Support needed by families during COVID-19 when a close relative is admitted to a health facility in the Khayelitsha district

By

MONDLI INNOCENT CHIYA

STUDENT NUMBER: 220165785

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Supervisor: Prof Karien Jooste

Co supervisor: Ms Amy Williams

Bellville Campus

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DECLARATION

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ETHICAL STATEMENT

The author, whose name appears on the title page of this dissertation, has obtained, for the research described in this work, the applicable research ethics approval. The author declares that he has observed the ethical standards required in terms of the Cape Peninsula University of Technology's Code of Ethics for Researchers and the policy guidelines for responsible research.

Signature: …… …………………

Student name: Mondli Chiya (Student No. 220165785)

Date: November 2023

ABSTRACT

Professional nurses, as part of a multidisciplinary team in the community, have a vital role to play as providers of care for family members living in the same home, when they need support in circumstances where a relative is seriously ill and hospitalised.

When a family member becomes ill, it affects the wellbeing of other family members, causing changes in the life of the whole family. It is therefore unclear how nurses support families during COVID-19 when a close relative is admitted to a health facility (hospital). Using the Critical Care Family Needs Inventory developed by Molten (1979) and revised by Leske in 1991, most studies have confirmed the basic needs of relatives of patients. The nurse is able to be part of supporting families when working in a hospital or clinic.

The purpose of the study was to understand the support needed by family members who had a close relative with COVID-19 admitted to a health facility. In this study the family member (participants) is residing in Khayelitsha and had their family relatives were admitted to any health facility in the Western Cape. A descriptive phenomenological research design was used. The accessible population was family members in Khayelitsha who had a close relative with COVID-19 admitted to a health facility.

Phenomenological interviews were held with 11 participants. A pilot interview was conducted. The interviews took between 30–45 minutes to complete and took place at a time that was convenient for the clinics. Participants took part voluntarily and gave their informed consent. The transcripts and recordings did not have any form of identification on them apart from a number. Trustworthiness was ensured during the process of conducting the study and all ethical principles were adhered to. Data was analysed using Colaizzi's descriptive phenomenological method of coding. The transcripts were analysed by an independent coder, who reached consensus with the researcher on the themes and categories that emerged from the data.

The findings indicated that authentic information should regularly be made available to relatives to establish a trusting relationship with staff. This was to address the essential needs of family members, who had to be identified to assist in relieving their pain. The need of families for ‘nearness’ should be understood and means more than physical proximity to a close relative. Comfort should be given to the family members through comprehensively supporting them, to diminish feelings of hurt created by the unforeseen impact of COVID-19.

It is concluded that family members should have a means of communication with a relative in hospital, as a lack thereof is an added traumatic event, apart from the original reason for admission of the relevant. Family-centeredness is a principle that should become practice and not just agreed with. The underlying thread throughout the report was that participants had experienced a sudden disruption to their family structure, leading to a measure of adjustment, which was hard to deal with. It is recommended that the professional nurses should assist family members in traumatic circumstances, by showing compassion in many ways. Trusting relationships is essential and can be demonstrated by nurses who show respect for human lives.

Key concepts: Nurses, experiences, COVID-19, nursing practice, support

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DEDICATION

The COVID-19 pandemic is considered the most crucial global health calamity of the century, and the greatest challenge that humankind has faced since World War II (Chakraborty & Maity, 2020).

The year 2020 was one of great distraught for many people around the world. I would therefore like to express my deepest and most sincere condolences to everyone who lost a close family member due to COVID-19.

I would like to take this opportunity to dedicate this thesis to anyone who has been infected or affected by COVID-19, especially Lelethu Mlambo and her family, who lost a mother.

I would also like to dedicate this thesis to my family, especially my parents Nomlindo Mavis Chiya and Sibongiseni Nicholas Chiya – thank you for being such great parents. I love you.

To my sons (twins) Sbongokuhle and Asbonge'okuhle, I hope you grow older and become better people one day – and remember, "the sky is the limit."

