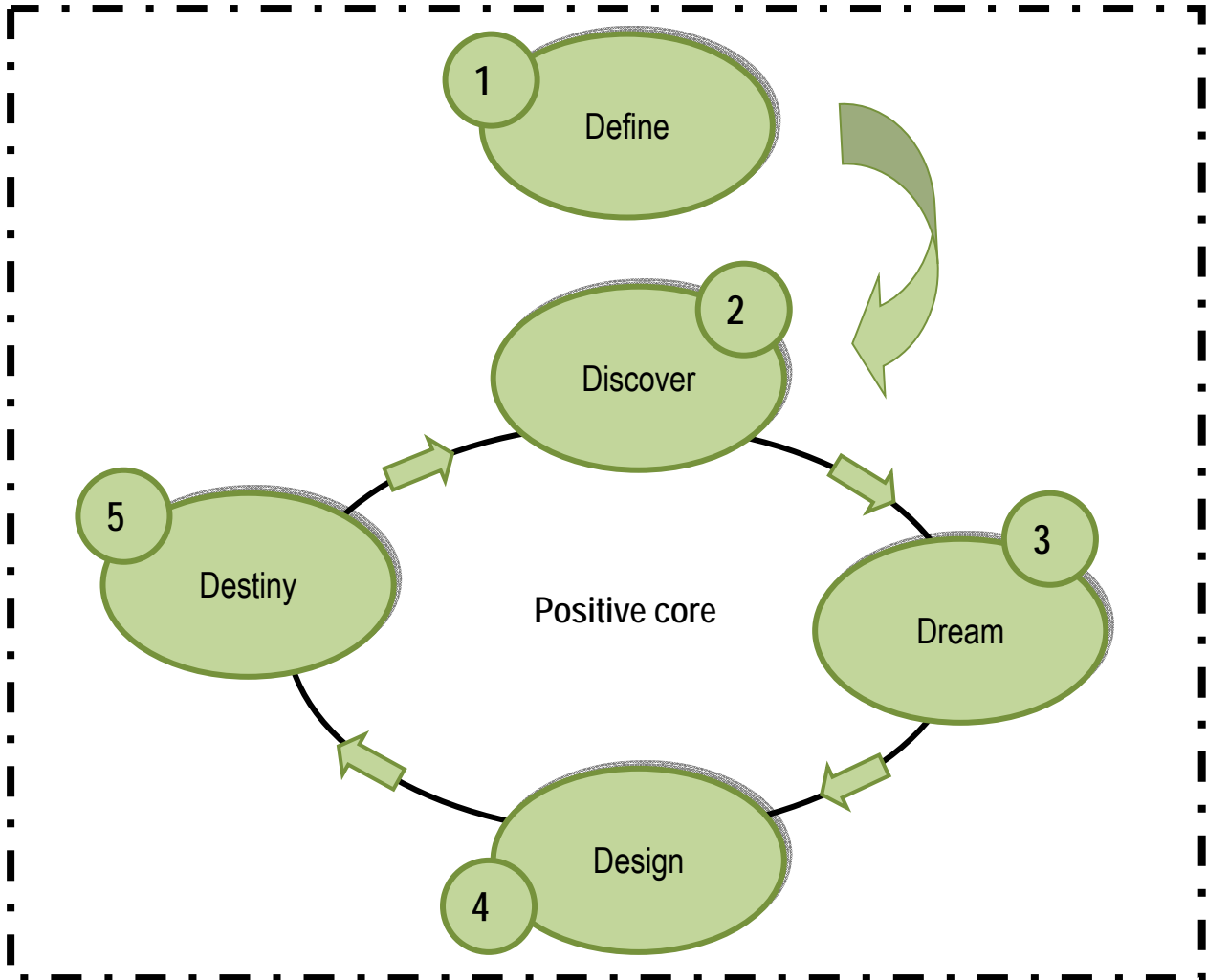


Figure 1.2: Appreciative Inquiry- 5D Cycle. Adapted from Cooperrider et al. (2005:34) and Whitney and Trosten-Bloom (2003:6).

The five phases include Define, Discover, Dream, Design and Destiny. The application of the use of Appreciative Inquiry as an approach in this study is explained in Sections 1.10.1.1 to 1.10.1.6.

1.10.1.1 Positive core

Reed (2007:32), as well as Bitzer and Botha (2011:396), assessed that the positive core is made up of three elements namely: strengths, goals and achievements and may be articulated in many ways. It is the view of Cooperrider et al. (2005:30-31) that the positive core is seen as the 'golden thread' that is woven throughout the four phases of the 5D-Cycle. Appreciative Inquiry starts and ends with appreciating that which gives life to an organisation or a programme (Cooperrider et al. 2005:31).

In the study, the positive core refers to the emergency care received by the patient that is done from a positive approach. In implementing an Appreciative Inquiry initiative, the authors have found it useful for organisations and consultants to be clear about the project's purpose, process, and overall plan for implementation (Cooperrider et al. 2008:39). The chosen topic should reflect the positive core of the organisation (Kavanagh, Stevens, Seers, Sidani & Watt-Watson 2010:2).

1.10.1.2 Define

The definition phase is explained by Watkins and Mohr (2001:25) as the external and first phase where goals are planned and developed. These goals will include outlining of questions and inquiry procedures as well as the approach and task management. According to McKenna, Daykin, Mohr and Silbert (2007:3), the definition phase is the phase where one has to decide who to invite to the interviews and who will go about inviting the participants. The authors add that one has to set up a planning team that will co-design and direct the strategic planning process. This team will then identify the stakeholders and how to engage them as part of the process. During the definition phase the interview guide has to be created that will assist with gathering the required information regarding the strengths, viewpoints, aspirations and resources of all the participants (McKenna et al. 2007:3) Furthermore, Bitzer and Botha (2011:398) argued that 'define' is used to frame the questions and the inquiry protocol with the participation strategy.

1.10.1.3 Discovery

In the discovery phase, a positive core is defined and people have the feeling of belonging to the organisation (Cooperrider & Avital 2004:142). People develop co-operation to build the future of the company. As people are working towards the same goal, they create the capacity to accept each other's differences (Cooperrider & Avital 2004:142). Furthermore Cooperrider, Whitney and Stavros (2008:104) argue that face-to-face interviews are conducted through sharing of stories and these are identified. The collected data should assist the Appreciative Inquiry team to understand the strengths that lend the organisation life where it is functioning well (Cooperrider et al. 2008:104). McKenna et al. (2007:3) view the discovery phase as one whereby participants inquire into the strengths and opportunities of an organisations or a programme by asking powerful and positive questions.

In the context of this study, despite the challenges pertaining to patient satisfaction with the care they received, the participants were encouraged to discover what currently was viewed as the best pertaining to the management received in the emergency department.

1.10.1.4 Dream

During the dream phase, people are given the opportunity to dream about the future plan and express how to implement the plans. A positive attitude will be identified if trustworthiness is established (Cooperrider & Avital 2004:142). According to Cooperrider et al. (2008:130), the dream phase encourages the participants to discuss what is best for the organisation and a better world. Fry et al. (2002:7) view the dream phase as the passionate thoughts about a 'positive image as a desired and preferred future'. According to the view of McKenna et al. (2007:4), the dream phase is the phase of aspiration and has results which are aligned with the SOAR approach.

Cooperrider et al. (2005:112) believe that the goal of the dream phase is to facilitate communication amongst stakeholders as well as to allow participants to identify common themes. With the support of Watkins and Mohr (2001:25), this is accomplished by means of sharing stories within a group during the discovery phase. Allowing participants to recognise common themes encourages a group to observe and value the stories shared, instead of judging or analysing them. The positive themes are viewed as the basic structures for the rest of the Appreciative Inquiry process (Cooperrider et al. 2005:112).

In the context of this study, the study participants were encouraged to positively dream and envision the best possible future they have for patient satisfaction. In other words, what did the patients view to be the ideal care to enhance patient satisfaction?

1.10.1.5 Design

The design phase according to Reed (2007:33), determines 'what will be', or 'what should be' (Whitney & Trosten-Bloom 2003:9). Cooperrider et al. (2005:142) state that the design phase starts by posing challenging propositions. These propositions are sometimes referred to as possibility propositions since a proposition bridges 'the best that is' and is written in the here and now (Cooperrider et al. 2005:142).

Through a positive dream, people will increase awareness and the power to decide which design will be adopted for the organisation (Cooperrider & Avital 2004:143). The adopted design should be sustained

and supported. (Cooperrider & Avital 2004:143). According to Cooperrider et al. (2008:162), the dream phase focuses on achieving the goals of the organisation. The positive core of the organisation's future is based on images that emerge through the grounded examples (Cooperrider et al 2008:162). In the context of this study, the design phase included recommendations based on inputs from all the participants (patients).

1.10.1.6 Destiny

Implementation is done throughout the Destiny phase where it then strengthens the affirmative capacity of the system (Cooperrider, Whitney & Stavros 2005:30-31). Cooperrider and Avital (2004:143) are of the opinion that one can elevate an organisational consciousness through inquiry and open dialogue. Focusing on envisioning positive possibilities and through the articulation of organisational design ideals, one may open the way for sustainable change. Cooperrider, Whitney and Stavros (2008:200) state that the goal of the destiny phase is to ensure that the dream can be realized. The Destiny phase represents the conclusion of the Discovery, Dream and Design phases and the beginning of the evolving creation of an appreciative learning culture. Reed (2007:33) stated that the Destiny phase allows energy to move towards planning of actions, working out what will need to be implemented in order to realise the proposed solutions that were made during the designing phase. Commitment is needed by all involved (Reed 2007:33).

Appreciative Inquiry was utilised during data collection for the researcher to ask participants positive questions. Appreciative Inquiry is based on the 5-D cycles that are (i) define, (ii) discovery, (iii) dream, (iv) design and (v) destiny. The framework involves asking positive questions to a group of participants in order to craft and implement action plans towards excellence (Reed 2007:2). In addition, Cooperrider and Avital (2004:142) argue that each phase in the Appreciative Inquiry 5-D cycle offers something different to the potential for elevating organisational consciousness. In this study, the healthcare professionals working in the emergency department were involved. The 5-D cycle of Appreciative Inquiry was used to guide the format of the questions that were asked during the appreciative interview. The questions asked to the participants were based on the best experiences, such as "what is" (discover), wishes "what could be" (dream) and vision "what should be" (design) to enhance patients' satisfaction. Based on the feedback of Appreciative Inquiry through appreciative dialogue with the patients, the destiny of "what will be" was recommended.

In the context of this study, the designed action planned to enhance patient satisfaction was presented to the management and healthcare professionals of the specific emergency department in Limpopo Province.

1.11 RESEARCH DESIGN AND METHODS

The research design is defined as a plan or structured framework of how you intend conducting the research process in order to solve the research problem (Babbie & Mouton 2011:647). The study used a qualitative, descriptive and explorative design. The rationale for using a qualitative design was based on the recommendation of Cameron, Schull and Cooke (2011:738) who suggested that a qualitative design could explore differences in patients' views which cannot be determined when using a quantitative design.

Polit and Beck (2008:758) describe the research methods as the steps, procedures and strategies for gathering and analysing data in a study. The research methods in this study are discussed in terms of population, sampling, data collection and analysis. The research methods are summarised in Table 1.1.

Table 1.1: Summary of the research methods

Population and sampling	Data collection	Data analysis	Establishing trustworthiness
<p>Population All patients receiving care in the emergency department of a tertiary hospital in the Limpopo Province</p> <p>Sampling Purposive and convenient sampling</p> <p>Sample size Total of 13 patients participated</p>	<p>Appreciative Inquiry was used as an approach to collect the data:</p> <ul style="list-style-type: none"> • Appreciative Inquiry questions were formulated and included in an Appreciative Inquiry interview guide • Appreciative Inquiry interviews were conducted 	<p>Content analysis was utilised, making use of the data analysis principle of coding</p> <p>Literature review</p>	<p>Based on Guba's model of trustworthiness (Lincoln & Guba 1985), the following five strategies were used:</p> <ul style="list-style-type: none"> • Credibility • Dependability • Confirmability • Transferability • Authenticity

The research design and methods used in the study are discussed in depth in Chapter 3.

Table 1.2: Summary of the strategies used to enhance trustworthiness

Strategy	Action	Application criteria
Credibility	Prolonged engagement	<ul style="list-style-type: none"> • Researcher profile, the researcher was actively involved in the emergency department during consultation of the patients. • The researcher worked as a registered nurse in the emergency unit for thirteen years (general nurse, preceptor of Trauma and Emergency nurses on training)
	Persistent observation	<ul style="list-style-type: none"> • The researcher utilised positive open ended questions and consistently pursued interpretations in different ways from the participants. • Followed a process of constant and tentative analysis.
	Triangulation/Crystallisation	<ul style="list-style-type: none"> • Used an independent coder to assist the researcher to develop the meaning of collected data. • Positive open-ended appreciative interview guide was utilised in all the participants.
	Referential adequacy	<ul style="list-style-type: none"> • Made extensive field notes • Transcribed verbatim
	Member checking	<ul style="list-style-type: none"> • Used independent coder to assist in coding of data and the development of themes, categories and sub-categories • Used expert supervisors
Transferability	Thick transcription	<ul style="list-style-type: none"> • Provided rich, comprehensive description of data obtained. • Provided in-depth description of research methodology and data collection technique
Dependability	Dependability audit	<ul style="list-style-type: none"> • Kept personal log and field notes • Used an independent coder to assist the researcher to ensure that the collected data is accurate for analysis.
	Dense description	<ul style="list-style-type: none"> • Described research methodology in-depth as well as

		the research process
	Triangulation/Crystallisation	<ul style="list-style-type: none"> • Compared independent coder's data analysis with researcher's version to enhance correctness

Strategy	Action	Application criteria
Dependability	Peer examination	<ul style="list-style-type: none"> • Collected data was given to the supervisor and co-supervisor for review • Used independent coder
	Code-recode procedure	<ul style="list-style-type: none"> • Held a consensus discussion between independent coder and researcher
Confirmability	Confirmability audit	<ul style="list-style-type: none"> • Provided a dense description of the methodology and results. • Included literature control, more than one participant and co-controller • Used independent coder • Used experienced supervisors
	Triangulation and reflexivity	<ul style="list-style-type: none"> • The researcher prevented over-involvement of own perceptions, background, views and interest by applying strict ethical guidelines and bracketing

Adapted from Brink et al. (2012:172), Polit and Beck (2012:589) and LoBiondo-Wood and Haber (2010:577) (Holloway & Wheeler 2010:304).

Trustworthiness will be discussed in depth in Chapter 3.

1.12 ETHICAL CONSIDERATIONS

According to Polit and Beck (2010:553), as supported by Brink et al. (2012:59), together with Hinkle and Cheevers (2014:24), ethics is defined as a system of moral values that is concerned with the degree to which research procedures adhere to professional, legal and social obligations to study participants. Ethical approval to conduct the study was granted by the Student Research Ethics Committee of the Faculty of Health Sciences at the University of Pretoria (see Annexure A.1), the Department of Health of Limpopo Province (see Annexure A.2) and the tertiary hospital management

(see Annexure A.3). Each participant who volunteered to participate signed a participant information leaflet and informed consent document (see Annexure B).

The Belmont Report articulated three primary ethical principles on which the standards of ethical conduct in research are based: (a) beneficence, (b) respect for human dignity and (c) justice (Polit & Beck 2008:170). These principles are supported by the following human rights that require protection in research: (1) self-determination, (2) privacy, (3) anonymity, and confidentiality, (4) fair treatment, and (5) protection from discomfort and harm, as suggested by Burns and Grove (2011:114). The ethical considerations used in this study are summarised in Table 1.3, and a detailed discussion follows in Chapter 3

Table 1.3: Summary of ethical considerations

Ethical considerations	Description
Informed consent	Informed consent was obtained in writing by the researcher from all the participants prior to the interview to ensure that the ethical aspect of the study was taken into consideration (view Annexure B)
Right to self-determination	All the participants were assured that they had the right to withdraw from the study at any time without any penalty, should they wish to do so.
Right to privacy	The participants knew when and how information would be gathered. No information would be gathered without participants' knowledge or consent.
Confidentiality	All questions asked by the participants with regard to the study were answered by the researcher. The researcher assured the participants that high professional standard was maintained regarding all issues of confidentiality
Anonymity	All data collected were treated anonymously so that data cannot be linked with the participants. In transcripts of interview participants were referred to as respondents (Annexure C)
Voluntary	Participation in this study was completely voluntary. It means that patients could choose to participate or not to.

Adapted from Polit and Beck (2008:170) and Burns and Grove (2011:114).

1.13 LAYOUT OF DISSERTATION

The layout of the dissertation is provided in Table 1.4.

Table 1.4: Layout of chapters

Chapters	Chapter title	Description
Chapter 1	Orientation of the study	Presents the outline and introduction to the research as well as a brief introduction of the research design and methods that were used in this study
Chapter 2	Literature review	Discusses Appreciative Inquiry used to guide the data collection process as well as patient satisfaction
Chapter 3	Research design and methods	The research design and methods are discussed in depth
Chapter 4	Research findings and discussion	This chapter contains the findings of the research and a discussion of the related literature
Chapter 5	Conclusions, limitations and recommendations	The conclusions, limitations and recommendations of the research are discussed based on the findings

1.14 CONCLUSION

In Chapter 1, an orientation to the study was provided by discussing the care received in an emergency department because it is vital for patients. Chapter 2 provides an in depth discussion of literature relating to Appreciative Inquiry that was used to guide the data collection process as well as patient satisfaction.

2 LITERATURE REVIEW

2.1 INTRODUCTION

An orientation to the study was provided in chapter 1. Chapter 2 provides an in-depth discussion of patient satisfaction and Appreciative Inquiry (AI) that was used as an approach to collect data. Appreciative Inquiry is discussed in terms of its historical overview, definition, core principles, the 5D-cycle utilised, the SOAR approach, Appreciative Inquiry versus the traditional processes and its overall use together with its application in nursing and its benefits.

2.2 DEFINITION OF PATIENT SATISFACTION

Satisfaction is described as the good feeling that you have when you have achieved something or when something that you wanted to happen does happen (Oxford Advanced Learner's Dictionary 2005:1297). Chow, Mayer, Darzi and Athanasiou (2009:436) describe patient satisfaction in terms of healthcare simply as *"the degree to which a patient feels they have received high-quality of care. If a patient feels they have received high-quality care, they are more likely to be satisfied."* Furthermore, patient satisfaction is defined by Zia et al. (2011:9) as *"when the patients' own expectations and their relatives for treatment and care are met."* Patient satisfaction is an important indicator of the quality of care and service delivery in a hospital setting. Patient satisfaction is defined by Bjertnaes, Sjetne and Iversen (2012: 40) as patient outcome measure.

2.3 THE IMPORTANCE OF EVALUATING PATIENT SATISFACTION

Patient satisfaction is regarded as one of the ultimate goals that a health system should strive for as it reflects the effectiveness of the health system (Jiang et al. 2009:223). Evaluation needs to be done to identify the pitfalls in service delivery by healthcare professionals in order to implement changes, and to improve the quality of care. The National Health Act No 63 of 2003 of South Africa supports the view that patient satisfaction pertaining to the quality of care received should be evaluated.

The World Health Organization (WHO) held a conference in March 2010 in Madrid, Spain, concerning the global consultation relating to migrant health. The World Health Organization (2010:10) emphasized the right to health for all, irrespective of nationality. It specified the right of foreign patients to receive emergency care. The aim of the conference was to ensure that every patient receives emergency treatment without being intimidated. It is the view of Lees (2011:25) that the Department of Health should insist that patients will be involved in decision making in the National Health System (NHS) by having greater control in informing strategic commissioning decisions. The aim of the government is to improve patient experience by allowing the patients to rate the service received in an emergency department. First preference will be given to patients who use the National Health System (Lees 2011:25). According to the study, it discusses the rationale for using patient feedback to engage with patients and the public, to seek their views and explore their experiences of health care, to support and promote quality measurement (Lees 2011:25).

According to Welch (2010:64), patient satisfaction is supposed to be placed in the context of quality improvement. The quality includes clinical care, cost efficiency and service quality. Patient satisfaction was developed into a theoretical framework and six aims were articulated for health improvement. The aims are as follows: *Safety* of the patient to avoid injuries where the patient is supposed to get help. *Effectiveness* of providing service to the patients who will benefit from it. *Patient centred* where care is provided in a respectful and responsive manner according to patients' needs. *Time* management by reducing waiting periods that delay service delivery. *Efficient* management whereby the equipment, supplies, and energy are not wasted, and *equitability* of providing equal care to all the patients irrespective of sex, ethnicity and social status (Welch 2010:65; Cherry & Jacobs 2014:378), as supported by the nurses pledge of service (Muller 2011:3).

2.4 RELEVANT LEGISLATION

First, in the Constitution of the Republic of South Africa Act 108 of 1996 (Republic of South Africa 1996: Chapter 2) in terms of Section 27(3), it is stated that urgent medical treatment may not be refused in the private or public sector. This implies that any patient in need of urgent treatment should receive medical treatment by the nearest hospital so that the patient is stabilised in order to improve the patient outcome. The Constitution of the Republic of South Africa (Act No 108 of 1996), also states in Chapter 2 in the Bill of rights (as quoted by Muller (2008:6), that everyone has the right to access to health care

services, including timely emergency care at any health care facility that is open. Second, is the National Health Act 61 of 2003 (Republic of South Africa 2003:47): This Act states that all health establishments must comply with the quality requirements and standards prescribed by the Minister after consultation with the National Health Council.

The Nurses' pledge of service from the South African Nursing Council is quoted in Muller (2011:3). According to this, a professional nurse pledges that: 1) The total health of my patients will be my first consideration. 2) I will hold in confidence all personal matters coming to my knowledge. 3) I will not permit considerations of religion, nationality, race or social standing to intervene between my duty and my patient. 4) I will maintain the utmost respect for human life so as to preserve life because the patient is my first priority. The government has established eight Batho-Pele principles (Muller 2011:19) to satisfy every client with service delivery. According to the Batho-Pele principles (as quoted in Muller (2011:19), every patient needs to be treated with courtesy so that the patient can feel respected and appreciated. Based on this legislations, all healthcare professions are obliged to provide quality care to all the patients who visit the emergency department with respect and dignity. Transparency should be maintained so that patients are able to consult the relevant people as the healthcare professionals will be identified with a name tag of the institution. In cases where the patient does not understand what type of services are offered in the emergency department, a relevant information is provided by skilled knowledgeable healthcare professional.

2.5 QUALITY CARE

Rad, Som and Zainuddin (2010:25) define quality as to whether or not the patient or customer's perception has met his/her expectations. According to the National Health Act 61 of 2003 (Republic of South Africa 2003:47), all health establishments must comply with the quality requirements and standards prescribed by the Minister after consultation with the National Health Council. The quality requirements and standards contemplated in the subsection may relate to human resources, health technology, equipment, hygienic premises and the delivery of health services, business practices, safety and the manner in which the users are accommodated and treated. The Office of Standards Compliance and the Inspectorate for Health Establishments must monitor and enforce compliance with the quality requirements and standards contemplated in the subsection. The quality of patient's

satisfaction is supposed to be evaluated to ensure that the set standards by the Minister are adhered to in order to improve the quality of care.

The Department has established standards for quality care to meet the needs of the patients by means of patients' satisfaction survey and questionnaire. Over the years, healthcare professionals have utilised various methods, from complaint boxes to satisfaction surveys, to gather information that can improve patient satisfaction. Satisfied patients improve healthcare professionals' job satisfaction. Rad, Som and Zainuddin (2010:25) argue that the healthcare professionals should be concerned with the following four characteristics of service delivery:

2.5.1 Intangibility: Intangible services are performances and experiences rather than objects, and intangibility means that the patient normally cannot see, feel, smell, hear or taste a service before concluding an exchange agreement with the service provider (Rad, Som & Zainuddin 2010:25).

2.5.2 Perishability: Because of the service's perishability, service providers can neither keep nor store the service because it has to be encountered on the spot (Rad, Som & Zainuddin 2010:25).

2.5.3 Inseparability: The inseparability aspect of services means customers can never separate the service provider from the service itself (Rad, Som & Zainuddin 2010:25).

2.5.4 Heterogeneity: This variability of service performance occurs at various levels. For example (a) the quality of service performance varies from one service to another, (b) the quality of service performance varies from one service performer to another, and (c) the quality of service performance varies for the same performer on different occasions (Rad, Som & Zainuddin 2010:26).

A quantitative study was conducted in Saudi Arabia in a teaching hospital about patients' experience of nursing quality. According to Momani and Korashy (2012:42), a number of researchers examined generally patients' satisfaction with nursing care together with perceptions of quality of nursing care because the two concepts are used interchangeably. The results of the study were based on the following themes as characteristics of good nursing care: that is pleasant, caring, prompt, and provision for needs (Momani & Korashy 2012:43).

A possible way to evaluate quality of care is to utilise Appreciative Inquiry, this method is a positive approach to evaluation.

2.6 APPRECIATIVE INQUIRY

An orientation to the study was provided in chapter one. An Appreciative Inquiry was used in a theoretical framework to approach the study in a positive way (see Figure 1.2). The background, research problem and questions were identified. Methodology, paradigm and setting of the study were discussed. This chapter will give an overview of Appreciative Inquiry.

2.6.1 HISTORICAL OVERVIEW

According to Cooperrider and Whitney (1999:20), Appreciative Inquiry originated in the work of David Cooperrider. In 1980, Cooperrider was a doctoral student at the Case Western Reserve University on the topic of organised dynamic (Preskill & Catsambas 2006:8; Reed 2007:22; Coghlan, Preskill & Catsambas 2003:7). According to Reed (2007:30), Cooperrider, Whitney and Stavros (2008: xxvii) studied an approach on how to identify factors that contribute to the organisation's health and excellence. Cooperrider worked under the guidance of his advisor Dr Suresh Srivastva, and the encouragement of the Cleveland Clinic leaders who were seeing the potential of Appreciative Inquiry for more widespread organisational development.

Cooperrider et al. (2008:xxvii) further stated that Appreciative Inquiry was first used in 1980 when Cooperrider was helping Al Jensen undertake his dissertation on physician leadership at Cleveland Clinic. Cooperrider founded the Taos Institute in 1990 together with other Appreciative Inquiry practitioners that included Diana Whitney, Harlene Anderson, Ken and Mary Gergen, Sheila McNamee and Suresh Srivastva (Coghlan et al. 2003:5; Preskill & Catsambas 2006:9). The Taos Institute hosts workshops on Appreciative Inquiry and related topics. It has published books on dialogue, social constructionist thinking and social change. Appreciative Inquiry was then introduced by Cooperrider and Srivastva as a source of positive possibilities (Cooperrider et al 2008: xxvii, Reed 2007:23). Appreciative Inquiry focuses on what is best in people and searches for what works best. It is embedded in excitement, creativity and pride (Preskill & Catsambas 2006:3, Reed 2007:187,

Stevenson 2011:3). It is the view of Havens, Wood and Leeman (2006:467) that the utilisation of Appreciative Inquiry as a tool assisted them to develop a new way of thinking.

2.6.2 DEFINING APPRECIATIVE INQUIRY

According to Cooperrider and Srivastva (1987:159), Appreciative Inquiry refers to both a search for knowledge and a theory of international collective action that are designed to help evolve the normative vision and will of a group, organisation, or the whole society. Cooperrider and Whitney (2000:5) defined Appreciative Inquiry as a philosophy of knowing that has been applied as a methodology for managing organisational change, community building, system design and scientific research. According to Preskill and Coghlan (2003:1), Appreciative Inquiry is seen as a practice in search of what is best. The authors are of the opinion that it is a participative, collaborative and systematic approach towards inquiry, seeking what is right, so that a desired future can be created.

According to Cooperrider and Avital (2004: xii), Appreciative Inquiry is a constructive inquiry process that searches for everything that "gives life" to organisations, communities, and mostly to living larger human systems that are effective, creative and healthy in their interconnected ecology of relationships. To appreciate, means to value and to recognise that which has value and it is a way of knowing and valuing the best of life (Cooperrider & Avital 2004:xii). Appreciate means valuing things that have value. It is a mode of knowing that is connected to the idea of aesthetic appreciation in the arts. To appreciate is to be grateful or thankful because it is way of being and maintaining a positive stance along the journey of life. The authors further stated that to appreciate something is to increase it in value (Cooperrider & Avital 2004: xii). Appreciative Inquiry is defined as "...a philosophy model of change and a set of tools and techniques that support discovery, dreaming, design and creation of a vision ..." (Keefe & Pesut 2004:103). Preskill and Catsambas (2006:1) defined Appreciative Inquiry as "a group process that acquires information, identifies and further develops the best of what is in the organization in order to create a better future".

The definition of Appreciative Inquiry was first used by Cooperrider before he started the first chapter in the Appreciative Inquiry Handbook (Cooperrider, Whitney & Stavros 2005:1). Appreciative is defined as "to value, recognize the best in the people or the world around us; affirm past and present strengths successes, and potentials; to perceive those things that give life to living systems (Cooperrider et al. 2005:1). Furthermore, Havens, Wood and Leeman (2006:463) defined Appreciative Inquiry as "a

philosophy and methodology for promoting positive organizational change". In addition, Cooperrider, Whitney and Stavros (2008:2) stated that Appreciative Inquiry is "an organizational development process and approach to change management that grows out of social constructionist thoughts and its application to management and organizational transformation".

2.6.3 THE CORE PRINCIPLES

Principles are defined as rules or beliefs that govern the way you behave (Oxford Paperback Dictionary & Thesaurus 2009:726). The principles of Appreciative Inquiry were born out of theories and related studies. Five principles will be discussed as formulated by Cooperrider who worked with other authors. According to Reed (2007:26), and also Cooperrider, Whitney and Stavros (2008:8), Cooperrider identified the first five principles in his original work. The additional principles, six through eight, are evidence of the continuing evolution of the approach. These principles are the core of Appreciative Inquiry's theoretical foundation towards positive organisational change. The principles show that it is the focal point on the positive image that results in a positive accomplishment (Cooperrider et al. 2005:9). Organisations therefore have to make the conscious decision to focus on the positive in order to direct the inquiry (Cooperrider et al.2005:9) as supported by Bitzer and Botha (2011:396). Appreciative Inquiry started with five basic principles that moved Appreciative Inquiry from theory to practice (Cooperrider et al. 2005:8). The five basic principles include: (i) the constructionist principle, (ii) the simultaneity principle, (iii) the anticipatory principle, (iv) the poetic principle, and (v) the positive principle. Preskill and Catsambas (2006:9) added three more principles subsequently that include: (vi) the wholeness principle, (vii) the enactment principle and (viii) the free choice principle. In Table 2.1, the principles of Appreciative Inquiry are summarised. Each principle will be discussed briefly in Sections 2.6.3.1 to 2.6.3.8.

Table 2.1: Summary of eight principles of Appreciative Inquiry

Principle	Description
The constructionist principle	Social knowledge and organisational destiny are interwoven. In reality when people interact they share the same goals and be are able to improve the needs of the organisation.

Principle	Description
The principle of simultaneity	Inquiry and change cannot be separated they should be simultaneous. Inquiry is thought to be intervention. When individuals engage in conversations they ask questions, they begin to change their thinking and the way they act. People identify and discover the challenges during questioning.
The poetic principle	The metaphor to describe human organisations as an open book, the past present and future are infinite sources of inspiration, learning and interpretation. The choice of inquiry in the organisation influences the direction of the organisation.
The anticipatory principle	The future of the organisation is based on generating constructive organisational change or improvement of collective imaginations. The image of the future is what will guide the organisation in determining how the future can be achieved.
The positive principle	Large amount of positive affect and social bonding, attitudes such as hope, inspiration and cheerful joy require momentum change.
The wholeness principle	Togetherness in the organisation brings out the best of people. If the stakeholders are involved they build a collective capacity, therefore the whole story should be understood and one needs to engage with the whole system.
The enactment principle	To achieve change one need to have a vision first. Positive change occurs when the organisation has a model of the ideal future and to live an example of the future.
The free choice principle	If people have freedom to choose how and what they contribute, they perform better and become committed.

Adapted from: Cooperrider et al. 2005, Bushe and Kassam 2005 and Preskill and Catsambas 2006.

2.6.3.1 The constructionist principle

Reed (2007:26) attempted to establish the truth by checking the factual accuracy of accounts by ignoring possible interpretations so that there are different stories of what is happening existing alongside each other. For the purpose of Appreciative Inquiry, attention is paid to the processes of

construction, so that people can come to tell different stories about the past, present and future and how the stories have the power to shape and reflect the way people think and act (Reed 2007:26).

Cooperrider et al. (2005:166) state that "social knowledge and organizational destiny are interwoven", which means that how one knows and what one does are closely interwoven. Cooperrider et al. (2008:8) also emphasised that the cooperation between the imagination and the reasoning function of the mind is an important resource for generating constructive organisational change. According to Stefaniak (2007:43), conversation is socially constructed through the world, whereas individuals are connected through relationships.

2.6.3.2 The principle of simultaneity

This principle states that inquiry and changes are simultaneous, and they are not separated and sequential stages in development (Reed 2007:26). An inquiry is an intervention in the way it stimulates reflection and thought that leads to different ways of thinking and doing, and this needs to be acknowledged throughout (Reed 2007:26, Cooperrider et al. 2005:8). The authors are of the opinion that this data becomes the stories out of which the future is constructed. Stefaniak (2007:43) stated that change begins during an interview with the people in the organisation. The opinion of Watkins and Mohr (2001:38) on the principle of simultaneity is one of asking questions that set the stage for what is still to be 'discovered' and that this then leads to conversation about construction of an organisational future. According to Whitney and Trosten-Bloom (2003:58), change occurs at the time that a question is asked.

2.6.3.3 The poetic principle

Reed (2007:26) emphasises the way people continually author their world by choosing the parts of their stories they are most interested in at one time and experimenting with different plotlines. Watkins and Mohr (2001:38) and Cooperrider et al. (2005:8) stated that an organisation's story is frequently being co-authored. AI supports people through the collective process and individuals by engaging their attention, energy and taking them through the authoring process to make it accessible (Reed 2007:26). Fry et al. (2002:5) points out the co-authors of the story are people within an organisation as well as outside who interact with the organisation.

Bushe and Kassam (2005:166) and Cooperrider et al. (2008:9) argue that it is more than a metaphor to describe human organisation as an open book. In the past, present and future are infinite sources of

inspiration, learning and interpretation. In other words, one can study practically any topic related to human experience (Bushe & Kassam 2005:166, Cooperrider et al. 2008:9). The view of Stefaniak (2007:43) is that what people choose to investigate creates our world. The past, present and future are the sources of learning and meaning.

2.6.3.4 The anticipatory principle

In this principle, Bushe and Kassam (2005:166) and Cooperrider et al. (2008:9) suggest that the way people think about the future will shape the way they move towards the future. If they view the future as full of possibility, they will move toward these possibilities. Conversely, if they feel that the future is doomed and hopeless, they will not do anything that will waste their energy and time (Bushe & Kassam 2005:166, Cooperrider et al. 2008:9). Appreciative Inquiry starts with an idea of the future that is based on what works well and directs energy toward exploring ways in which this can be developed further (Reed 2007:27).

Bushe and Kassam (2005:167) and Cooperrider et al. (2005:9) argued that what one does today is guided by the image of the future. Furthermore, Cooperrider et al. (2005:9) are of the opinion that collective imagination and dialogue with regard to the future is a valuable resource to generate constructive change or improvement. Stefaniak (2007:43) argued that actions are led by positive images of the future. The interpretation by Whitney and Trosten-Bloom (2003:64) of the anticipatory principle is that it creates an atmosphere eliciting conversation among stakeholders within the organisation in connection with the creation and existence of the future of the organisation.

2.6.3.5 The positive principle

Reed (2007:27) pointed out that this principle suggests that a focus on asking positive questions engages people more deeply, and for a longer time. It is argued that people turn towards ideas and images naturally that provides nourishment and energy. Furthermore, Reed (2007:27) stated that people's interest is captured in an effective way to get them involved in change. And the capturing is done effectively through invitations for the people to explore positive questions. Appreciative Inquiry incorporates the positive principle in the way it asks questions (Reed 2007:27).

According to Cooperrider et al. (2005:9), the positive principle is a more concrete principle that indicates the drive towards change which requires great amounts of positive effort and social bonding attitudes and the joy of creating. Cooperrider et al. (2008:9) as well as Stefaniak (2007:43) state that the more

positive the questions used to guide a group building an organisational development initiative are, the longer lasting and more effective will be the change. Preskill and Catsambas (2006:10) stated that positive action is the result of positive image. Reed (2007:27) explains more about the positive principle by stating that focusing on the positive, engages participants to move towards the desired future.

2.6.3.6 The wholeness principle

According to Whitney and Trosten-Bloom (2003:69), the wholeness principle is viewed as the experience where one can understand the whole story, which can furthermore be viewed as a combination of various stories. The principle of wholeness brings out the best in people and organisations (Mikkelsen 2005:246; Preskill & Catsambas 2006:10; Whitney & Trosten-Bloom 2003:69). Wholeness means all the stakeholders are included in order to build a collective capacity (Preskill & Catsambas 2006:10).

2.6.3.7 The enactment principle

According to Whitney and Trosten-Bloom (2003:72), the enactment principle is viewed as one that suggests that transformation occurs by living in the present in the way we wish or desire to live in the future. Preskill & Catsambas (2006:10) argue that change is recognised when people display a positive attitude towards change. Positive change occurs through role modelling when people are living examples of the future (Preskill & Catsambas 2006:10). The principle of enactment is explained by Mikkelsen (2005:46) as acting 'as if' is self-fulfilling.