ABBREVIATIONS AND ACRONYMS

CHC	Community health clinic
FCC	Family-centred care
ICU	Intensive care unit
NICD	National Institute for Communicable Diseases
PHC	Primary healthcare
PTSD	Post-traumatic stress disorder
WHO	World Health Organisation

GLOSSARY

Family	A group consisting of parents, guardians and their children living together as a unit.
Close relative	A dependent, biological, adopted, foster or stepchild that is a member, family-related person living in the same home as the parent/guardian of the house (Law Insider, 2020).
Support	To hold up or add strength to, literally or figuratively.
Patient	Persons admitted to a hospital, into the high care unit or, intensive care unit.
Family needs	Requirements of a family, which when they are met, relieve or reduce distress or improve their senses of adequacy or wellbeing.

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CHAPTER ONE
ORIENTATION TO THE STUDY

1.1 Introduction

Epidemic outbreaks have negative effects on individuals and society at large (Duan & Zhu, 2020). Duan and Zhu (2020) argue that the negative effects of epidemics at individual level take the form of psychological issues, while at societal level they lead to a shortage of professionals to provide psychological intervention.

As with previous epidemics, the coronavirus (COVID-19) pandemic was a shock of global proportions, impacting families when their members contracted COVID-19. COVID-19,that caused an increase in stress when relative/s had a member admitted or there was a sudden admission of a family member to hospital, as well as an economic burden when the breadwinner of the family contracted the disease. How each family experiences the repercussions of COVID-19 is impacted by the presence of vulnerable parents, children, and the socio-economic status and conditions, and psychological make-up of people (Conti, 2020; Jackson, Bradbury-Jones, Baptiste, Gelling, Morin, Neville & Smith, 2020; Pragholapati, 2020:3).

The COVID-19 epidemic posed a remarkable threat to the health of the community (Zhao, Zhao, Guo, Yuan, Ran, Wu, Yu, Li, Shi & He, 2022:1; Pan & Zhang, 2020:1), but this health crisis did not affect everyone in the same way (Jackson et al., 2020). The COVID-19 pandemic outbreak has affected people all over the world socially, mentally, physically, psychologically, and economically (Pragholapati, 2020:3). However, in conceptualising the ramifications of the COVID-19 global pandemic, it became clear that the need for nurses, especially primary healthcare (PHC) nurses, has never been greater (Jackson et al., 2020).

Families differ in many facets, but what is similar among them is how family members value each other in one way or another, particularly during times of challenges – and especially when a family member is admitted to hospital (Bartoli, Trotta, Simeone, Pucciarelli, Orsi, Acampora, Di Muzio, Cappitella & Rocco, 2021:927). In conceptualising the word “family”. Blessing (2020) argues that a modern way of understanding a family is to look at it as, where two or more people share the same

goals and values, while having a long-term commitment to one another, and living together. In contrast, conceptualisation of “family” is that it consists of a close relative such as a spouse, dependent child or any other person living in the same home as the parent of the house. It could be a person connected with another by blood or affinity (Law Insider, 2020).

This study conceptualised a family member to be a close relative, referred to as a person staying in the same household as the parent of the house, regardless of sharing blood, or when there is commensality.

Family members are not psychologically prepared when a family member experiences a critical sickness, and their lives becomes disrupted and disorganised, contributing to their stress (Apostol-Nicodemus, Tabios, Limpoco, Domingo & Tantengco, 2022:1; Khatri Chhetri & Thulung, 2018:1). The short-term impact of having a close relative admitted to a health facility (hospital) with COVID-19, cannot be underestimated. Family members facing such situations are likely to experience significant stress and anxiety due to the restriction of hospital visitation (Amass, Van Scoy, Hua, Ambler, Armstrong, Baldwin, Bernacki, Burhani, Chiurco, Cooper & Cruse, 2022:625).