2.6.3.8 The free choice principle

Whitney and Trosten-Bloom (2003:75) suggest that people treated as volunteers may allow personnel and organisational authority to surface. People perform better and are more committed when they have the freedom to choose how and what they contribute. Free choice stimulates organisational excellence and independence amongst personnel organisational power (Preskill & Catsambas 2006:10). Freedom of choice allows for better performance and commitment (Whitney & Trosten-Bloom 2003:75; Mikkelsen 2005:246; Preskill & Catsambas 2006:11). Furthermore Preskill and Catsambas (2006:10) set out the eight principles of Appreciative Inquiry that have been discussed and on which the assumptions are based.

2.7. THE 4-I MODEL

According to Preskill and Catsambas (2006:15), some of the Appreciative Inquiry practitioners decided to use another model (the 4-I Model) from the Encompass model.

It is as follows: Inquire Imagine, Innovate and Implement — working towards the topic of inquiry.

2.7.1 Phase 1: Inquire

The process will start by asking the participants to pair themselves together with someone they understand so that participants will be able to share their stories. The guide will include the peak experiences, values and wishes (Preskill & Catsambas 2006:16). On the peak experiences, the participants will be reminded of thinking about the good experiences they had in the Emergency Department, what contributed to the success the participant had experienced as suggested by (Preskill & Catsambas 2006:15). This phase is further supported by Rothwell and Sullivan (2005:56) who say that inquire is based on conducting generic interviews, developing customised interview protocols, pilots and revision of protocols.

2.7.2 Phase 2: Imagine

This is the step where the vision is developed for the future of the emergency department. Participants are invited to reflect individually on a question (Preskill & Catsambas 2006:20). Rothwell and Sullivan (2005:56) stated that in this stage the researcher has to organise the collected data, develop some themes, and develop a provocative proposition. The researcher will consult the supervisor and co-supervisor to validate the collected data. The team creates values, dedication, team spirit and continuous communication with a vision, as suggested by (Holman, Devane & Cady 2009:209).

2.7.3 Phase 3: Innovate

According to Preskill and Catsambas (2006:15), in this phase the participants' past, future, and visions become the reality. Participants identified themes after an interview so as to develop provocative propositions (Preskill & Catsambas 2006:15). Based on the data collected, the researcher drew recommendations for the assistance of the department regarding the care delivered to the patients in

the emergency department (Rothwell & Sullivan 2005:56). Strengths and opportunities were developed into meaningful aspirations. The researcher provided a positive environment conducive to creating and attracting best participants (Holman et al. 2009:209).

2.7.4 Phase 4: Implement

Participants chose motivating and interesting topics when the participants are self-organised (Preskill & Catsambas 2006:25). Participants are invited to celebrate the work they completed through the three phases of inquiry, imagine, and innovation (Preskill & Catsambas 2006:25). According to Rothwell and Sullivan (2005:56), the researcher needs to introduce the key stakeholders into the theory and create temporary structures from participation. The model consists of the following: inquire, imagine, innovate and implement (see Figure 2.1).

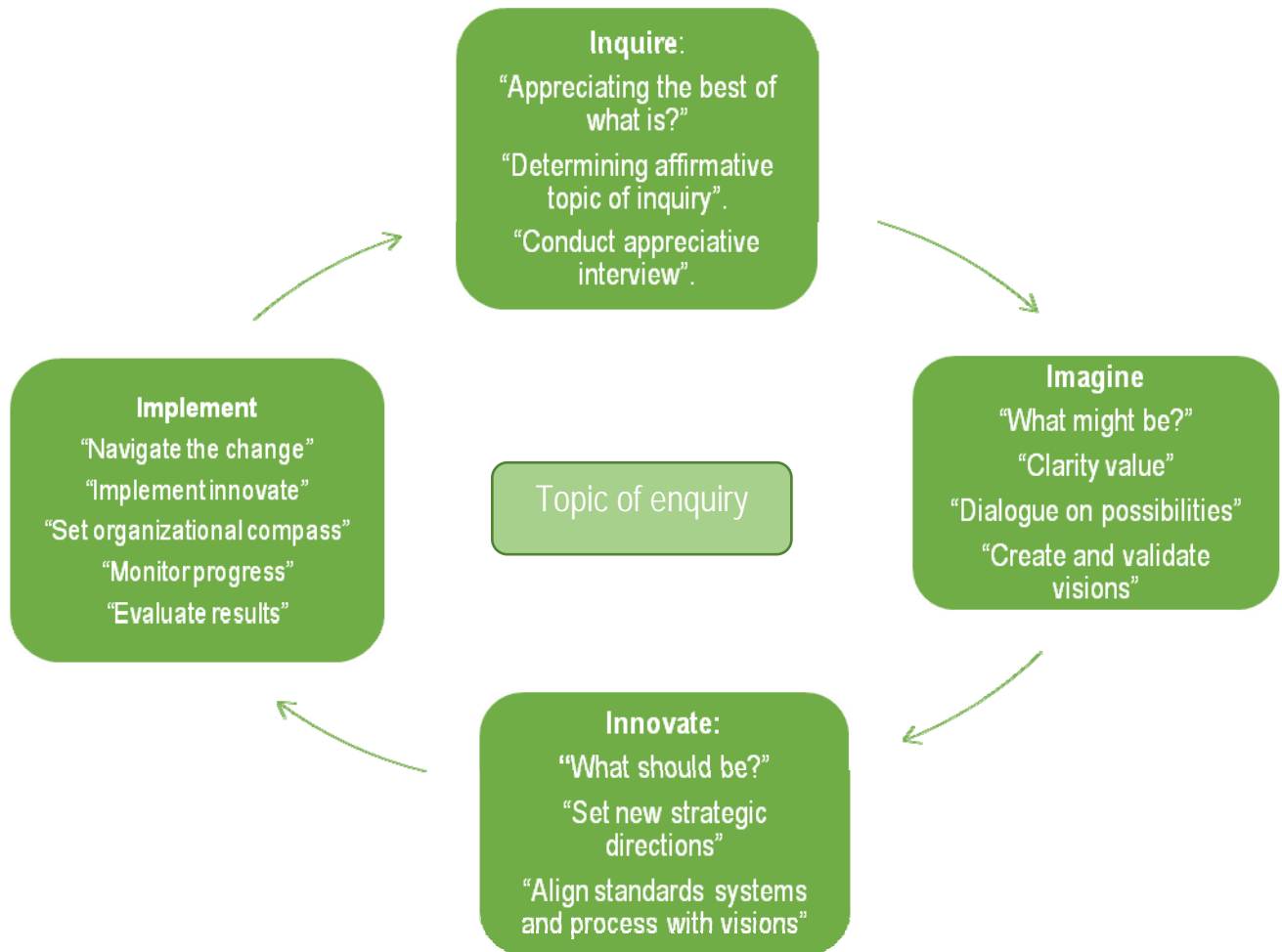


Figure 2.1: 4-I process. Preskill and Catsambas (2006:15).

2.8 IMPORTANCE OF QUESTIONS

Preskill and Catsambas (2006:1) are of the opinion that fundamental to organisational learning, change, growth, renewal and success is the asking of questions. It is necessary to consider learning orientation and challenges that matter most, so that people can reflect about the successful experiences they had in the past (Preskill & Catsambas 2006:1). Furthermore, Cooperrider et al. (2003:88) gave some examples of possible Appreciative Inquiry questions that give the flavour of how Appreciative Inquiry work can proceed. They pointed to the following three types of questions: (1) opening questions (2) questions centred on the topic, and (3) concluding questions.

2.9 ADVANTAGES

Cooperrider et al. (2005:936) reflect that Appreciative Inquiry creates a positive atmosphere of trust and regard. The process of Appreciative Inquiry creates opportunity for people to share their knowledge and to promote and embrace positive organisational change willingly (Cooperrider et al. 2005:936). The authors further state that Appreciative Inquiry increases employees' satisfaction and enhances productivity (Cooperrider et al. 2005: xi). In addition, Reed (2007:42) states, "Appreciative Inquiry focuses on supporting people getting together to tell stories of positive development in their work that they can build on". Appreciative Inquiry focuses on both change and innovation through positive development. For all the stakeholders, Appreciative Inquiry exhibits positive purpose and trust according to Reed (2007:42). Preskill and Catsambas (2006:135) say Appreciative Inquiry involves active participation by engaging all the stakeholders in structural storytelling. Appreciative Inquiry increases the motivation of individuals by focusing on past successes (Reed 2007:42; Preskill & Catsambas 2006:135).

Appreciative Inquiry builds high performance teams in order to make change possible. Appreciative Inquiry also unites labour and management in mutually envisioned partnerships (Cooperrider et al. 2005: xix). The use of Appreciative Inquiry is focused on redirecting analysis towards success. Appreciative Inquiry is successful since it rather treats people as human beings, and not as objects (Whitney & Trosten-Bloom 2003:19). Furthermore, Whitney and Trosten-Bloom (2003:20) indicated the following six reasons why Appreciative Inquiry works:

- 1) Encourages people to have interpersonal relationships, rather than identifying one another as per role played.
- 2) Allows everybody to participate in a group.
- 3) Allows people to dream and share their dreams together.
- 4) Creates an environment for active participation.
- 5) Gives people the opportunity to decide on what they wish to do and supports them.
- 6) Encourages people to be positive.

2.10 UTILISED IN EVALUATION

To evaluate is to form an opinion of the amount of value or quality of something after thinking about it carefully (Oxford Advanced Learner's Dictionary 2007:500). According to Preskill and Catsambas (2006:51), evaluation is a planned and a systemic process, so evaluation needs to be carefully designed. When designing an evaluation, the evaluator should ensure that useful and credible data is collected, the information of the client is met, and the evaluation resources are used wisely (Preskill & Catsambas 2006:51). Furthermore Cooperrider and Avital (2004:194) argue that the use of the Appreciative Inquiry approach to evaluation shifts the focus away from data and problems to people, and to what is working in the current programme. The Evaluation programme becomes a programme of appraisal because it benefits all the stakeholders (Cooperrider & Avital 2004:194).

2.11 TRADITIONAL APPROACHES

Appreciative Inquiry is the approach developed by Cooperrider in 1980 after realising that the traditional approach of focusing on problem solving was not good for organisational change (Challis 2009:9). The problem solving approach is used to resolve problems and the focus is on something that is broken and therefore needs to be fixed (Cooperrider & Srivastva 1987:147, Fry et al. 2003:260). Cooperrider developed Appreciative Inquiry as an approach of asking questions in a positive way by involving all the stakeholders. Appreciative Inquiry encourages the stakeholders to decide about the present and the future of the organisation. Passmore and Hain (2005:2) stated that traditional problem solving methods tend to produce conflict, if one focuses on something that is 'wrong', and it is likely to imply 'blame'. The perception is that by focusing on what is wrong threatens what has worked well in the past and may lead to conflict. Whitney and Trosten-Bloom (2003:16) hold that deficit-based methods focus on problems and how to conquer them.

According to Cooperrider (in Fry et al. 2002: ix), the approach of Appreciative Inquiry is used to modify the rules of deficit-based change and bypass complexities (see Table 2.1a below). The aim of Appreciative Inquiry is to focus on uncovering existing strengths, hopes and dreams so that the focus is on positive potentials, and so Appreciative Inquiry transforms people and organisations (Whitney & Trosten-Bloom 2003:14).

Table 2.2: The shift from deficit-based to positive change

Step / Phase	Deficit-based change	Positive change
Intervention focus	Identified problem	Affirmative topics
Participation	Selective inclusion of people	Whole system
Action research	Diagnosis of the problem Causes and consequences Quantitative analysis Profile of need Conducted by outsiders	Discovery of positive core Organization at its best Narrative analysis Map of positive core Conducted by members
Dissemination	Feedback to decision makers	Widespread and creative sharing of best practices
Creative potential	Brainstorm list of alternatives	Dreams of a better world and the organisation's contribution
Results	Best solution to resolve the problem	Design to realize dreams and human aspirations
Capacity gained	Capacity to implement and to measure the plan	Capacity for on-going positive change

Adopted from Whitney and Trosten-Bloom (2003:17).

Appreciative Inquiry views challenges in a positive way to ensure that individuals are accommodated. The table below indicates the comparison of problem solving and Appreciative Inquiry.

Table 2.3: Comparison of problem solving and appreciative inquiry

Problem solving	Appreciative Inquiry
"Felt need" Identification of problem	Appreciating and valuing the best of "what is"
Analysis of Causes	Envisioning "what might be"
Analysis of possible solution	Dialoguing "what should be"
Action planning (Treatment)	Innovating "what will be"
Basic Assumption: An organisation is a problem to be solved.	Basic Assumption: An organisation is a mystery to be embraced.

Adapted from Cooperrider, Whitney and Stavros (2008:16).

According to Stavros and Hinrichs (2009:10), SWOT (Strengths, Weakness, Opportunities and Threats) was used as a standard tool of strategic planning. It was used at any level of organisation, but it is traditionally employed at a senior management level. SOAR (Strengths, Opportunities, Aspirations and Results) is used at top management level, but includes all the stakeholders at many levels. According to O'Neill (2007:1), it is more powerful to focus on the strengths of individuals and organisation rather than working on deficiencies. SOAR is an asset-based approach to strategic planning. The SOAR approach is based on Appreciative Inquiry – an approach which creates results that are based on strengths and successes (O'Neill 2007:1).

It is the view of Preskill and Catsambass (2006:28) that two results are found when Appreciative Inquiry and problem solving approaches are compared. The first result is the language-based deficit versus the affirmative result. The second result is that the problem solving approach does not consider the parts of the whole system versus the holistic system. O'Neill (2007:2) identified negative results of utilising SWOT analysis that included: "lack of focus on the most important and highest impact goals, Lack of shared vision, no plans to support goals, and no review or evaluation of the plan after it has been developed".

Table 2.4: Comparison of SWOT and SOAR approaches

SWOT	SOAR
Strengths <ul style="list-style-type: none"> • Organisation's resources and capacities • Basis for development 	Strengths <ul style="list-style-type: none"> • -What are we doing really well? • -What are our greatest assets? • -What are we most proud of accomplishing? • -What do our strengths tell us about our skills?
Weaknesses <ul style="list-style-type: none"> • Absence of strength, lack of resources or capability • Flipside of a strength, downside of focusing on competitive advantage 	
Opportunities <ul style="list-style-type: none"> • External circumstances that support profit and growth • Unfulfilled customer's needs, new technology, favourable legislation. 	Opportunities <ul style="list-style-type: none"> • How do we collectively understand outside threats? • How can we reframe to see the opportunity? • What is the enterprise asking us to do?

	<ul style="list-style-type: none"> • How can we best partner with others?
SWOT	SOAR
Threats <ul style="list-style-type: none"> • External circumstances that hinders profit and growth, for example more competitors, changes to revenue streams, restrictive regulations 	
Aspiration <ul style="list-style-type: none"> • Considering strengths and opportunities, who should we become? • How do we allow our values to drive our vision? • How can we make difference for our organisation and its stakeholder? 	
Results <ul style="list-style-type: none"> • What are our measurable results? • What do we want to be known for? • How do we tangibly translate Strengths, Opportunities, and Aspirations? 	

Source: Adapted from Stavros and Hinrichs (2009:11).

The table below will summarise the differences between the two approaches.

Table 2.5: Differences between the two approaches

SWOT ANALYSIS	SOAR APPROACH
Analysis orientated	Action orientated
Weaknesses and Threats focus	Strengths and Opportunity focus
Competitive focus- just the better	Possibility focus - Be the best
Incremental improvement	Innovation and Breakthroughs
Top down	Engagement of all levels
Focus on analysis - Planning	Focus on Planning - implementation
Energy depleting - There are so many weaknesses and threats.	Energy creating - We are good and can become great.
Attention to Gaps	Attention to Results

Source: Adapted from Stavros and Hinrichs (2009:12).

2.12 CRITICISMS

According to Reed (2007:39), Appreciative Inquiry has been accused of being naive because it concentrates on positive experiences, some of which are badly sanitised pictures of human life. Appreciative Inquiry's concentration on positive aspects ignores or suppresses negative experiences. The use of Appreciative Inquiry in the health services where stresses and pressures are high does not mean the conversation avoids negative experiences (Reed 2007:39). Appreciative Inquiry does not ignore problems and neither does it deny problems (Preskill & Catsambas 2006:26; Watkins & Mohr 2001:9; Whitney & Trosten-Bloom 2003:18). Instead, Preskill and Catsambas (2006:26) argue that Appreciative Inquiry addresses challenges, problems and conflict by shifting the focus towards hope and the possibilities of that which has worked in the past. Watkins and Mohr (2001:9) confirm this view and argue that if one focuses on the problems instead of the positives, it includes the focus of who is to blame and this may lead to resistance to change. Both authors indicate that by focusing on the problems, more images of the problems and what is wrong can be created (Watkins & Mohr 2001:9). In the context, conversations may need to address the negative positions before they can move on to appreciating strengths.

The view of Fineman (2006:273) is that 'positiveness' leads to a 'separation' thesis that distinguishes positive and negative acts, experiences, and emotions artificially. Furthermore, the author argues that in favour of the positive narrative, appreciative inquiry fails to value the opportunities for positive change that are possible from negative experiences (Fineman 2006:276).

2.13 UTILISATION IN NURSING

Appreciative Inquiry has been used successfully in the nursing profession as well as in programme evaluation (Coghlan, Preskill & Catsambas 2003:37). Appreciative Inquiry is a participatory process that addresses various issues within an organisation or programme (Coghlan, Preskill & Catsambas 2003:16). Appreciative Inquiry was utilised in this study to evaluate the emergency management received in an emergency department as well as to improve the quality care of patients.

Farrel, Douglas and Siltanen (2003:364) utilised Appreciative Inquiry in a study to explore and develop a nursing college's community of interest. The results of the study recommended conversation about

the shared values of the college's past and of its vision for the future. Keefe and Pesut (2004:103-109) conducted a study within the nursing profession where Appreciative Inquiry was successfully used. The study was conducted with regard to adapting to change in leadership techniques for faculty members and new leaders.

Apprciative Inquiry was utilised by Challis (2009:9) in a study entitled: 'An Appreciative Inquiry approach to registered nurses (RN) retention'. Appreciative Inquiry was utilised as a way to implement organisational change, so as to focus on what is right and working, rather than assumptions of deficiency (Challis 2009:9). The outcome of the study was not to formulate a list of issues that staff identified as negative in their work environment, instead the process elicited elements in the practice environment that were perceived as positive (Challis 2009:12). The Appreciative Inquiry approach was used in the study so as to include everybody in the study and to encourage nurse leaders to focus on positive solutions to enhance retention, rather than finger pointing and assignment of blame for high turnover rates. It will benefit the organisation as well as the profession (Challis 2009:12).

For the purpose of this study, Appreciative Inquiry was utilised as research methodology. It is discussed in detail in Chapter 3. The results obtained during the appreciative interviews were utilised to evaluate the emergency care received in an emergency department by the patients. Data collected from the Discovery, Dream, and Design phases were utilised to make recommendations about quality improvement in emergency care received by patients in the emergency department of a Limpopo tertiary hospital.

2.14 CONCLUSION

In this chapter, the historical overview, definition of Appreciative Inquiry, principles, assumptions, model, advantages, traditional approaches and criticisms were discussed. In Chapter 3, an overview is provided of the research methods used to conduct the study.

3 RESEARCH DESIGN AND METHODS

3.1 INTRODUCTION

In Chapter 2, an overview of the theoretical underpinning on which the study is based was discussed. In Chapter 3, the research design and methods utilised to address the research question are discussed in depth. In this study, a qualitative, descriptive design were utilised to address the research question. The research methods are discussed in terms of the population, sample, data collection and data analysis.

3.2 AIM OF THE STUDY

The overall aim of this research is to explore patients' views of the care they received in the emergency department in the Limpopo Province. Appreciative Inquiry was utilised to evaluate the views of patients regarding the emergency care they received at an emergency department in the Limpopo Province.

3.3 RESEARCH DESIGN

According to Rebar et al. (2011:175), research design is described as a plan of acquiring an overall new knowledge, or of confirming existing knowledge. Research design is defined as a plan or structured framework of how you intend conducting the research process in order to solve the research problem (Babbie & Mouton 2011:647). Furthermore, Brink et al. (2012:217) describe the research design as the overall plan for gathering data in a research study. Burns and Grove (2009:211) are of the opinion that the research design is the blueprint for conducting a study that maximises control over factors that could interfere with the validity of the findings. In this study, a qualitative, explorative and descriptive design was employed. Each of these aspects will be discussed in Sections 3.3.1 to 3.3.3.

3.3.1 Qualitative design

Holloway and Wheeler (2010:3) state that qualitative research is "...a form of social inquiry that focuses on the way people make sense of their experiences and the world in which they live". Burns and Grove (2011:545) describe qualitative design as a systematic, subjective methodological approach used to describe life experiences and give them meaning. Polit and Beck (2012:739) describe qualitative design as the investigation of phenomena in an in-depth and holistic fashion, by using a flexible research design and through the collection of rich narrative materials. According to Brink et al. (2012:217), research design is described as a plan for gathering overall data in a research study. The researcher concentrated on the narrative stories of participants during interviews, to capture the information and understand their views on care received in the emergency department.

A qualitative approach was used, guided by the 5-D cycle of Appreciative Inquiry (see Figure 1.2) as developed by Cooperrider et al. (2005:5) as well as Cooperrider and Avital (2004:142) (see Figure 3.1) to direct the study. As a systematic, interactive subjective approach, qualitative research was used to explore the views of patients regarding care they received in the emergency department as suggested by Burns and Grove (2009:717). A qualitative study refers to research that is conducted to promote the understanding of human experiences and situations. The understanding will assist in the development of theories that describe these behaviours and situations according to Burns and Grove (2011:545) as well as Holloway and Wheeler (2010:5). The views of patients assisted the researcher to construct descriptive data as data was collected in the real life situation where the patients were receiving care in the emergency department. Furthermore, Burns and Grove (2011:20) state that qualitative research is the more effective method of investigating emotional responses rather than quantitative research, as human experiences are difficult to quantify.

Polit and Beck (2008:219) state that the researcher should be a research instrument, by remaining neutral and avoiding influencing the results of the study. The researcher will not be able to control the data situation because the results will depend on the outcomes of patients' views. Holloway and Wheeler (2010:5) argue that qualitative study allows the researcher to build good relationships with the participants. The researcher was immersed in a real life situation in the emergency department of a Limpopo Province hospital. The researcher used the strategies of observing, questioning and listening in order to collect rich data. For the researcher to understand the participants' views of the care received, it is necessary to be in the setting for a lengthy period as suggested by Holloway and Wheeler

(2010:5). The researcher understood the setting in which the study was conducted well because she had been an emergency nurse for thirteen years in the emergency department.

The qualitative study took place in the natural setting of the emergency department of a tertiary hospital in the Limpopo Province, as suggested by LoBiondo-Wood and Haber (2010:86) and Creswell (2007:37). Qualitative studies are based on various inquiry strategies, which include narrative, phenomenology, ethnography, grounded theory and case studies, as suggested by Creswell (2007:35) as well as Taylor and Francis (2013:3). Data was collected utilising Appreciative Inquiry where the patients shared their views (telling stories) pertaining to the care received in the emergency department.

Polit and Beck (2008:219), Holloway and Wheeler (2010:3), as well as Creswell (2007:37) have identified the characteristics of a qualitative design that include the following aspects:

- **A natural setting:** The researcher collects data in the field where the participants experienced the issue under study. The field refers to the emergency department where the patients are admitted.
- **Multiple data sources:** There should be an integration of data strategies during data collection. The voice recorder was utilised during interview to capture the information. The Appreciative Inquiry interview guide was utilised to guide the collection of data as well as field notes and transcripts of the interviews.
- **Flexibility and elasticity:** Qualitative designs are able to adjust to that which is learned throughout data collection. With the additional questions that could be asked, the interviewer was able to re-phrase the questions if they were not understood.
- **Holistic account:** The researcher tended to strive towards the understanding of the entire concept (views of patients). There is identification and reporting on a range of factors that are implicated in the situation under study. Therefore, patients who are admitted in the emergency department are applicable to the study.
- **Intense involvement from the researcher:** Data was personally collected by the researcher through the appreciative interviews with patients and the analysis of data was also done by the researcher. Informed consent in writing was obtained by the researcher prior to the Appreciative Inquiry interview.

- **The researcher is the key instrument:** The researcher was actively involved with the participants. The researcher did not depend on an instrument designed by others researchers. The researcher designed the Appreciative Inquiry guide in collaboration with the supervisors.
- **Inductive data analysis:** This requires the researcher continuously to analyse the data using the steps of Tesch for content analysis. Therefore, the researcher listened continuously to the interviews and read through the transcribed interviews to identify emerging themes.
- **Interpretive inquiry:** The researcher made interpretations based on the information provided by patients interviewed, field notes and transcripts. This enabled the researcher to interpret what the participants had experienced relating to the care received in the emergency department.

According to Taylor and Francis (2013:19), qualitative research acknowledges that circumstances influence people and phenomena to change. This implies that transferability of the findings is appropriate to the wider group of the population studied, unlike generalised research findings. Furthermore, the authors stated that in qualitative research participants are involved to confirm that the interpretations represent a faithful account of what it was like to act as a source of information as the actors (Taylor & Francis 2013:19). The participants were allowed to listen to the voice recorder to validate the recorded interview to approve for the correctness of the information given by them. Throughout the utilisation of Appreciative Inquiry, which is more of a narrative approach, participants were encouraged to share through conversation their hopes, dreams, visions and beliefs relating to the care received (Fry et al. 2002:3).

3.3.2 Explorative design

The researcher engaged in an exploratory design to gain a deeper understanding of patients' views regarding the care they received in the emergency department as suggested by Bless and Higson-Smith (2004:41). Furthermore, Mouton (2002:103) notes that interesting patterns in the collected data can be discovered through exploratory engagement. As the researcher's aim in this study was to explore patients' views regarding the care received in the emergency department, a qualitative, explorative design was suitable. Gerrish and Lacey (2006:20) state qualitative, explorative designs are appropriate when little is known about the phenomenon (patients' views) of interest and when the purpose of the research is to explore, rather than to explain.

3.3.3 Descriptive design

According to Polit and Beck (2012:226), as well as Burns and Grove (2011:256), the purpose of a descriptive design is to observe, describe, and document aspects of a situation as it naturally occurs. This study was descriptive in nature because it described in words the views of patients regarding the care received in the emergency department, as suggested by Merriam (2009:16). In addition, Terre Blanche et al. (2006:558) describe descriptive design as the design that aims to describe a specific phenomenon. All interviewed patients were given the opportunity to describe the care received in the emergency department. The researcher described the challenges and positive aspects the patients experienced regarding the care received in the emergency department.

According to Burns and Grove (2009:696; 2011:536) descriptive design is useful in identifying an interesting phenomenon with the variables within the phenomenon, as well as the development of conceptual and operational variables and to describe the variables. According to Merriam (2009:16), the end result of qualitative design is highly descriptive data in nature. In the view of Brink et al. (2012:112) and Burns and Grove (2011:256), descriptive design is used when more information is required with regard to the specific field of the study, since it provides an image of the phenomenon as it occurs naturally. For the purpose of this study, the phenomenon of interest is the views of patients regarding the care they received in the emergency department. The authors further state that descriptive design can be utilised for the development of theories to identify the challenges within the existing practice, to rationalise one's current practice, to make judgements, and also to determine what others have done in a similar situation (Brink et al. 2012:112; Burns & Grove 2011:256).

3.4 RESEARCH METHODS

Method is described by Rebar, Gersch, Macnee, and McCabe (2011:394) as the method section of a research report that describes the overall process of implementing the research study, including those who were included in the study, and how information was collected together with interventions, if any were tested. Furthermore, Taylor and Francis (2013:3) argue that a method refers to what the researcher does to collect and analyse data. The research methods relate to the target population, sampling, sample size, data collection technique as well as data analysis. Each of these aspects will be discussed in Sections 3.4.1 to 3.4.5.

3.4.1 Target population

The target population is the entire group of people that meets the sampling criteria, whereas the accessible population is the subset of the people within a country, city or unit (Burns & Grove, 2011:290). Furthermore, Sarantakos (2013:477) states that the target population is part of the general population about which research data are required. For the purpose of this study, the identified target population included the patients admitted to an emergency department of a tertiary hospital in the Limpopo Province and who were eligible according to the following inclusion criteria:

- 18 years and older
- able to understand and speak English
- admitted to the emergency department
- discharged from the emergency department following care received.

3.4.2 Sampling

Sampling is *"the procedure for choosing a sample"* as suggested by Sarandakos (2013:476). Furthermore, Polit and Beck (2012:742) define sampling as *"the process of selecting a portion of the population to represent the entire population"*. According to Burns and Grove (2011:548), sampling is the process of selecting a group of people, events, behaviours, or elements that are representative of the population being studied.

The sampling technique utilised in the study was purposive and convenient sampling. Purposive sampling is indicated as the researcher selects participants who are considered to be representative of the population (LoBiondo-Wood & Haber 2010:584). Furthermore, Polit and Beck (2012:724) indicate that convenient sampling is a non-probability sampling procedure that involves the selection of the most readily available people for a study. Convenient sampling was chosen as the researcher identified the selected participants based on the inclusion criteria set for this study and who were willing to participate voluntarily. The researcher collected data in the emergency department after hours (from 16h00 to 20h00 during the week and on weekends) on selected days to ensure that data collection did not interfere with her work as a clinical facilitator of trauma and emergency nursing students. The researcher collected data on weekends during day offs to ensure that all days off the week are observed. On weekends the data was collected from 10:00 to 1400 and also at night from 19:00 to 23:00 on selected Saturdays and Sundays.

3.4.3 Sample size

A sample refers to a "*subset of a population selected to participate in a study*" (Polit & Beck 2010:567). Although qualitative studies use small samples, they also yield a rich amount of data from these relatively small samples (Green & Thorogood 2004:80). A qualitative research study is not dependent on the number of participants included in a study, but rather on the quality and depth of the descriptions described by the participants (Holloway & Wheeler 2010:144).

For the purpose of the study, the identified sample consisted of 13 patients who were treated in the emergency department on the specific days of data collection. The sample was adequate to provide sufficient in-depth information and was also representative of the accessible population; based on the fact that saturation of data was reached after the 11th interview. The researcher conducted two additional interviews to confirm data saturation.

3.4.4 Data saturation

According to Burns and Grove (2009:721) and Holloway and Wheeler (2010:146), data saturation occurs when additional sampling provides no new information, only redundancy of previously collected data emerges. The researcher collected data from the participants until data saturation was reached. According to Brink et al. (2012:173), data saturation is reached when no new information is provided by additional participants. Data saturation is described by Terre Blanche et al. (2006:564) as the point in an interpretive study where the researcher has explored the data to satisfaction and has a clear sense of what conclusions can be drawn from data analysis.

In the view of Polit and Beck (2012:180), the aim of qualitative studies is to discover meaning and to uncover multiple realities and generalisability is not a guiding consideration. Qualitative research is unlike quantitative research that is concerned with the measuring of attributes and relationships in a population, and therefore a representative sample is needed to ensure that the measurements accurately reflect and can be generalised to the population (Polit & Beck 2008:353). Qualitative studies therefore focus on data saturation rather than sample size.

3.4.5 Data collection

According to Creswell (2007:117), data collection offers the researcher the opportunity to assess the research design within the various inquiry approaches. Burns and Grove (2011:535) define data collection as "*the identification of the subjects and precise, systematic gathering of data relevant to the research purpose or the specific objectives, questions or hypothesis (where relevant) of the study...*".

Furthermore, Polit and Beck (2012:725,) argue that data collection is the gathering of information for the purpose of addressing a research problem. In the view of Polit and Beck (2008:751), data collection is the formal procedure researchers develop to guide the collection of data in a standardised fashion. Data collection will be discussed under the following headings: Gaining access (see Figure 3.1), Appreciative Inquiry interviews (see Figure 1.2) and field notes. Each of these aspects will be discussed in Sections 3.4.5.1 to 3.4.5.3.

3.4.5.1 Gaining access

The researcher aimed to pursue a rigorous process in gaining access to the participants, as the patients (participants) were regarded as a vulnerable population. The researcher obtained an approval from: (1) the Student Research Ethics Committee of the Faculty of Health Sciences at the University of Pretoria, (2) the Department of Health Limpopo Province, and (3) the Tertiary Hospital Management.

Access was enhanced based on the fact that: (1) the researcher is a professional nurse with 13 years' experience in the emergency department and (2) is currently the clinical facilitator. This ensured that the researcher is known in the setting and in turn enhanced access. Once ethical approval was obtained (see Annexure A1, A2 and A3), a formal meeting was scheduled with emergency department nurses. During the meeting, the researcher gave a brief overview of the intended study, ensuring that all the emergency nurses understood the rationale for the study and emphasises the fact that the study was not intended to identify "*problems*" with the care rendered to patients, but rather to focus on what worked well and what could be done better. The emergency nurses were allowed to ask questions to ensure that everybody understood the nature of the study.

Prospective participants meeting the inclusion criteria were identified by the emergency nurses treating patients, these patients were informed about the study specifically emphasising the value of the study. Patients, who volunteered to become participants in the study, were introduced to the researcher. The researcher waited in the unit manager's office to interview participants following discharge from the

department. The researcher introduced herself to the participant prior to conducting the interview. The researcher discussed the information leaflet step-by-step with the participants to ensure the participant understand what was expected of him/her. The Appreciative Inquiry interview was conducted after the participant had signed the informed consent form (see Annexure B).

View Figure 3.1 for a schematically representation of how the researcher gained access to the setting, which enabled her to conduct the study.

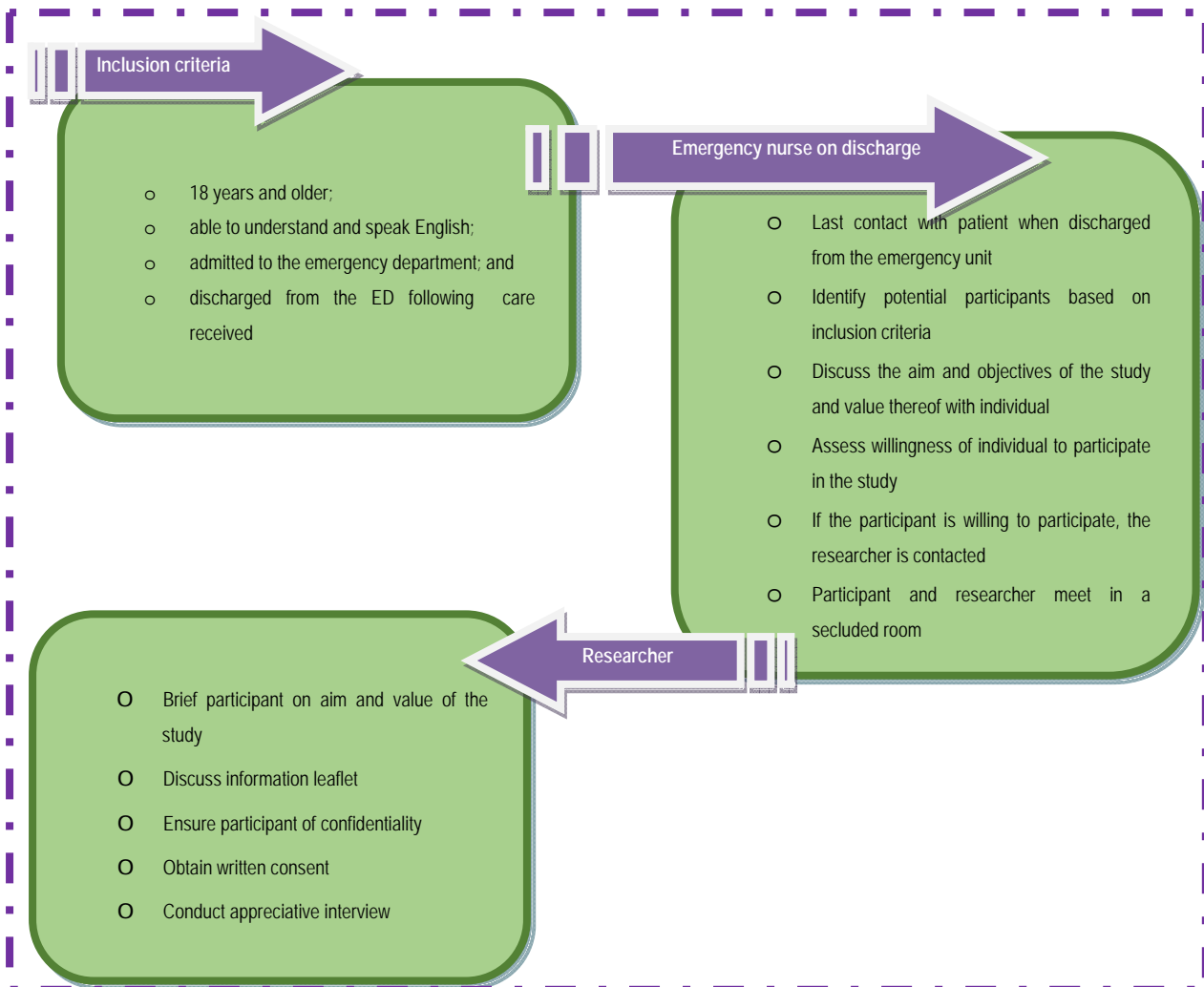


Figure 3.1: Schematic representation of gaining access to conduct the interview

3.4.5.2. The Appreciative Interview

It is the view of Burns and Grove (2011:85), as well as Merriam (2009:85) that interviews are an ideal data collection method in qualitative studies, whereby the researcher can collect participants' responses through a face-face interview.

For the purpose of this study, the appreciative interview was utilised to collect data. Open-ended questions were designed utilising the 4-Ds of Appreciative Inquiry to guide the questions, as suggested by Reed (2007:123).