The infectious nature of this pandemic had a marked impact on the ability of nursing staff to communicate with the families of admitted patients (Griffin, Karas, Ivascu & Lief, 2020:1341). Further, regulated visitation policies during the first wave of the COVID-19 pandemic had an enormous impact on the ways in which medical practitioners communicated with patients and their families. Regulated visitation required nurses to use innovative strategies to adapt to new communication techniques (Krewulak, Jaworska, Spence, Mizen, Kupsch, Stelfox, Parsons Leigh & Fiest, 2022:169). Because of limitations in hospital visits, family communication with relatives and the healthcare team became complex and fragmented (Griffin et al., 2020:1341).

Family members may also suffer from post-traumatic stress disorder (PTSD), depression and anxiety, and may further have difficulties in coping with their new role as caregivers (Fernandez-Canani, Burga-Cachay & Valladares-Garrido, 2022:1;

Nekhlyudov, Duijts, Hudson, Jones, Keogh, Love, Lustberg, Smith, Tevaarwerk, Yu & Feuerstein, 2020).

There are many factors which family members may encounter during supporting their own, and nurses emerge as playing an important role during this difficult time. Hospital visiting hours has been severely curtailed to reduce the spread of infection between patients, families, and staff members (Digby, Manias, Haines, Orosz, Ihle & Bucknall, 2023:1).

Nurses play an important role in infection prevention, isolation, containment and public healthcare, disaster preparedness and management, as well as in emergency responses in many countries across the world (Grochtdreis, de Jong, Harenberg, Görres & Schröder-Bäck, 2023:2).

Nursing care of patients, such as in an intensive care unit (ICU) or high-care unit, should have input from their families. Family-centered care is focused on patient participation in a way that fosters collaboration between patients, families, and the healthcare staff. (Hart, Turnbull, Oppenheim & Courtright, 2020:93).

A COVID-19 pandemic requires a focus on community engagement, as a process of working collaboratively with the concerns of families with a member in hospital with COVID-19, to incorporate their interests in decision-making processes (Turin, Abedin, Chowdhury, Ferdous, Vaska, Rumana, Urrutia & Chowdhury, 2020:7). Interacting with a vulnerable population such as traumatised family members and the role of the nurse in engaging with them can address grassroot concerns in the process of making informed decisions (Turin et al., 2020:9). The professional nurse can be a part of supporting families when working in a hospital. This research investigates the support needed by families during COVID-19, when a close relative is admitted to a health facility. In this study a health facility referred to any hospital in the in the Western Cape, Cape Town.

1.2 Background on Covid-19 in the Western Cape

1.2.1 The spread of the virus

First reported in Wuhan, a city in Hubei province, People's Republic of China, on December 31, 2019, an outbreak of respiratory sickness was later shown to be caused by a novel coronavirus, officially termed coronavirus disease 2019 (COVID-19). (Cheng, Chang, Chiang, Chien, Cheng, Yang, Huang & Hsu, 2020:748).

Between December 18 and December 29, 2019, five patients were admitted to the hospital due to acute respiratory distress syndrome, and one of those patients died (Rothana & Byrareddy, 2020). On 2 January 2020, 41 admitted hospital patients had been identified as having a COVID-19 infection. Family relatives with underlying diseases, such as, diabetes, hypertension, and cardiovascular diseases (Rothana & Byrareddy, 2020:6), were prone to COVID-19. The COVID-19 outbreak was declared an international public health emergency on 30 January 2020 by the World Health Organisation (Sohrabi, Alsafi, O'neill, Khan, Kerwan, Al-Jabir, Iosifidis & Agha, 2020:71). The WHO officially announced the outbreak of the novel COVID-19 to be a pandemic on 11 March 2020 (El-Shabasy, Nayel, Taher, Abdelmonem & Shoueir, 2022:161).