The questions were based on the following 4-Ds:

- **Discover** (appreciating “**what is**”),
- **Dream** (“**what might be**”),
- **Design** (“**what should be**”)
- **Destiny** (“**what will be**”)

Evaluation is primarily regarded as negative (Coghlan, Preskill & Catsambas 2003:15). However, evaluation can be approached in a positive manner. Utilising Appreciative Inquiry as an evaluation process offers an opportunity to evaluate practice in a positive manner in order to create change (Coghlan et al. 2003:37). Furthermore, Reed (2007:169) affirms that in a climate in which service users (patients) and service providers (healthcare professionals) can be in conflict, the use of Appreciative Inquiry can be utilised as a positive inquiry process, building on the strengths and achievements of all stakeholders (patients and healthcare professionals).

Appreciative Inquiry interview was used to guide the process in exploring patients' views regarding the care they received in the emergency department. The individual interviews involved asking positive questions to participants (patients) in order to craft and implement action plans towards excellence as suggested by (Reed 2007:2). In addition, Cooperrider and Avital (2004:142) argue that each phase in the Appreciative Inquiry 5-D-cycle offers something different to the potential for elevating organisational awareness. In this study, the healthcare professionals working in the emergency department will be made aware of how patients viewed the care received. This will be done during the presentation of research findings on research presentation day in the department.

The researcher wished to create awareness in the emergency department pertaining to how patients viewed the care they received. Raising awareness by asking positive questions is the first step in the change process (Reed 2007:27). Having appreciative dialogue with the patients, provided an opportunity for healthcare professionals to become aware of “*what is*” working and “*what could be*” in future. The interview can be viewed as a conversation whereby questions are asked and the interviewer listens (Denzin & Lincoln 2005:643). The method of interviews are often utilised to collect

data in qualitative designs (Merriam 2009:87). The author states that the interviews may be one-to-one or in a group, with the aim of obtaining special information. Furthermore, interviews may be necessary when the researcher cannot observe participants' feelings or behaviour, or when the researcher is interested in past events that cannot be replicated (Merriam 2009:88). This is especially true in this instance, since the researcher aimed to explore patients' views of the care they received in the emergency department in the Limpopo Province. Each participant's view was regarded as unique. The value of the inputs each participant made to enhance future patients' satisfaction in the emergency department was acknowledged.

The appreciative interview was conducted utilising the following three steps.

Step 1: Preparing for interview

Appreciative inquiry interviews are conversational, purposeful and require advance thought and preparation. Careful thought was given to the wording of the specific questions to be included in the interview guide. The researcher made decisions about a place where the interviews should be conducted as suggested by Polit and Beck (2008:399).

The following questions were included in the appreciative interview:

1. Think about the care you received in the emergency department. Will you please share with me the following:
 - 1.1. What did you value most about the care you received?
 - 1.2. What did you value about the healthcare professionals (emergency nurses and doctors) that assisted you?
2. What are your wishes for the care of future patients in the emergency department?
 - 2.1 What do you think we should do to increase the satisfaction of patients with the care in this department?
3. Based on your experience, what suggestions do you have for healthcare professionals (emergency nurses and doctors) on what can be implemented to increase patients' satisfaction with the received care.

Step 2: Conducting the interview

The following pointers were followed when Appreciative Inquiry interviews were conducted as suggested by Cooperider et al. (2005:94):

- **Explain Appreciative Inquiry**

It was vital to explain the process thoroughly to all the participants, because the Appreciative Inquiry interview is unfamiliar to participants. The researcher explained the process to the participants herself. A participant's information leaflet (see Annexure B) was also handed to each participant that explained the process in depth (Cooperider et al. 2005:94).

- **Respect anonymity**

All the participants were assured that the data collected would be kept anonymous. Data collected would be analysed according to specific themes; this guaranteed the participants' anonymity since it would not be possible to associate any names with information shared. Furthermore, each interview guide was allocated a number and no names appeared on the interview guides.

- **Starting with specific stories- the interview rhythm**

It was important to start the interview with specifics that were relevant to the participants in order to probe his/her storytelling. The researcher then naturally listened intently and learned from this experience. The researcher therefore had to be an active listener. The first question of the Appreciative Inquiry interview guide was for the participants to describe their most satisfying, or peak experience, that was also the focus of the study (Cooperider et al. 2005:94).

- **Generalising about "life-giving" forces**

Attempting to guide the participants to think more abstractly about the present time within the organisation with focus on peak experiences was related to the topic of choice. Questions were formulated in an affirmative fashion in order to focus on the singular, or more peak experience(s), within the emergency department.

- **Listening for themes - "life giving" factors**

A good listener found stories that contained information relating to the "life giving" factors. Should the given information not have contained this vital data, probing was utilised to elicit this data from the

participants. Themes were also identified from the interview that was presented in a dialogue in the dream phase.

- **Keeping track of time**

The researcher needed to keep track of the time due to the fixed schedule. The researcher asked participants for more time as it was required. Ideal questions were paced according to the scheduled time.

- **Having fun and being yourself - it's a conversation**

Do not approach the interview as hard work, but look forward to it as an enjoyable journey. It is important to welcome each participant and make her or him feel important. It is vital for the researcher to take time to listen. Always value the best in each participant. The researcher has to be humble, always be her or himself, be a perpetual learner, and always have fun.

During the introductory stage of the appreciative interview, the researcher explained the aim and value of the study, as well as the role the interview played in the research and the approximate time required. Permission was obtained from the participant to record the interview using a tape recorder. The rationale for using a tape recorder was explained and the researcher indicated that notes are going to be taken during the interview. The participant was reminded that he/she can withdraw at any time if he/she wishes and that there will be no consequences if he/she decides not to continue (Botma et al. 2010:207).

The appreciative interview took place after hours in the unit manager's office, which had been negotiated. As the unit manager does not utilise the office after hours, the office provided a quiet room in the emergency department where the interview was conducted. The researcher took 30 minutes to establish a rapport between herself and the interviewee, and a comfortable environment was created before the participant was briefed once again about the aim and value of the study. Once the researcher was certain that the participant understood the contribution that he/she could make, the researcher then asked for consent to audiotape the entire interview. De Vos, Strydom and Delpont (2011:337) suggest that videos and audiotape offer reliable information, as the information will be organised in a systematic manner so that a specific tape is linked to a specific person, date and time.

During the course of the appreciative interview, the researcher asked the questions. The same questions were asked to all the participants. The researcher was probing throughout the interviews whenever she thought that she could obtain a more detailed explanation of what the participant had stated. Probing was also used to obtain further details of the events that took place in the emergency department. The researcher maintained a natural and easy manner in order to make it easier for the participant to impart the necessary information at all times. The researcher used communication skills, such as paraphrasing and active listening during the interview. She also clarified any uncertainties and encouraged the participant's lines of thought and used reflection to obtain more in-depth information as suggested by De Vos et al. (2011:343). The anxiety levels of both the researcher and the participant were reduced as probing was utilised promptly by the researcher and participants were encouraged to search for elaboration. "Once the interview was completed, the researcher summarised the key meaning and reasons" (Holloway & Wheeler 2010:92).

Step 3: Post interview procedures

The researcher listened to and checked the taped-recorded interviews to check for audibility and completeness soon after the interview was over. An experienced person was used to transcribe the interviews. The researcher checked all the transcriptions to ensure the accuracy and quality thereof, which in turn will ensure that the transcription of interviews is done with rigour as suggested by Polit and Beck (2012:584).

3.4.5.3 Field notes

According to Polit and Beck (2012:728), field notes are described as the notes taken by researchers to record the unstructured observations made in the field, and the interpretations of those notes after data collection. Holloway and Wheeler (2010:339) describe field notes as a record of observations in the field. During data collection, the researcher was able to take field notes by using persistent observation while probing. Field notes were only taken after the researcher had explained to the participants the importance of taking them, and how are they going to assist her during data analysis. Through non-verbal cues, the researcher was able to interpret some of the behaviour that was displayed by the participants.

3.5 DATA ANALYSIS

According to Polit and Beck (2012:725), data analysis is the systematic organisation and synthesis of research data. Streubert-Speziale and Carpenter (2007:96) state that data analysis requires researchers to dwell with or become immersed in the data. The authors further state that the purpose of data analysis is to preserve the uniqueness of each participant's experience and simultaneously permit an understanding of the phenomenon. The researcher aimed to explore each patient's unique view regarding the care they received in the emergency department.

Content analysis as suggested by Brink et al. (2012:201) was used to analyse the data. Data analysis began when the researcher and co-coder independently listened to the participants' verbal descriptions, followed by reading and re-reading the verbatim transcriptions. The researcher and co-coder identified and extracted significant statements that were transcribed onto index cards. Content of data collected (appreciative interview guide) was analysed where words in the text were classified into chosen categories. A systematic means of measuring the intensity of the occurrences of words, phrases and sentences was provided (Burns & Grove 2005:554).

The following steps were utilised during the data analysis as suggested by Brink et al. (2012:194) as well as Holloway and Wheeler (2010:282):

- coding the data for categories and sub-categories,
- labelling the categories,
- integrating the categories into themes, and
- integrating all the data,
- describing a phenomenon.

Once the researcher had completed the coding process and identified the emerging themes and categories from the data, a discussion was scheduled with the co-coder to confirm the identified themes and categories. The inputs from the co-coder were incorporated to refine the coding process as it enhanced the trustworthiness of the research findings, as suggested by Botma et al. (2010:227).

3.6 TRUSTWORTHINESS

According to Polit and Beck (2012:745), trustworthiness can be defined as the degree of confidence the qualitative researcher has in their data, and can be assessed using the criteria of (a) credibility, (b) transferability, (c) dependability, (d) confirmability, and (e) authenticity. Holloway and Wheeler (2010:302) state that trustworthiness in qualitative research means methodological soundness and adequacy. Both authors use the same criteria. Furthermore, LoBiondo-Wood and Haber (2010:588) pointed out that trustworthiness ensures the rigour of the research in a qualitative study. Streubert-Speziale and Carpenter (2003:364) define trustworthiness as establishing validity and reliability of qualitative research. Qualitative research is trustworthy when it accurately represents the experience of study participants. Brink et al. (2012:171) argue that qualitative validity employs the procedures to ensure accuracy of findings. The key principle of qualitative research is to clarify the notion of objectivity as it manifests in the research (Lincoln and Guba (1985), as referenced in Babbie and Mouton 2011:276). Each of the strategies utilised to establish trustworthiness in this study will be discussed briefly in Section 3.6.1 to 3.6.5.

3.6.1 Credibility

Credibility refers to a criterion for evaluating integrity and quality in qualitative studies, referring to confidence in the truth of the data; analogous to internal validity in quantitative research (Polit & Beck 2012:724). According to Polit and Beck (2010:492), credibility involves two aspects. Firstly, carrying out the study in a way that enhances the believability of the findings, and secondly, taking steps to demonstrate credibility to external readers. Brink et al. (2012:172) argue that credibility highlights the confidence in the truth of the data and its interpretation. The authors further ensured that the investigations should be done in order to ensure that the findings demonstrate credibility so that the reader can believe them (Brink et al. 2012:172). Credibility is the alternative to internal validity, in which the goal is to demonstrate that the inquiry was conducted in such a manner as to ensure that the subject was accurately identified and described (De Vos et al. 2011:419). One of the best ways to establish credibility is through prolonged engagement with the subject matter (Brink et al. 2012:172; Streubert-Speziale & Carpenter 2004:49), as supported by Babbie and Mouton (2012:277).

According to Holloway and Wheeler (2010:303), credibility corresponds to the notion of internal validity. This means that the participants recognise the meaning that they themselves give to a situation or condition and the truth of the findings in their own social context (Holloway & Wheeler 2010:303). The research findings are at least compatible with the perceptions of the people under study. Brink et al. (2012:172) and Polit and Beck (2012:589) stated that credibility will be ensured through prolonged, persistent observation and triangulation. Prolonged engagement was ensured as the researcher was interacting with the participants through self-introduction, explanation of the purpose of the study, and how the study will benefit the community of Limpopo province before signing an informed consent. The participants were given time to decide whether to participate or not and questions were also invited for clarification. The researcher further ensured prolonged engagement by assuring the participants that their identity will not be revealed when the results are published. Persistent observation was ensured during appreciative interviews as the researcher was able to observe the behaviour of the participants and through probing where the researcher observed that the participant was not comfortable in giving positive responses to the question asked.

As the appreciative interview was in progress, the researcher asked different questions to obtain different views from each question. The voice recorder was used, together with the field notes that were also taken. The collected data and analysis were verified by the researcher's supervisor and the co-supervisor as an expert in the field of research.

3.6.2 Transferability

Transferability of qualitative data refers to the extent to which qualitative findings can be transferred to other settings or groups; analogous to generalisability (Polit & Beck 2012:745). Transferability refers to the probability that the study findings have meaning to others in similar situations (Streubert-Speziale & Carpenter 2004:49). Holloway and Wheeler (2010:303) said transferability means that the findings in one context can be transferred to similar situations and participants. The knowledge acquired in the context will be relevant in another, and those that carry out the research in another context will be able to apply certain concepts originally developed by others. The study was limited to a specific tertiary hospital in Limpopo Province. The researcher compiled a thick description to provide other researchers with data to use in order to replicate the study in other hospitals.

3.6.3 Dependability

Polit and Beck (2012:725) define dependability as a criterion for evaluating integrity in qualitative studies, referring to the stability of data over time and over conditions, analogous to reliability in quantitative research. Brink et al. (2012:172) are of the opinion that dependability ensures that when the same evidence has to be repeated with the same or similar participants in the same or similar context, the findings would be similar. According to De Vos et al. (2011:420), this is the alternative to reliability, in which the researcher attempts to account for changing conditions in the phenomenon chosen for the study, as well as changes in design created by increasingly refined understanding of the setting. Streubert-Speziale and Carpenter (2004:49) argue that dependability is a criterion met once researchers have demonstrated the credibility of the findings.

Holloway and Wheeler (2010:303) state that if the findings of the study are to be dependable, they should be consistent and accurate. That is, that the readers will be able to evaluate the adequacy of the analysis through following the decision-making process of the researcher. The context of the research must also be described in detail. To achieve the measure of dependability an audit trail is necessary. This will help the readers to follow the path of the researcher and demonstrate how he or she achieved their conclusion. Dependability was achieved by the researcher by the involvement of a supervisor and the co-supervisor for the verification of analysed data.

3.6.4 Confirmability

Confirmability is defined as a "*criterion for integrity in a qualitative inquiry, referring to the objectivity or neutrality of the data and interpretations*" (Polit & Beck 2012:723). According to Brink et al. (2012:119), confirmability guarantees that the findings, conclusions and recommendations are supported by the data and that there is internal agreement between the investigator's interpretation and the actual evidence. Confirmability has taken the place of objectivity. The researcher is judged by the way of achieving the findings and conclusion, and the aim is not the results of the researcher's prior assumptions and preconceptions. Both the details of the research, and the background and the feelings of the researcher should be open for scrutiny (Holloway & Wheeler 2010:303).

Confirmability was ensured by asking for the assistance of the researcher's supervisor when data was analysed. In the current study, confirmability was ensured by means of bracketing. Bracketing is

described by LoBiondo-Wood and Haber (2010:575) as the process by which the researcher identified personal biases about the phenomenon of interest to clarify how personal experiences and beliefs may colour what is heard and reported during data collection and analysis. The researcher put aside the preconceived ideas and concentrated on what the participants had said.

3.6.5 Authenticity

According to Polit and Beck (2012:720), authenticity is described as the extent to which qualitative researchers fairly and faithfully show a range of different realities in the analysis and interpretation of their data. It is the view of Brink et al. (2012:173) and Streubert-Speziale and Carpenter (2003:361), that authenticity can be described as the mechanism by which the qualitative researcher ensures that the findings of the study are real, true, or authentic. Authenticity guarantees that the research study has been done by the researcher herself. Holloway and Wheeler (2010:304) state that the study is authentic when appropriate strategies are used for the true reporting of the participants' ideas. According to Holloway and Wheeler (2010:304), authenticity consists of fairness whereby the researcher needs to be fair to the participants and gain their acceptance by obtaining consent before data collection. Ontology, which means that those involved in the study will be helped to understand their social world and their human condition through the research, is also a part of authenticity. Educative authenticity refers to the understanding of one another by the participants in the study. Catalytic authenticity means that decision making by participants should be enhanced by the researcher, and tactical authenticity refers to empowerment of participants by the researcher (Holloway & Wheeler 2010:304).

3.7. ETHICAL CONSIDERATIONS

According to Polit and Beck (2010:553, 2012:727), ethics is defined as a system of moral values that is concerned with the degree to which research procedures adhere to professional, legal and social obligations to study participants. Furthermore, LoBiondo-Wood and Haber (2010:577) point out that ethics is a theory, or discipline that deals with principles of moral values and conduct. The researcher obtained an approval letter from the ethical committee of the University of Pretoria, the Department of Health Limpopo Province and the management of a tertiary hospital to conduct the study (see Annexure A). The researcher obtained informed consent in writing from every participant in order to ensure that the ethical aspects of the study were taken into consideration (view Annexure B).

Participation in this study was completely voluntarily. The participants chose whether to or not to participate in the study without any penalty and were free to stop participating in the middle of the interview if they were not comfortable.

The Belmont Report articulated three primary ethical principles on which the standards of ethical conduct in research are based: (a) beneficence, (b) respect for human dignity, and (c) justice (Polit & Beck 2012:152), together with Brink et al. (2012:35). These principles are supported by the following human rights principles that require protection in research: (1) self-determination, (2) privacy, (3) anonymity and confidentiality, (4) fair treatment and (5) protection from discomfort and harm (Burns & Grove 2011:107).

3.7.1 Principle of beneficence

According to Burns and Grove (2011:107), the principle of beneficence includes that the researcher needs to secure the well-being of the participant, who has the right to protection from discomfort and harm. Polit and Beck (2012:152) argue that the researcher has an obligation to avoid, prevent and minimise harm, especially because patients are going to be utilised. The study was conducted after gaining approval from the University of Pretoria and the Department of Health of Limpopo Province.

Polit and Beck (2012:153) stated that the relationship that the participants are entering into with the researcher should not be exploited. The authors said qualitative researchers are often in a better position than quantitative researchers to do good, rather than just to avoid doing harm because of the relationship they often develop with the participants (Polit & Beck 2012:153). The researcher reassured the participants that the information provided would not be used against them. The principle allowed the researcher to take an active role in preventing discomfort and harm and to promote good on the site of the research. The researcher conducted the study to protect the participants from discomfort and harm and to bring about the greatest possible balance of benefits compared to harm.

3.7.2 The principle of respect of human dignity

Human rights are claims and demands that have been justified in the eyes of an individual or by the

consensus of a group of individuals. Having rights is necessary for the self-respect, dignity, and health of an individual. Researchers and reviewers of research have an ethical responsibility to recognise and protect the rights of human research subjects (Burns & Grove 2009:198). The right to self-determination and the right to full disclosure are based on this principle. The principle of self-determination means that participants have the right to decide voluntarily whether or not to participate in the study, without incurring the risk of any penalty or prejudicial treatment (Polit & Beck 2012:154) as supported by Brink et al. (2012:35). The principle of respect for human dignity encompasses the right of people to make informed, voluntary decisions about study participation (Polit & Beck 2012:154). The researcher obtained a written informed consent form from every participant in order to ensure that the ethical aspect of the study was taken into consideration. The informed consent form was obtained after the researcher had explained the purpose, significance and the results of the study to the participants, and how the institution would benefit from the study. The researcher made sure that all the participants signed the informed consent form after the explanation given was understood and they were told that participation in the study was strictly voluntary. The participants who were not comfortable during the interview were allowed to withdraw without any penalty.