On 30 March 2020, COVID-19 statistics for South Africa showed that there were 1326 positive cases in the country, with 324 reported cases in the Western Cape province and a total of 3 deaths nationwide (Gibson & Rush, 2020:3). In response to the COVID-19 pandemic, a nationwide lockdown was announced for 21 days on 26 March 2020 (Gibson & Rush, 2020). The lockdown was in place from 26 March 2020 to 30 April 2020 and enforced by the police and the military (Adebiyi, Roman, Chinyakata & Balogun, 2021:233). During this time, people were not allowed to leave their residences, other than for medical attention, and essential goods and services (Gittings, Toska, Medley, Cluver, Logie, Ralayo, Chen & Mbithi-Dikgole, 2021:948). It has been described as one of the world’s strictest lockdowns ever (Magome, 2020).

In South Africa, on 20 August 2020 the number of confirmed cases was 563 598, with 10 621 deaths and 417 200 recoveries. At the same time, there were 100 213 confirmed cases in the Western Cape (Table 1.1). COVID-19 risks were not limited to

death and hospitalisation, but included psychological impacts (Dubey, Biswas, Ghosi, Chatterjee, Dubey, Chatterjee, Lahiri & Lavie, 2020:780).

At midnight on 4 April 2022, the National State of Disaster was lifted, although some transitional provisions (such as wearing face masks indoors and restrictions on public gatherings), remained in place for another 30 days (Struckmann, 2023:21). On 22 June 2022, Health Minister Joe Phaahla repealed the country's COVID-19 regulations, including the mask mandate. While the pandemic had not ceased, the number of new cases, especially those requiring hospitalisation or leading to death, were 698 841 confirmed (Table 1.1) (Struckmann, 2023:21).

Table 1.1: Number of confirmed COVID-19 cases in the Western Cape over 6-month intervals, August 2020–February 2023

Date	10 August 2020	20 December 2020	20 June 2021	20 December 2021	20 June 2022	15 December 2022	1 February 2023
Confirmed	100213	174665	308376	560 843	698 841	708 724	710 754
Deaths	86 861	5493	12 054	20 292	22 218	22 457	22 478
Recoveries	4 329	134192	284924	505 357	672 917	682 140	686 825
Active case	-	-	-	35 194	3 706	199	1 451

Source: https://sacoronavirus.co.za/

SARS CoV-2 vaccines have been shown to reduce severe infection and death as well as transmission of the pathogen. Vaccination is therefore considered an essential measure in mitigating and ultimately ending the pandemic (Sprengholz, Henkel, Böhm & Betsch, 2023:240). As of 18 October 2022, South Africa recorded 4 023 358 confirmed COVID-19 cases and 102 246 deaths. By 9 October 2022, 37 679 458 vaccine doses had been administered (WHO, 2022:22).

Most countries initiated large-scale vaccination campaigns after the first vaccines were licensed, and as at April 2022, about two-thirds of the world's population had received a first shot (Sprengholz et al., 2023:240).

1.2.2 Health implications

Along with its high infectivity and fatality rates, COVID-19 had a universal psychosocial impact by causing mass hysteria, an economic burden, and financial losses. Mass fear of COVID-19, termed “corona-phobia”, generated a plethora of psychiatric manifestations across the different strata of society (Dubey et al., 2020).

There was emerging evidence that hypertension and diabetes were risk factors for death from COVID-19 (Patel, Nielsen, Badiani, Assi, Unadkat, Patel, Ravindrane & Wardle, 2020:110). The Marmot Review showed that COVID-19 increases the risk of cardiovascular disease, obesity, diabetes and hypertension, and suggested that people of low socio-economic status have increased susceptibility to COVID-19 mortality (Patel et al., 2020:110). COVID-19 caused panic in the community and triggered psychological problems in the socio-economic domain that could impact families for a longer period than the pandemic itself (Dubey et al., 2020:6).

1.2.3 Economic implications

The COVID-19 global pandemic had a profound effect on all aspects of life for families and communities. In the upheaval wrought by the novel COVID-19 pandemic, the lives of loved ones were lost, livelihoods were threatened, and ways of living were disrupted, with the “new normal” ahead being unclear and precarious (Walsh, 2020).