3.7.3 The principle of the right to justice

According to Burns and Grove (2009:198), the principle of justice holds that each person should be treated fairly and should receive what he or she is duly owed. In research, the strategies and procedures used for selection of subjects and their treatment during the course of the study, should be fair and just (Holloway & Wheeler 2010:55). This principle includes the right to fair selection and treatment and the right to privacy (Brink et al. 2012:36). According to Polit and Beck (2012:155), the selection of study participants should be based on research requirements and not on the vulnerability or compromised position of certain people. Polit and Beck (2012:155) further state that the principle of justice imposes particular obligations towards individuals who are unable to protect their own interests to ensure that they are not exploited for the advancement of knowledge. The researcher who is forced to use vulnerable people is supposed to get permission from the institution, or relatives (Polit & Beck 2012:155).

Burns and Grove (2011:114) define privacy as the freedom people have to determine the time, extent, and general circumstances under which their private information will be shared with, or withheld from

others. The researcher has to reassure the participants that the information collected from them will be confidential and privacy will be maintained throughout the study. The researcher also ensured that the participants know how and when the information will be shared. The researcher complied with the requirement of fair treatment as the researcher honoured the agreement as per the information leaflet. The permission was obtained from the participants during the appreciative interview to use a tape recorder and the taking of field notes. The researcher assured the participants of confidentiality and anonymity and respected their privacy. The participants' names were not provided; instead, codes were used, so that the information can be identified.

The patients who participated in the study were told by the researcher when and how the information would be gathered. No information was collected without their knowledge and informed consent so that the participants were not exposed to any circumstances that they were not prepared for. The researcher was available for the participants to clarify or answer their questions regarding the study. The information leaflet had the researcher's details, namely name, cell phone number and email address, as well as the supervisor's details (see Annexure B).

3.8 CONCLUSION

In this Chapter, the research method was discussed. Chapter 4 provides an in-depth overview of the research findings. A literature control was conducted to support the research findings.

4 RESEARCH FINDINGS AND DISCUSSION

4.1 INTRODUCTION

In Chapter 3, the research design and methods used in the study were discussed. Chapter 4 focuses on the research findings obtained as well as providing an in-depth discussion on related literature.

4.2 OVERVIEW OF THE RESEARCH FINDINGS

The researcher conducted 13 appreciative interviews with participants relating to the care the patients received in an emergency department of a tertiary hospital in the Limpopo Province. Data was collected through face-to-face interviews with participants.

The interviews were guided by the following main questions:

1. Think about the care you received in the emergency department. Will you please share the following with me:

1.1. What did you value most about care you received?

1.2. What did you value about the health care professionals (emergency nurses and doctors) that assisted you?

2. What are your wishes for the care of future patients in the emergency department?

2.1. What do you think we should do to increase the satisfaction of the patients with the care in this department?

3. Based on your experience, what suggestions do you have for us as health care professionals (emergency nurses and doctors) on what we can implement to increase patient satisfaction with the care?

Two main themes were identified, namely *positive and negative views*. See Table 4.1 for a summary of the themes categories and sub-categories derived from the study.

Table 4.1: Summary of the themes, categories and sub-categories

Themes	Categories	Sub-Categories
4.2.1 Positive views	4.2.1.1. Attitudes	<ul style="list-style-type: none"> • Patience • Friendly • Helpful
	4.2.1.2. Communication	<ul style="list-style-type: none"> • Introduction • Process(ED)
	4.2.1.3. Management	<ul style="list-style-type: none"> • Treatment • Supportive care
4.2.2. Negative views	4.2.2.1. Waiting time	<ul style="list-style-type: none"> • Triage • Consultation • Special investigations
	4.2.2.2. Attitude	
	4.2.2.3. Communication	
	4.2.2.4. Management	
	4.2.2.5. Resources	<ul style="list-style-type: none"> • Human • Equipment

Each identified theme and related category will be discussed in depth in Sections 4.2.1 and 4.2.2. The themes, related categories and sub-categories will be discussed as they relate to South African and international literature.

4.2.1 Theme 1: Positive views

The researcher conducted one on one interviews with patients who volunteered to participate in the study. During the interviews, the participants reflected back on the care received in the emergency department. The participants indicated positive views reflected by healthcare professional from arrival in

the emergency department until the time of the patient's discharge. The following quotations support the derived theme.

Supporting quotations:

"...since I arrive here I have been welcome with warm hands by security up to inside in the hospital, at the reception I've been welcomed..."

"...and after that they (nurses and doctors) welcome me well..."

"...It was good, they were good to me. They didn't judge me when I told them I overdosed myself..."

Discussion: Patients who are satisfied after visiting the emergency department will recommend the hospital to others and even come back for further management (Soremekun, Takayesu & Bohan (2011:687). In addition, Oluwadiya, Olatoke, Ariba, Omotosho and Olakulehin (2010:207) together with Muntlin, Carlsson and Gunningberg (2010:321) stated that patients are more satisfied if they are treated holistically and not as a case. In addition, Schultz, Qvist, Mogensen and Pederse (2013:233) argue that patients felt that they were taken seriously and the attention received was helpful for a speedy recovery.

Three categories were derived from Theme 1, namely: *attitude*, *communication* and *management*. Each category will be discussed in Sections 4.2.1.1 to 4.2.1.3.

4.2.1.1 Attitude

The participants indicated appreciation of a positive attitude displayed by healthcare providers during the stay in the emergency department. The participants indicated that a positive attitude will help to build a good relationship between the healthcare providers and the patients.

Supporting quotations:

"... For example when I (patient) came here I (patient) asked where I (patient) must go, they (the porters) showed me a place where the nurse are..."

"... Yes, the Doctor told me (patient) that I'm (patient) ok and he (doctor)'s going to admit me (patient) and he (doctor) was very good to me..."

"...It was also nice because she (doctor) explained everything even though I (patient) was a bit scared when I (patient) came to hospital..."

Discussion: Attitude is described as the pattern of feelings, beliefs, and reactions that an individual holds regarding particular people and ideas and it is often formed based on an individual's past experiences (Boyle, Williams, Brown, Molloy, McKenna, Molloy & Lewis 2010:2). According to Quinn and Hughes (2008:89), attitude has three components namely: cognitive, which consists of the belief an individual holds about the attitudinal object; the effective component, which is concerned with feelings the individual holds about the attitudinal object; and the behavioural aspect, which is the predisposition to act in some way.

Nurses were truly empathetic when the patients were involved in ongoing activities and full attention was given to the patients (Olofsson, Carlström & Bäck-Pettersson 2012:209). Furthermore, Olofsson et al. (2012:209) stated that patients appreciated the nurses' attitude of staying calm despite the stressful situations of the emergency department. Physicians and nurses had a positive attitude of screening hazardous alcohol use so that referral for treatment for those aspects of clinical care and management was carried out (Mabood, Zhou, Dong, Ali, Wild, & Newton 2012:5).

Three sub categories emerged from Category 1 namely: *patience, friendly and helpfulness*.

- **Patience**

The participants appreciated healthcare professionals who were patient with them as the patients were able to verbalise all their problems to the healthcare professionals. The participants felt that healthcare professionals treated them holistically because the healthcare professionals were not only concerned about their illness, but also about them as a person with different health needs.

Supporting quotations:

"... The way they talk, they (nurses) were patient, good, I don't know..."

"...they (nurses) were not impatient..."

"...or was, no one was impatient to talk to me all the staffs was good..."

Discussion: According to Warner, Saxton, Indig, Fahy and Horvat (2012: 89), most of the women who were treated with sensitivity and compassion reported the emergency department staff as good. What the women liked most was when the staff took time to acknowledge the pregnancy loss and the fact that the emergency department staff did not use the medical language when talking to them. Stenner, Courtenary and Carey (2011:40) said that nurses were very patient compared to the doctors because the nurses were able to provide the patients with the information either verbal or written. Stenner et al. (2011:42) stated that the ability of the nurses to prescribe treatment and make decisions let the patients have confidence in the nurses. The authors further said a mutual trust was developed due to the confidence the patients had in nurses and moreover the nurses were able to identify some of the problems that the doctors had missed (Stenner et al. 2011:42).

- **Friendly**

Participants were impressed about the way healthcare professionals displayed friendliness to them during their period of stay in the emergency department. The participants appreciated the good service that was rendered with a smile.

Supporting quotations:

"..They won't be angry at you; they have a smiling face in fact when they come to help a patient..."

"... I mean they were friendly and they spoke to me in a calm voice, because usually we hear that whenever nurses talk to you they scream at you, so they were talking to me in a calm voice..."

"...Her service was very good and she was kind to me, I say that because nurses have a reputation of being very rude, so she was very kind..."

Discussion: According to Arli, Aslan, Purisa and Turkey (2009:1), the patients appreciated being treated by a healthcare professional, who was smiling, had a professional appearance and who is knowledgeable. It is the view of Stenner et al. (2011:41) that patients felt free and comfortable to

express themselves so as to enable the nurses to understand their condition and lifestyle. According to the Nursing Update (2013/2014:22), the white uniform of the nurses portrays patients' safety, assurance, friendliness and protection.

- **Helpfulness**

Helpfulness was identified by the participants who were observing the healthcare professionals during the service delivery as the healthcare professionals were able to help the relatives and the patient before being seen by the doctor and even afterwards while still waiting for medications. The participants also mentioned that most of the nurses who helped them had no language barrier as the healthcare professionals were trying to speak the language the patients were speaking.

Supporting quotations:

"...For all of the nurses, even in the passage. My sister was getting medication for me and most of the nurses that passed, were inquiring her (my sister), why was she still here, what she (my sister) was waiting for ...They (nurses) were very much concerned about me..."

"...Yes even the other patients that they (nurses) were observing, I could see that they (nurses) are concerned..."

"... The other thing that also amazes me is that I know the most spoken language here is Sepedi, but most of the nurses came to me, asked me what is my name and what it mean, which language do I use, if that person (nurse) can speak the language they would use that language. Some would try..."

Discussion: According to Bagchi, Dale, Verbitky-Savitz, Andrecheck, Zavotky, and Eisenstein (2011:254), effective communication was improved between the healthcare professionals and the patients through the help of the interpreters that were provided in an emergency department for provision of additional information on body gestures and non-verbal communication. It was helpful to safeguard everybody in the waiting area by attending to aggressive and disruptive patients as quickly as possible on their arrival in the emergency department (Pich, Hazelton & Kable 2013:160). In addition, Geskey, Geeting, West and Hollenbeak (2013:1002) argue that it was helpful to utilise a computerised consultation management system in an emergency department by emergency department consultants to write the prescription as it reduced time spent by the patients.

Wiler, Gentle, Halfpenny, Heins, Mehrotra, Mikhail and Fide (2010:155) stated that the comfort of patients was increased due to the implementation of advanced triage protocols and this decreased the time to pain treatment. The implementation of the fast track system triage was helpful on triaging non-urgent complaints treatment patients. In this way, patient satisfaction was increased in an emergency department (Quattrin & Swan 2011:41).

4.2.1.2 Communication

Effective communication was appreciated by participant interviewees because more information was given to them during the stay in an emergency department. According to the participants, communication shows that healthcare professionals are concerned about their patients. The participants further stated that if healthcare professionals are communicating to the patients, it shows that the healthcare professionals are interested in you as a person.

Supporting quotations:

"...Ja, I think to me it is important because when you enter a house somebody just pass by and didn't greet you it's not Good but when somebody greets you, you feel welcomed and you can explain everything because you feel free..."

"... Yes, The nurses in there just keep us (patients) informed that the Doctor is around and we have to wait..."

"...she (nurse) was talking to me (patient), she (nurse) wanted to find out what my name was, what was wrong with me, and what happened..."

Discusssion: Muller (2011:202) indicated that during the communication process attention is paid to various barriers of communication structures and interpersonal communication skills. According to Cooper, Endacott and Cant (2010:3) as well as Kilner and Sheppard (2010:128), communication is an essential aspect of patient safety in the emergency department. Meade, Kennedy, and Kaplan (2010:667) stated that increasing communication between healthcare professionals and patients in the waiting area is a good strategy to reduce the number of patients who leave the hospital without being seen. Communication is a non-technical skill amongst healthcare professionals that allows them to ensure the safety of patients, as well as allowing the gathering of information and data that must be reported in the medical records (Bagnasco, Tubino, Piccotti, Rosa, Aleo, Di Pietro, Sasso, Passalacqua, & Gambino 2013:168). In addition, Andersson, Jakobsson, Furåker & Nilsson (2012:65)

emphasised that provision of information is an important factor as it reduces frustration by keeping the patients informed at all times.

Soremekun et al. (2011:687) identified a strong correlation between the physician's interpersonal skills and patient satisfaction that was increased, due to improved physician communication and interpersonal skills, and that it had increased patients' understanding of their care and satisfaction. Drennan, Naughton, Allen, Hyde, O'Boyle, Felle, Treacy and Butler (2011:814) argued that the increased level of patient satisfaction and adherence to medication regimes has been found to be associated with the information given by the healthcare professionals.

Two sub-categories that were derived from the communication category are: *introduction* and *process*.

- **Introduction**

Participants felt satisfied and welcomed when the healthcare professionals introduced themselves to them. Introduction to the participants was valued because the healthcare professionals were greeting them and letting the participants be open to them during the management process.

Supporting quotations:

"...The moment I arrived there I was greeted by the nurses there and she (nurse) showed me where to go so when we (participant and the nurse) were there and she introduced herself (nurses) to me there so that I must know her (nurse) and she (nurse) also asked me my name and address and my problem so I felt that I had to explain everything to her (nurse) and that is why I said that I felt it was Good..."

"...She (nurse) introduced herself as a nurse and she (Nurse) told me what is happening here and told me they (nurses) will assess me and the Doctor will take a lead to let me open a file or send me to the clinic..."

Discussion: Muller (2011:16) emphasised that the patients have the right to know the person who is rendering the service to her/him at all times. According to Nursing Update (2013/2014:23), patients and families preferred to be attended to by an identified healthcare practitioner to encourage a relaxed atmosphere. Families argued that approachability is enhanced through the casual uniform the nurses put on. The patient has the right to know who is treating and rendering healthcare service to him/her at all times (Muller 2011:17). It is the view of Andersson et al. (2012:62) that practitioners should introduce themselves rapidly and state their functions as the first step before examining the patient.

- **Process**

Participants appreciated the fact that all the process of consultation was explained to them. The participants were directed to go and open a file, and on coming back the healthcare professionals directed them where to go and what to do and even the outcomes of the procedures they followed were explained.

Supporting quotations:

"...He asked me the questions and I explained to the Doctor and he had to take blood to be investigated and X-ray for me, we had to go to X-ray and wait and when we came back we had to wait for the X-ray to be reviewed and after that they told the results for the blood is not yet ready and we have to wait and that they cannot continue without the results..."

"...Yes after the Doctor did come and I explained about my pain they ordered something for pain and the I was feeling a little bit better even though it was after a long time then when you come back you have to wait and the Doctor is still busy seeing other patients and when he is finished there he will come and review the X-ray and review and we can't diagnose because we are still waiting for the blood. The blood took time to come..."

"...: I went to Casualty and they saw (nurses and a doctor) me, the Doctor saw me and they (nurses) said that I must go for an X-ray..."

Discussion: According to the patients' rights charter, patients have the right to informed consent whereby the patients should be informed about the way in which the treatment or rehabilitation can affect his/her lifestyle, the availability of the treatment and the alternatives, and the significance of the treatment (Muller 2011:16). Patients should get information on the service they are entitled to receive as the principle of Batho Pele in South Africa (Muller 2011:19). Schultz et al. (2013:233) state that patients in the emergency department experience the end of the waiting time process when they are placed in the examination room.

The third category that emerged from the data was management.

4.2.1.3 Management

Participants highlighted the fact that it would be better if they could be managed by one doctor in casualty so as to be able to build a good rapport. Participants responded positively to the management

received as they reported they were happy about the service received. Participants were satisfied and did not have anything to say about the improvement of the healthcare professionals.

Supporting quotations:

"...Especially the nurses who was treating my wound. The nurses from the first nurse to the second nurse up to when I went for the X-ray and when I arrived for the X-ray, those people (x-ray staff) they were the same as the people (nurses) who treated me before, they (x-ray staff) greeted me well, I received a very Good treatment from the x-ray I went..."

"...and checked my x-ray and checked my wound and said to another nurse to take me to another room and do some other treatments..."

"...did excellent work that makes me think there is no more to improve and point that this is wrong or this is right so the way they (nurses and doctors) treated me there is nothing that I worry and they are already improved..."

Discussion: Most of the patients who return to the emergency departments are satisfied with the management with fewer complaints (Katz, Aufderheide, Gaeth, Rahko, Hillis & Selker 2013:1). According to Martin, Harrahill and Moore (2011:414), the implementation of the designated trauma nursing programme improved management of trauma patients by shortening time to definitive diagnosis, the maintenance of trauma process and improvement of patient and family satisfaction. Schultz et al. (2013:232) argued that patients in the emergency department are encouraged to pull the alarm cord if they need anything while waiting in the waiting area for management.

Two sub-categories were derived from the management theme. These are *treatment* and *supportive care*.

- **Treatment**

Participants responded positively towards the treatment they received from the healthcare professionals. Some of the participants highlighted that they never thought that the type of treatment they received from the emergency department of a tertiary hospital was of such a high standard.

Supporting quotations:

"...she was even saying some couple of jokes so I felt even better myself, and saying that I am now not really sick with treatment she gave me, all the nurses and doctors who attended me were very nice..."

"..Yeah...according to me, the way they (nurses) were treating me with care and respect, if they (nurses) treat all patients like that, I want them (nurses) to keep it that way..."

"..but the service that I get, I didn't know where I would get it, because they took me to where I had to go, I forgot that I am injured..."

Discussion: Luxford, Safran and Delbanco (2011:512) are of the view that a Chief Executive Officer emphasised the point that patients are the first priority for every healthcare professional, and the mission is to improve patient care in most of the organisations. Warner et al. (2012:87) are of the view that healthcare professionals play a major role to reduce the traumatic impact and psychological results associated with early pregnancy loss in defining the miscarriage experience.

According to Kuhn, Worrall-Carter, Ward, and Page (2013:166), emergency treatment for acute myocardial infarction is determined by means of transport to the emergency department. This has been witnessed from the two hospitals whereby all patients who were transported by ambulances were attended to immediately, unlike the patients who were transported in other ways. According to Batho-Pele principles, all patients are to be treated with courtesy and consideration (Muller 2011:19).

- **Supportive care**

This was appreciated by the participants as the healthcare professionals were able to transport them wherever they were supposed to go, this was more especially by those who were unable to walk due to injury. The participants remarked about the friendliness and how co-operative the healthcare professionals were towards them.