The COVID-19 pandemic had a significant impact globally, but those most affected are those individuals and groups routinely disadvantaged by the social injustice wrought by the misdistribution of power, money, and resources (Xafis, 2020:223). While holding a job during this crisis was lifesaving for poorer families, however, the breadwinners were more vulnerable from contracting the disease and further exposing the whole family to this risk more particularly high to large or extended families that occupy sub-optimal housing (Xafis, 2020:227).

The impact of COVD-19 in developing countries was felt from multiple dimensions, as the pandemic was complemented by the destruction of all socio-economic ties (Khambule, 2022:4). To reduce the spread of COVID-19 infections, the South African government proclaimed the stay-at-home orders and urged the people to adhere to social distancing and the lockdown regulations (Parry & Gordon, 2021:800).

Following the World War II, the COVID-19 pandemic has emerged the century's most pressing global health disaster and the biggest threat to humankind (El-Shabasy et al., 2022:162). During this pandemic there was a need to support the families of patients admitted to healthcare facilities, to provide care and to facilitate meaningful engagement despite the obstacles.

The support provided by nurses is imperative in assisting family members who are left to deal with loss or if one member suddenly leaves home. This is because it prepares family members for effective decision making and deciding on caregiving roles, with the aim of reducing families experiencing anxiety, depression, and posttraumatic stress post the hospitalisation of the relative (Hart et al., 2020:93).

1.3 Literature

The literature addresses family-centred care, the needs of family members and PHC delivery.

1.3.1 Family-centred care

According to the Institute for Patient and Family-Centred Care. Family-Centred Care (FCC) can be defined as an approach for the planning, delivery, and evaluation of healthcare which is based on mutually beneficial partnerships between healthcare providers, patients, and families (Fernández-Martínez, Mapango, Martinez-Fernandez & Valle-Barrio, 2022:2).

In this philosophy of care, the psychological and developmental needs of the patient and the family's well-being are best achieved when the healthcare system supports the pivotal role of the family in partnership with healthcare providers to provide care for relatives (Prasopkittikun, Srichantaranit & Chunyasing, 2020:74).

The goals of FCC during physical distancing remain the same and are focused on: (1) respecting the role of family members as care partners, (2) collaboration between family members and the healthcare team, and (3) maintenance of family integrity (Hart et al., 2020: 94).

To practise FCC effectively, nurses must understand and advocate a philosophy of care and see the family as the constant, sharing information with them to uphold the

family's strength and individuality, and the patient and family's developmental, emotional, and financial needs, with appropriate design of the healthcare delivery system, and staff support (Hong & Cross Francis, 2020:96).

Several studies addressed problems that arose from healthcare providers when utilising an FCC approach, due to lack of understanding of what specific actions constitute FCC, and a lack of skills for integrating the principles of FCC into practice (Prasopkittikun et al., 2020:75).

Hospitals where FCC is part of the organisational culture find that not only patient, family, and staff satisfaction ratings increase significantly, but patients' health outcomes also improve (Shamali, Esandi Larramendi, Østergaard, Barbieri-Figueiredo, Brødsgaard, Canga-Armayor, Dieperink, Garcia-Vivar, Konradsen, Nordtug & Lambert, 2022:4576; Clay & Parsh, 2016:40). FCC does not remove control from competent patients to make decisions concerning their own healthcare. Shamali et al. (2022:4576) argue that when nurses consider family members as an important element in the process of care, they are more likely to initiate effective interactions with them. FCC emphasises that a patient's healthcare decisions should be contextualised in terms of their broader life experiences. This also recognises the role that a patient's family members play in extended and at-home care planning and caregiving (Krajnc & Berčan, 2020:357; Clay & Parsh, 2016:40).

An FCC approach to care is an important feature of nursing care, grounded in recognition of the family as a social unit that is connected not just by blood (Bouchoucha & Bloomer, 2021:4).

During the COVID-19 pandemic, the participation of family members was threatened; however, allowing families, patients, and the healthcare team to collaborate should have been the core of FCC (Hart et al., 2020:93).

1.3.2 Family members and their needs

The family is one of the basic units of society and has a great influence on its members (Khatri Chhetri & Thulung, 2018:1). It is important to understand the needs of impacted family members and survivors, to ensure overall well-being of the family unit. It has been shown how the impact of COVID-19 on family members can have a domino

effect on other family members, especially those close to them, such as their partner, parents, and children (Shah, Ali, Nixon, Ingram, Salek & Finlay, 2021:11).

When a family relative becomes sick, it affects the well-being of other family members and causes changes in the lives of all of them. Critical illness often occurs without warning, and there is little time for patients and their families to prepare for it. If family member's immediate needs can be met, desirable consequences can be achieved for both family members and patients. To meet family members' needs, nurses must be able to identify their needs accurately (Amass et al., 2022:625; Khatri Chhetri & Thulung, 2018:1).

However, research suggests that family members do not always perceive that they are included in the treatment of their relatives, and they believe that their needs are not adequately addressed by nurses (Laranjeira, 2022:2; Kynoch, Cabilan & McArdle, 2016:24;). It is also suggested that the support to the family members of patients is based on traditional role interpretations instead of nurses' intuition, practical experiences and perceptions of the family's' needs, and thus is much less evidence-based (Kynoch et al., 2016).

Many members of families who miss their loved ones and live in a state of perpetual worry when their relatives are admitted to a health facility. Families of very critically sick and dying patients were not allowed, to visit their loved ones and were not able to say a final goodbye (Ones, 2020:87). Families who struggle with the stress of having a loved one in a health facility often think that they are being left alone, and that no one will help them. They fear that the relative will die or be permanently disabled and lack clarity about the status and prognosis of the relative, while financial difficulties and a change in family roles triggers anger, guilt, denial, grief and depression (Elay, Tanriverdi, Kadioglu, Bahar & Demirkira, 2020:825).

Nursing care must address the needs of the whole family. The needs of patients in high or intensive care and those of their families are especially complicated by the related physical and emotional demands. Accurate assessment of human basic needs is one of the first steps in providing appropriate care to hospitalised patients and their families (Khatri Chhetri & Thulung, 2018:9). It is necessary to specifically understand the problems and demands of family members to establish a safe healthcare system

that can respond to their needs effectively (Bartoli, Trotta, Pucciarelli, Simeone, Miccolis, Cappitella, Rotoli & Rocco, 2022:53).

Family-centered care (FCC) highlights the importance of involving the family during the patient's stay in hospital, and the responsibility of clinicians to provide emotional support to the family (Berntzen Lind, Alfheim & Tøien, 2023:2; Davidson, Aslakson, Long, Puntillo, Kross, Hart, Cox, Wunsch, Wickline, Nunnally & Netzer, 2017).

1.3.3 Primary healthcare delivery

PHC is the first level of contact between patients and the health system. Its main objectives are to promote the health of individuals and the community; to prevent illness of individuals and family members; to provide medical care for common illnesses, and acute and chronic illnesses; and to manage ongoing psychosocial problems that are either related to Covid-19 or created by medical illnesses (Alnaser, 2020:61). The main principle of PHC that makes it superior to other disciplines is the provision of personal care to individuals, taking into consideration the family and population's health, and the concept of offering continuity of care. Moreover, the care that is given should be efficient, appropriate, sustainable, affordable, and cost-effective (Alnaser, 2020).

The COVID-19 pandemic posed an unprecedented challenge for science and society and demanded rapid and diverse responses by health systems that needed all of their components to be reorganised (Medina, Giovanella, Bousquat, Mendonça & Aquino, 2020:1).