Supporting quotations:

"...that nurse as well did a very Good job; he (nurse) was also supportive and friendly..."

"...they (nurses and doctors) were not rude, they (nurses and doctors) were not screaming at me, ja, they (nurses and doctors) were cooperative; let me put it that way..."

"...When I entered, they (nurses) asked me what was wrong with me. I opened a file from there taken to

the consulting room, after being examined by the doctor I (patient) was taken to X-ray. Everywhere I was going because I am injured I (patient) accompanied by a healthcare professional for assistance ..."

Discussion: According to Li, Westbrook, Callen, Georgia and Braithwaite (2013:6), in New South Wales, Australia, as the medical doctors were not prepared to give supportive care, the nurse practitioners (retired nurses) were introduced from 1990. Their duty was to improve the quality of care of patient management through health promotion, and prevention of disease. Education and encouragement had increased patient participation and decision making in the process of caring.

According to Dinh, Walker, Parameswaren and Enright (2012:192), it was stated that the high quality of care was provided in the fast track unit that comprised of both the nursing practitioners working together with doctors and other senior nurses. Patients in the emergency department got attention for their symptoms from different healthcare professionals (Schultz et al. 2013:234).

4.2.2. Theme 2: Negative views

Participants had negative attitude towards healthcare providers due to lack of information given to the patient. The prolonged waiting time was also a problem to patients as the department visited was full, and the patients waited for a long time. Patients stated that they were uncomfortable and ignored when some of the healthcare professionals showed no concern about their problems.

Supporting quotations:

"...I was a little bit scared because they (the nurses) did not explain to me and I thought the final Doctor will come and explain..."

"...The service was very poor and I won't come back here unless they (health care providers) have changed the way they (healthcare professionals) talk to us (patients)..."

"...I don't even want to go back again. I stayed there (x-ray) for 4 hours. It was so full of patients like me and the staff there (X-ray) seem not to care about us (patients)..."

Discussion: According to some of the literature, the community is no longer happy to utilise public hospitals because of the negative attitudes and behaviours of healthcare providers (Nahi, Mojgan, Tayebah & Fatemeh 2012:751). Nicks and Manthey (2012:3) are in agreement with Nahi et al.

(2012:751). The two authors are of the opinion that dissatisfaction has caused the community not to return to the emergency department if appointments are made for further management. Negative behaviours are misinterpreted as a norm that is more salient and that leads to increased conformity to norms (Perkins, Craig, & Perkins 2011:704). Warner et al. (2012:89) reported that despite how busy the emergency department was, the patients complained about the bad attitude that was displayed by healthcare professionals.

The following five categories were derived from the negative theme: waiting time, attitude, communication, management and resources. Each category will be discussed in Sections 4.2.2.1 to 4.2.2.5

4.2.2.1. Waiting time

The participants complained about the prolonged waiting period they had to endure without being assisted by the healthcare professionals, and the prolonged waiting period in the x-rays section and while waiting for the review of x-rays and blood results.

Supporting quotations:

"...: I arrived at about quarter past eight (08:15) in the morning so the nurses came to check me and they have seen me but I'm still waiting for a Doctor and the Doctor came here after 2 hours and then he (nurse) told me I can go and open a file..."

"...the staff there (x-ray) is taking their own time. I was waiting here for 6 hours..."

"...because the other patients here in the room are complaining, they said they were here for a long times..."

Discussion: Prolonged waiting times delay patients access to the healthcare provider on time, and the service for other emergency department patients is delayed due to overcrowding that leads to lack of space for management of other patients (Magita, Beccaro, Cotter & Woodward 2011:142). In addition, Welch and Savitz (2012:149) as well as Horwitz, Green and Bradley (2010:133) highlighted the effect of the waiting period on management of the patients, whereby the patients left the emergency department without being seen. In most cases, non-urgent patients are the ones who complain about the long waiting period in an emergency department as the patients are triaged at the lowest category (Quattrini & Swan 2011:40).

Quattrini and Swan (2011:40) as supported by Bernadette and McCann (2013:180), further emphasised that long waiting periods result in overcrowding, because healthcare professionals in the emergency department have no control over the type of patients who visit the department, the pace of arrival, and even the acuity of the level. Warner et al. (2012:87) who conducted a study in Sydney, Australia reported that a woman had a miscarriage of a 14-week foetus in the public toilet while waiting to be seen. This state of affairs was also reported by Roper, Holleran and Harding (2010:36) and Broadbent, Moxham and Dwyer (2014:28), who stated that patients had serious complications and even died while waiting to be seen in an emergency department.

The following three sub-categories emerged from the findings they are: *triage*, *consultation* and *special investigations*.

- **Triage**

The waiting period during triage was identified as a challenge, as patients felt that it is time consuming and wasteful because after being seen by the triage nurse, the patient is not sure whether she/he will be seen in the emergency department or sent to the nearest clinic. Some patients felt that it will be better if the healthcare professionals treat patients as first come first served and there was no need to sort them because they all need medical management.

Supporting quotations:

"...They (triage nurse) checked my blood pressure and then she (triage nurse) wrote it on a piece of paper and then she (triage Nurse) told me I must wait for a doctor and he is the one who will tell me if I must open a file or go to the clinic..."

"...The nurse came and told us to wait there (waiting area for triage) and then while we were waiting he (the nurse) then started to arrange us (patients) according to our illnesses, I don't know how they (the triage nurses) are checking the priorities but he (nurse) came and he (nurse) was checking how serious our problems are..."

"...Yes, you (patient) will be seen by a nurse and she (nurse) will take your blood pressure and the doctor will then tell you (patient) to open a file or go to the clinic..."

Discussion: According to Morphet et al. (2012:149) and Nicks and Manthey (2012:2), mental healthcare users reported the frustration they are faced with in the emergency department about the

triage system. They witnessed cases whereby they feel neglected because when people are brought in by ambulance they were already in the emergency department, but those people are treated before them. The aim of the triage scale was to improve the assessment and management skills of emergency department triage nurses, but the consistency thereof is not guaranteed, as patients are still not satisfied about the triage system (Morphet et al 2012:149).

Weichenthal and Hendey (2011:79) emphasised the outcomes of triage are not good because most of the patients die while waiting to be triaged in the emergency department. Furthermore, Xu, Chiu Wong, Yee Wong Chin, Tsui, and Hsia (2012:272) categorised patients in order to decrease the length of stay and overcrowding in the emergency department by using a triage score, as also reported by Horwitz et al. (2010:134). In addition, Bambi, Scarlini, Becattini, Alocci, and Ruggeri (2011:334) argued that patients discharge themselves during waiting time in the triage area due to excessive length of stay.

- **Consultation**

Consultation was identified as a critical issue because when the patients are in the consulting rooms they are sure that they will be seen as soon as possible. Sometimes it is not possible due to shortage of doctors, and the need to attend to emergency patients, as the critically ill patients are given the first priority. The participants felt neglected and discriminated against amongst other patients.

Supporting quotations:

"... Yes, even in the cubicle, you don't just come in and be seen. They (nurses) will tell you the Doctor is where and you have to wait until the Doctor comes. I waited there (consulting room) for 2 hours..."

"...they only have one Doctor and now we (patients) have to be patient because he (the doctor) can't divide himself and we (patients) have to wait and I don't know if the other one was away but they(nurses) told me there is only one..."

"...I was in the cubicle waiting for the doctor. The doctor was busy with the emergencies, I think maybe if they can just after the registered nurse asked me about the problem, they diagnose and if possible they can give somebody a painkiller..."

Discussion: According to the South African Batho Pele principle, patients need to be consulted about the level of the quality of the public service they receive and should be given a choice about the

services that are offered (Muller 2011:19). Arli, Aslan, Purisa and Turkey (2009:1), as well as Oluwadiya et al. (2010:207) are of the view that patient experiences of care received in the emergency department are related to their perceptions of not receiving the attention they expect and this leads to anxiety.

Geskey et al. (2013:1002) reported that the computerised consultation was used to save time, but the challenge was that it turned out to be unfavourable due to suboptimal staff that delayed consultations in the emergency department. In addition, Kuhn et al. (2013:166) argued that the mode of transport determined the consultation of metropolitan patients. All patients who are brought in by an ambulance are treated within 8 (eight) minutes on arrival, faster than those who are under triage and brought by other means of transport except the ambulance (Geskey et al. 2013:1002).

- **Special investigations**

Participants identified the special investigations as a challenge due to the time it takes to wait for the performance of the procedures. They had to wait for the results so that the casualty doctor could refer them, or ask for a second opinion from the specialist.

Supporting quotations:

"...and she was taking all kind of tests, like blood pressure and urine test to check whether I am pregnant or not..."

"...The service that I got here in this department (casualty) was Good but I waited for a long time while I was waiting for the results as the Doctor took blood from me and sent it to the laboratory so I am still waiting and they (blood results) are not coming..."

"... Yes and when you get back the bed is occupied by somebody else and you have to wait for the results or for the Doctor to come and review the X-ray and you have to wait on the benches..."

"...I was feeling a little bit better even though it was after a long time then when you come back you have to wait and the Doctor is still busy seeing other patients and when he (doctor) is finished there he (doctor) will come and review the X-ray and review and we (casualty doctor) can't diagnose because we (casualty doctor) are still waiting for the blood..."

Discussion: Patients in the emergency department are bothered by unnecessary tests and different practitioners who examine them (Arli 2009:1). Furthermore, Grudzen, Richardson, Hopper, Ortiz,

Whang, and Morrison (2012:8) argue that the emergency department is a place to manage emergency patients so as to preserve life; the challenge that the physicians are faced with is the implementation of palliative care that will lead to medico-legal concerns and the performance of many procedures that lead to obstacles due to the overflow of many patients.

According to Zun (2012:831), the diagnosis of a psychiatric patient is based on special tests that may have to be done in the emergency department. But, this poses a challenge for the emergency physician and the psychiatric professionals because the two parties do not agree that the tests should be done in the emergency department. According to Kocher, Meurer, Desmond, and Nallamothu 2012, as cited in Crawford, Morphet, Jones, Innes, Griffiths and Williams (2013:3), special investigations have been shown to prolong the stay of patients in the emergency department.

4.2.2.2. Attitude

The attitude that was displayed by healthcare professionals was unacceptable. The patients felt that there is nobody to help them despite the many hours they spend in the emergency department.

Supporting Quotations:

"... The pain was getting worse and worse and I was thinking that these(nurses and doctors) people are not thinking about us (patients) because I took my time to be the first person here(in the emergency unit) and that I will be helped as soon as possible and go home but I had to understand that they(nurses and doctors) have their(nurse and doctors) routine and it wasn't Good because I wasn't feeling Good and the pain was getting worse and worse and at the hospital I expected to be helped..."

"...: Yes, but I was thinking that it took a long time and it was mixed with report taking and they were teaching each other and that took a long time..."

Discussion: Kotzé (2008:89) states that a person without a positive disposition, a love for close relationships with people, and a healthy sense of humour should stay away from a career in nursing. According to Artis and Smith (2013:260), self-harm patients complain about the bad attitude of healthcare professionals that was perceived wrongly, as it reflects the individuals' private attitudes. Saunders, Hawton, Fortune and Farrel (2012:210) emphasised that according to the report given, attitudes were mixed with both positives and negatives. Furthermore, Zun (2012:830) argues that the attitude of healthcare professionals towards the psychiatric patients has a negative impact on the

outcomes of the treatment, and the attitude of psychiatric patients towards healthcare professionals also plays a role in obstructing emergency treatment to be received.

4.2.2.3 Communication

Participants identified lack of communication in the emergency department as the participants complained that, while waiting for results, or to be moved to another section, there is no one to update them. One patient, who was referred by a private practitioner, believed that the referring doctor had arranged for admission with the specialist doctor, but it was not the case.

Supporting quotations:

"...: I think that when you are waiting, we (patients) need somebody to keep us informed about what's happening because they (nurses) are keeping quiet and we (patients) don't know maybe they forgot us. If they come and just inform us (patients). The Doctor comes and asks the same questions the nurse asked. If one Doctor can see us (patients) and tell us (patients) what is wrong and what to do. It is an issue to wait for this Doctor and that Doctor and the X-rays, if those (doctors) from casualty can help us..."

"...Ok. I was angry like I've got the letter and I'm dying here and I thought I'll get here and they will take me straight to where ever like the gynaecologist told me, I thought they will just book me in theatre and whatever, and be done, and when I got here I first had to go and open a file. I was very angry, I don't want to lie..."

"...Yes because if the doctor is very busy, the patients must know so that we, we mustn't query because it is that you see you can get more pain because you think too much of that you don't have, that you don't receive the treatment, let me say so ..."

Discussion: Booyens (2008:275) argues that when one-way communication prevails where patients are not involved, where the healthcare professionals are giving patients instructions, it results in frustration and stress on the patients' side because the message might be distorted or not understood. Despite what is happening in the emergency department, most patients attending the emergency department do not have enough information so that they can access two types, or even more, services at the same time, for example, the suturing of lacerations and blood tests (Land & Meredith 2013:40). In addition, Elmqvist, Fridlund and Ekebergh (2012:116) are of the opinion that there is lack of communication and less time to spend with patients as a front nurse because of running between the physician and the patient and this leads to lack of information provided to the patient. Clear prognosis is

not easy to provide on a dying patient, so it leads to communication problems and the appropriateness of active or therapeutic care (Bailey, Murphy, & Porock 2011:367).

4.2.2.4 Management

Patients had a problem of being seen by various doctors instead of one who can examine, do investigations and be able to diagnose, and did not like to wait for a long time for the second opinion.

Supporting quotations:

"...: It was bad, I didn't want to be a trouble and I have to obey but it was bad because the pain was just getting worse and worse and like when we arrived at the hospital you think that you're going to be helped quick and then the pain will be gone so if you have to wait even if you're in hospital you sometimes feel like not coming to hospital and it's better to feel the pain at home..."

"...I was frustrated because the Doctor who saw me first, they (nurses) say it is a casualty Doctor and when he (casualty doctor) saw the results and everything, he said to me the problem must be seen by a medical Doctor and I thought maybe because he is Doctor he can help me but they (the doctor and the nurses) said no a medical Doctor will come down and assist and I had to wait again..."

"...: I was feeling that pain and wished I had just gone to a private Doctor because I am really feeling pain..."

"... I had no say because this way they (the nurses) cannot change but it's not comfortable, it (triage room) is closed and there is no air coming in and out..."

"...No, they (nurses) gave me nothing because there are running shot of medications..."

Discussion: Warner et al. (2012: 89) and Arli et al. (2009:6) indicated that patients complain about the privacy and dignity that was not provided to them during management by the physician and the emergency department staff. It is the view of Johansen and Newark (2012:1) that the inter-personal conflicts of healthcare professionals reduce quality patient care in most of the emergency departments. According to Oluwadiya et al. (2010:207), some of the patients were shouted at and light hitting was experienced during their management by healthcare professionals in the emergency department. Management of elderly patients can be affected during history taking due to depression or an altered mental status (Grossmann, Zumbunn, Frauchiger, Delpont, Bingisser & Nickel 2012:323). According to Bailey et al. (2011:367), patients and relatives of the subacute trajectory of the dying and death experience less attention during management in the emergency department leading to dissatisfaction.

4.2.2.5 Resources

Lack of resources prolongs the period of stay in the emergency department. Sometimes patients wait for the medications that are not available in the dispensary. Shortage of the resources causes the patients to leave the emergency department with loss of hope in healthcare professionals.

Supporting quotations:

"...I (patient) was sitting on a wheel chair since I arrived in the emergency department, the beds were not available because I (patient) asked for it and told by the nurse that they are all occupied and some of the patients are standing without chairs...."

"...They (nurses) said just wait because they (nurses) can't give me something for pain because they are running short of medication..."

Discussion: Taboada, Cabrera, Epelde, Iglesias and Luque (2013:641) argue that resources limitation is shared by health systems around the world due the increasing demand of urgent care and overcrowding. According to Assid and springs (2011:537), the emergency department in the community hospital was working without any problems like high turnover of staff and patients who left the hospital before being seen, until the implementation of electronic medical records in July 2007. Then the hospital suffered lack of resources and staff turnover, so the problems led to patients complaining about staff that was no longer as engaged or helpful as they were before.

According to Zun (2012:830), healthcare professional in an emergency department are faced with a challenge of shortage of resources to perform emergency evaluation and treatment for the psychiatric patients, so the psychiatric patients seem to be a burden on healthcare professionals in an emergency department. Overcrowding of patients in the emergency department increases the negative impact on patient management due to demand on resources, and supply mismatches (Stoke-Buzzelli, Peltzer-Jones, Martin, Ford & Weise 2010:351).

The two sub-categories that were derived from the resources category are namely: *human resources* and *equipment*.

- **Human resources**

The service is very slow that leads to complaints of poor management by the patients. Staff ratio is inappropriate to the flow of emergency patients. Patients complain that they spend long hours waiting in the queue for review, or in the x-ray section for the x-rays to be taken.

Supporting quotations:

"...You know since I arrived here I have only seen one nurse and I ask myself if this poor nurse is working by herself. There is a lack of staff here and in X-ray I also think there is a lack of staff and the staff is too little here. There are also only a few Doctors here so I think the problem in this hospital is the staff..."

"Yes, because I will only see 3 or 4 people working there (x-ray) and we (patients) are so many for them (x-ray staff). There should be a separate cubicle for Casualty patients..."

"...It is either maybe the doctors are not enough for the casualty can't say they (casualty staff) were slow or somehow but I can say that they (hospital management) must look the staff for doctors ..."

Discussion: According to Nahi et al. (2012:751), healthcare professionals lack empathy for patients due to shortage of staff that leads to incompetence as judged by the patients. Geskey et al. (2013:1002) state that the identified increased number of admissions in the emergency department leads to the increased number of patient consultations that increases the demand on physician staffing and causes the physician to prioritise admissions over hospital discharges. Roethler, Adelman and Parsons (2011:132) as well as Beauchet, Launay, Fantino, Lerolle, Maunoury and Annweiler (2013:1) state that the management of geriatric patients in the emergency department is compromised due to lack of geriatric nurses. According to the authors, the statistics for trained geriatric nurses are very little, despite the increasing number of geriatrics visiting the emergency department.

Nurses feel overwhelmed by the volume of patients. Lack of support for working in a chaotic, uncontrolled environment forces nurses to be transferred out of the emergency department and leaves fewer nurses in the department (Bergman 2012:221), as supported by Weingarten (2009:28). Furthermore, Bergman (2012:223) said the emergency department concerned was closed due to shortage of nurses and physicians because the number of staff members was insufficient to provide quality care that was needed by the patients.

- **Equipment**

Participants appreciated the assisted service, but the challenge identified was lack of important equipment that can help the casualty doctor to finalise a diagnosis. Patients started to panic when the equipment was not available to perform the procedures or investigations.

Supporting quotations:

"...The service of the people was Good and the doctors and the nurses, but there was no ECG machine, they (nurses and doctors) were looking in another ward, the doctor goes to another ward to look for an ECG machine for me..."

"...It is only the ECG machine battery that is flat that I have to wait..."

"...I was thinking maybe I will die because there is nothing here that shows us (the patient and the doctor) what is wrong and I was very afraid..."

Discussion: Searle, Humans and Mogotlane (2011:377) report that the shortage of resources is a nationwide challenge and that it is aggravated by technology that is developing fast, whereby the old way of doing things is being replaced by new equipment. According to Muller (2009:240), the unit manager is responsible to ensure an adequate supply of equipment through good budgeting. Furthermore, Muller (2011:245) argues that the unit manager has to ensure that all personnel in the unit are aware of cost-containment and the need to implement disciplinary measures when there is proof of theft.

Booyens (2008:161) is of the view that sufficient equipment of high quality should be organised to meet the needs of the patients and to improve the healthcare professionals' productivity. VanArtsdalen, Goold, Kirkpatrick, Goldman, Eagle and Crawford (2012:301) report that more than one million people die every year due to lack of pacemaker therapy and this can also affect an individual's ability to function due to the poor exercise tolerance, persistent fatigue and recurrent syncope. Geskey et al. (2013:1002) argue that the number of patients in Korea is more than 90% with lack of bed availability for inpatients that leads to boarding in the emergency department. According to Meyer, Naudé, Shangase and Van Niekerk (2011:112), shortage of equipment is a contributory factor to anxiety and uncertainty experienced by healthcare professionals.

4.3 CONCLUSION

This chapter discussed data analysis, interpretation, and findings with reference to the literature reviewed. The findings revealed the participants positive and negative views in an emergency department.

Chapter 5 discusses the conclusions drawn, summarises the findings, briefly describes the limitations of the study, and makes recommendations for improvement in an emergency department and for further research.

5 CONCLUSIONS, LIMITATIONS AND RECOMMENDATIONS

5.1 INTRODUCTION

In Chapter 4, data analysis was presented with the interpretation and the findings about reviewed literature. Chapter 5 discusses the conclusion, the limitations of the study, the researcher's personal reflection, and the recommendations based on the findings from the participants.

5.2. AIM

The overall aim of this research was to explore patients' views of the emergency care they received in an emergency department in the Limpopo Province. Appreciative Inquiry was utilised to evaluate the views of patients regarding the emergency care they received in an emergency department in the Limpopo Province.

5.3. CONCLUSION

The two main themes were identified as positive and negative views of patients, as well as the categories: that were attitude, communication, management, waiting time and resources. The following sub-categories were identified: patients, friendly, helpful, introduction, process, treatment, supportive care, triage, consultation, special investigations, and human as well as equipment resources. These guided the conclusions made in the study. The conclusion and the recommendations relating to each theme, category and sub-category are provided in Sections 5.3.1 to 5.3.2.

5.3.1. THEME 1: POSITIVE VIEW RELATED TO PATIENTS SATISFACTION

The positive view was highly valued by the patients as it increased their satisfaction with the care received in an emergency department. As the satisfaction was increased, healthcare professionals noticed a good compliance on medication from the patients, and the recommended returned dates were valued. Patients recognised that the healthcare professionals were treating them holistically and the patients embraced the received care as part of the community. When patients are satisfied, healthcare professionals also feel good about the care rendered to the patients. Healthcare professionals have a feeling of job satisfaction and productivity is also increased. With the satisfaction from the healthcare professionals, the manager is able to give her/his workers praise when it is due, to increase the positive working climate and also to improve stress management by having an open door policy. A recognised positive view will decrease the lawsuits against the hospital.

5.3.1.1 Positive attitude (Staff's attitude towards patients)

The emergency department is the front line, or the eyes, of the hospital, so a healthcare professional with a good attitude at work will be a positive role model to others and more productive for the employer. Ensure that the patients are free to communicate with you as well as the colleagues to promote the image of the profession and the hospital. Give yourself time to communicate with the patients and consider the level of education and the culture of the patients. Be available and accessible to the patients who need help at all times. Commitment to work and willingness to help will be of good value to the patients and it makes a healthcare professional an asset of the institution. When nursing the patients, always touch them therapeutically and be gentle with them, so that cooperation is gained. The environment becomes conducive to healing if there is mutual respect between the two parties.

As a healthcare professional, ensure that a good rapport is established at all times so that patients are relaxed in your care. A positive attitude displayed by an employee increases the chances of the employee promoting her/his staff to ensure appreciation. During management of the patients, relatives should be considered by informing them about the progress of the patient in order to allay fears.

- **Recommendations**

The recommendations are made based on the wishes of the patients after data analysis.

Healthcare professionals should:

- Sustain a positive attitude always while on duty when managing patients.

- Have a good listening skill so that patients are comfortable and relaxed during management.
- Ensure a good inter-personal relationship with the patients.
- Sustain friendliness to ensure good service delivery to the patients.
- Promote a positive reputation of the institution and of an emergency department.
- Be available to the patients at all times when they need help.
- Create enough time to talk to the patients and display empathy

5.3.1.2. Communication

Communication dispels fear, so effective communication improves successful management of the patients in an emergency department. Without communication, nursing care will be dull because this will lead to distorted subjective data collection from the patients. For effective communication to take place, all barriers to communication should be identified and prevented. The information given to the patients and relatives improves the relationship between the healthcare professionals and the patients.

Effective communication allows patients to have freedom of speech and to be able to express their feelings to the healthcare providers. It is the responsibility of the institution to design the recommended nametags for employees to wear so that proper identification is maintained. Patients feel secure and comfortable if they are nursed by an identified healthcare professional with a recognised uniform. From the collected data, patients had confidence in healthcare professionals, due to the explanation given to them; the medical doctors also introduced themselves and explained what their roles were in the management of the patients.

The process that patients undergo in the emergency department is very hectic, especially if there is no one to explain it to the patient. Due to effective communication where transparency was displayed by healthcare professionals, patients felt respected and honoured because someone explained to them what to expect from the healthcare professionals. Each step was explained so that the patient had information of what they were waiting for.

- **Recommendations**

The following recommendations reveal what the patients need in the emergency department and what was of good value to them:

- Orientate the patient on how to write their complaints and compliments in the book provided for them.
- Have a courtesy nurse who will keep on updating patients about the changes that occur in the procedures.
- Emphasise patients' rights at all times to them.
- Staff should at all times wear the prescribed uniform with distinguishing devices and recommended name tags.
- Inform the patients about the procedures to be followed in the emergency department.

5.3.1.3 Management

Management of patients effectively and efficiently is of a paramount importance to patient satisfaction. It will be valuable if patients are treated by one medical practitioner, who is able to follow up the patient from admission until discharge in the emergency department. Patients feel that confidentiality is secured if they can talk to one person and they do not need to repeat the same story to different healthcare providers all the time. Confidentiality should be the motto for healthcare professionals at all times.

The good treatment that was received by patients improved the relationship between patients and healthcare professionals. If patients are satisfied with the treatment they receive this will improve the self-esteem of healthcare professionals and lead to good quality care being rendered to the patients. A good hospital will attract more patients.

- **Recommendations**

- Maintain a good relationship with the patients to gain their cooperation.
- Distract patients from their pain by talking to them not only about their illness.
- Educate healthcare professionals on how to handle the patients.
- Sustain the provision of good quality care to the patients in an emergency department.

5.3.2 THEME 2: NEGATIVE VIEWS RELATED TO PATIENTS SATISFACTION

The negative views were observed by patients from the healthcare professional as one of the behaviours that gave rise to dissatisfaction with the patient when receiving care in the emergency

department. All patients visiting the emergency department consider themselves as emergency patients, care rendered to them will always be viewed despite how busy the emergency department is. The negative behaviours will always be identified by the patients as they are in pain and need urgent attention from the healthcare professionals.

5.3.2.1. Waiting time

Waiting time in an emergency department has an enormous impact on the management of patients, because the patients sometimes wait without being informed about the reason for their waiting. Waiting was also experienced in other departments, like in the X-ray department. Most of the patients' conditions deteriorate while they are waiting in the waiting room, because there is no medical doctor to assess them. From the data collected, some patients stated that they were treated unfairly and some mentioned that they will never come back to the hospital. The expectations from patients who visit the emergency department are that they should be treated as quickly as possible.

Most of the patients who complained about the waiting time were those with minor ailments, as these patients are supposed to wait for the triage. When patients are in the triage room, they assume that the medical doctor will examine them. But when this does not happen, they are so surprised to be informed that the doctor will decide after checking the patient as to whether or not to open a file, or to send them to the local clinic. The patients realised that the nurse will check the vital signs before the medical doctor will assess the patient and that adds to the waiting time. If the medical doctor can authorise the patient at once to open a file, the patient will do so. But unfortunately, sometimes the examination rooms are full with emergency patients and other patients have to wait to be seen by the doctor.

After triage, the patients were overwhelmed by having to wait for the medical doctor in the consulting room. Nurses are directed by their scope of practice to function independently and dependently were they cannot perform some of the procedures without being prescribed by the medical doctor , so it is hard for patients to believe this, so they complain about waiting for the one medical doctor to examine them. On a busy day, some patients leave the hospital without being seen by the medical doctor. Due to the pain that patients experienced while waiting in the examination room, the patients wished that the medical doctor could prescribe something for pain to be given to them while they were waiting.

During the consultation with the medical doctor, other investigations such as blood samples are taken and sent to the laboratory. Such procedures add to the waiting time. After receiving the blood results, if there is need for a second opinion, the specialist needs to come and assess the patient. The specialist will also take time to come and the patient will become even more agitated due to the prolonged waiting time.

- **Recommendations**

After data analysis, patients came up with the following recommendations to be implemented so as to improve the service:

- Monitor waiting time against the set standards.
- Make a record of all the distractions or obstacles that occur during the process of management that prolong the waiting time.
- Develop sustainable policies to monitor waiting time that should be reviewed according to hospital policy.
- Allocate a doctor to the triage.
- Have independent trained triage nurses.
- Formulate triage policy.
- Appoint sufficient medical doctors and X-ray personnel.
- Set aside a room where emergency patients can be x-rayed so as not to be mixed with patients from the wards.
- Avoid routine investigations that are not important for the diagnosis of the patients.
- Allow nurses to draw emergency blood before the patient is seen by the medical doctor.

5.3.2.2. Negative attitude (Staff attitude towards patients)

When the care received in an emergency department does not portray the good image of healthcare professionals, the patients will never appreciate the care. If any healthcare professionals on duty fail to attend to patients' needs, patients are going to feel neglected and will never use the emergency department again. During the teaching moment, nurses should decide who of them is supposed to attend a lecture so that others will be available and patient care will not be jeopardised. Teaching in an emergency department should not be an excuse for the healthcare professionals not to attend to patients. One nurse can be allocated to take care of the patients while waiting for the medical doctor to arrive.

- **Recommendations**

- Teaching time should be scheduled according to the target group of the staff.
- All healthcare professionals who show signs of stress should be taken for counselling, or be referred to the psychologist.
- Environmental stressors should be reduced (give praise when it is due).

5.3.2.3. Ineffective communication

Ineffective communication is of a concern to the employee as it results in poor management of the patient. Most of complaints that are reported to the quality assurance staff are about communication in which the healthcare professional failed to update the patients about the reason for waiting. Patients become harassed or surprised to see patients who arrived after them taken to the consulting rooms before them. For those who are not vocal, it becomes more frustrating because they cannot even complain. They just sit in the waiting area until their time comes to go into the consulting room.

Due to lack of communication protocols, referral patients from a general practitioner become confused and angry when a triage nurse instructs the patient to queue despite the referral letter. A healthcare professional does not take the time to explain to the patient about how triage works in relation to prioritisation of patients. During the discussion of the relationship between the patients and the doctors, patients felt that they should be involved so that the patient can have autonomy over his or her life.

- **Recommendations**

- Healthcare professionals should be work-shopped on customer care and *Batho Pele* principles as well as the patients' rights charter.
- Have a language interpreter who will be on standby when a need arises.
- Appoint an operational manager to move around among patients to find out about the service rendered to them.
- The appointed operational manager should also keep the patients informed to increase their satisfaction.

5.3.2.4. Management

The management of patients by different medical doctors does not please the patients because they felt uncomfortable by repeating the same thing to different healthcare professionals. The patients felt

that they could not develop trust in any of the doctors because they thought that there was lack of confidentiality. Patients feel secure when the treatment received was from a nurse and one medical doctor.

Some of the patients said that they felt neglected because if the casualty doctor cannot prescribe any medication for the patients, and the nurses maybe failed to advocate for the patient, it meant the medication would only be prescribed after a long time when the second medical doctor came to assess the patient. Sometimes, when the patient asked for medication, the emergency doctor will tell the patient that the medication is going to have a negative impact on the symptoms before examination, and it is better to wait for the specialist.

- **Recommendations**

- Emergency department should have protocols to guide the nurses on management of patients in the absence of the medical doctor.
- Healthcare professionals need to function according to the code of conduct as stipulated by the different professional councils.

5.3.2.5 Resources

For effective quality care of patients, the employer should provide the employees with enough resources of equipment and personnel. Without the resources, the employee's stress level increases and the productivity decreases. This results in an increased absenteeism rate and turnover. The rate of infection increases due to lack of cleaning materials and gloves, the physical structure is also a contributory factor to infection due to lack of ventilation in the triage room and the use of one blood pressure cuff for many patients without disinfecting it in between. Shortage of staff is a challenge to patients because it exposes the patients to prolonged waiting time as the service is rendered by a small number of staff. The problem was also noticed in the X-ray department. Some of the patients assume that healthcare professionals are just taking their time to help them and the healthcare professionals are less concerned about the patients.

Patients are scared to visit an emergency department due to lack of equipment that puts the patient's life in danger. With no equipment in the emergency department, patients are going to be misdiagnosed

and mismanaged. Patients suffer complications while waiting for the equipment that has to be borrowed from another unit.

- **Recommendations**

- Equipment should be maintained according to manufacturer's guidelines. Check the equipment with each shift to ensure that it is in good working condition.
- Allocate one person who will be responsible for the control and maintenance of equipment.
- Broken equipment should be sent for repair as soon as possible and a record made after sending it.
- Have an inventory book to monitor and control all the equipment every month.
- The department should recruit enough personnel to ensure patient quality care is rendered in time.
- Allocate staff according to their capabilities and the flow of patients.
- Ensure that the placement of personnel is done according to their preferences.
- Management should be given to the patients promptly and pain relieving treatment should not be delayed.

5.4 FUTURE RESEARCH

The researcher makes the following recommendations for future research based on the findings of the study:

- Evaluate the satisfaction of the patients who are admitted to the emergency department.
- Monitor the waiting period and develop strategies to improve it.
- Re-evaluate the utilisation of the triage system.
- Improve communication between the healthcare professionals and the patients.
- Monitor and control equipment.
- Concentrate on factors contributing to patient satisfaction in an emergency department.

5.5 LIMITATIONS

The study was limited to one tertiary hospital where most of the patients from the different districts visit the hospital with a hope of receiving good quality care. The set criteria for data collection implicated some limitations to the researcher due to age and language factors. The research was conducted in a naturalistic setting of the emergency department; some of the identified participants were in a hurry to go home after being discharged, more especially at night and over the weekend due to transport problems. The study did not include patients who were candidates for admission to the hospital, only the patients who had been seen and were to be discharged were targeted.

5.6 PERSONAL REFLECTION

Initially on commencement of this degree, I asked myself a question, "Am I going to make it?" This question followed the little research that I did because most of the people I knew, had acquired many honours degrees. Then I looked at Magister Curationis as a challenge to many people. However, one thing is clear, I believed in myself and not others, so I know the worth of what I do in order to succeed. As a part time student, most of the time is hectic due to lack of support from work and misunderstanding of the new language of research. I developed mixed feelings whereby I felt like I will drop my studies, but my thanks are due to my co-worker who used to motivate me. I did the same for her in return when she felt the same way as I did. The motivation and the strength that I got from my supervisors during contact sessions were of a paramount importance. I started to gain momentum after discovering that there are people outside who will make you feel like you will graduate next week.

In life, there is a point to start and to finish what you have started. With the submission of the work done 3 (three) days before the contact session it was havoc due to lack of computer skills. I pushed myself to enrol for basic computer skills so that I would be able to communicate with my supervisors via e-mail. I registered for the master's degree while I was still working in the emergency department because my wish was to be a post basic lecturer. I was scared of teaching nursing dynamics because research is embedded in nursing dynamics. I joined the college and indeed I was allocated to teach nursing dynamics with two lecturers, who both resigned before the end of the academic year of the concerned students. With the knowledge and information that I got from my supervisors, I was able to stand on my own to teach research. The knowledge that I gained over the years of involvement in this study let me

realise how very important patients are, and the importance of spending time with them so that they can realise that they are important to healthcare professionals. The study was an eye-opener to me, so the identified challenges from the patients will be attended to and will improve the service delivery in an emergency department in Limpopo Province.

During interaction with patients throughout this study, I realised how much healthcare professionals neglect patients by not giving them information about their rights and Batho Pele principles. Indeed our patients who are not enlightened are deprived of their rights and responsibilities. What I have realised with the healthcare professionals is lack of self-esteem and confidence in them. As for nurses, the scope of practice is too vague for them; it gives them less opportunity to be independent. This study improved my academic writing skills and how to search for the information independently in the library. This study exposed me to read more articles and books and now, I am able to assist other colleagues with literature searches. For post basic students, I dedicate myself to assist them with their research projects because I realised that active participation is needed to improve my research skills. Every time that I knock off late due to students' research projects, I think of my supervisors as they used to knock off late and I have become so proud because I am following in their footsteps.

As a novice researcher the use of theories was a challenging as I was unable to identify the one to use that will concur with the topic. Appreciative Inquiry was a chosen theory on consultation with my supervisors but very challenging because it was my first exposure to hear about it, and hard to understand from the beginning. Through literature search and support from my supervisors, I became conversant to it. Appreciative Inquiry inspired me in so much that I started utilising it when confronted with situations that needs to be solved. With its positive approach, participants were found to be relaxed during an interview.

I became so uncertain about my topic because it was changed several times, so I became confused, not knowing whether to continue with the study or I thought it was a way of pushing me to drop the degree. The biggest frustration that nearly destroyed my study was when the university ethical committee changed the topic and I told my supervisor that maybe they are protecting me from something that I am not aware of. I started to realise during data collection that the changing of my topic was a blessing in disguise as there were no participants to meet my criteria in the emergency department, only a few were identified. With the changed topic, I did not encounter any problems during

collection as the participants were available. This journey needs someone who is enthusiastic, and ready to spend sleepless nights, not to mention to distort your personal life.

5.7 SUMMARY

Limpopo is a small, poor, highly rural province that is trying to meet the health needs of its population. The unfortunate part is that not every person after consultation in an emergency department is happy about the service received. Lack of resources is the challenge that is faced by the department on a daily basis. Skilled professionals with speciality are leaving the institution for greener pastures, so the staff turnover lets the remaining staff suffer all the allegations from the community. The researcher used a qualitative descriptive design to guide the study and an interview schedule was used to collect data. The positive and negative views from the participants made a wakeup call for the researcher that the researcher recommends for further research on the identified topic.