1.4 Theoretical assumptions

The predicament of family members with a hospitalised relative generated much interest in FCC in the community. Nursing practitioners, work from a guiding assumption that 'health and illness is a family affair' and that patients, residents, and their families are inextricably connected. Studies have identified family needs when relatives were critically sick. The Critical Care Family Needs Inventory developed by Molten in 1979, and revised by Leske in 1991, confirms the essential basic needs of family members in a pandemic as having: (i) information, (ii) assurance, (iii) support,

(iv) closeness or proximity, and (v) comfort (Khatri Chhetri & Thulung, 2018:10). In this study it was assumed that:

- The basic needs of the family members of a close relative who has been admitted must be assessed in order to be supported adequately.
- Adequate and honest information should regularly be provided to the family within a professional-ethical framework.
- Closeness to the patient means more than standing at the bedside of a close relative.
- Comfort is viewing a family member holistically, to ease the impact of the situation around the close relative with COVID-19.

Information that is provided as above helps the family to give meaning to a situation that is out of control (Mistraletti, Gristina, Mascarin, Iacobone, Giubbilo, Bonfanti, Fiocca, Fullin, Fuselli, Bocci & Mazzon, 2020:10). Receiving information about the patient hospitalised in an ICU is classified as among the most important needs of family members of such patients (Lin, Peng, Zhang, Huang, Chen & Lin, 2022:1939; Gaeeni, Farahani, Seyedfatemi & Mohammadi, 2015:8). A major task of nurses is to provide family members with the appropriate, clear, and compassionate information, as they need to participate in making decisions about relatives who are unable to speak for themselves (Khatri Chhetri & Thulung, 2018:8). Access to information about a patient's condition and quality relationships with nurses are high priority needs for families. Families have expectations of the healthcare providers fulfilling such needs; however, they are commonly overlooked or become secondary delivery of nursing care to the patient (Khatri Chhetri & Thulung, 2018:12-13).

There is a need for reassuring families regarding the fact that their loved ones have not been abandoned and are being taken care of, not only from a clinical point of view but also relationally. It is essential that doctors communicate to the families that they are taking the best care of the patient, and that their loved one is not suffering (Mistralleui et al., 2020). When family members live far away, it is important to dedicate time for telephone conversations or video calls, not only to respond to questions but also to give a face to the clinicians to create a trusting relationship (Lissoni, Del Negro, Brioschi, Casella, Fontana, Bruni & Lamiani, 2020).

Nurses need to be sensitive of family member's feelings, identify problems and help them to cope with the situation (lack of proximity) and feeling isolated from their loved ones. Apostol-Nicodemus et al. (2022:9) argue that a family members' anxiety stems from the inability to feel connected to the patient and to be informed about delivery of care. Regular, updated information on the patient's condition will enable families to understand the situation (Apostol-Nicodemus et al., 2022:9; Zainah, Sasikala, Nurfarieza & Ho, 2016).

Support of all parties is expected, so that those who have been most detrimentally affected by the pandemic can be supported and they may go through a healing process from the traumatic events. The role of government, health practitioners, and community leaders in providing health education related to COVID-19 could be of great help, so that people do not attach a negative stigma to those having COVID-19 (Pragholapati, 2020:2).

1.5 Problem statement

On Thursday 5 March 2020, the National Institute for Communicable Diseases confirmed that a suspected case of COVID-19 had tested positive in South Africa. The patient was a 38-year-old male who had travelled to Italy with his wife. They were part of a group of 10 people that arrived back in South Africa on 1 March 2020. The patient consulted a private general practitioner on 3 March, with symptoms of fever, headache, malaise, a sore throat and cough. The practice nurse took swabs and delivered them to the laboratory, and the results came back COVID-19 positive (Western Cape Government, 2020). This was the start of families being separated from their relatives.

Family support is more – not less – important during a crisis. However, during the COVID-19 pandemic, maintaining public safety necessitated the restriction of the physical presence of the families of hospitalised patients. In response, the health systems had to rapidly adapt family-centric procedures and tools to circumvent restrictions on physical presence inside hospital units. Families struggled to understand limited time and attention they received, and that staff had to devote to learning new skills in managing covid-19 (Hart et al., 2020:93).

Qualitative studies have shown that the reaction of family members to sudden occurrences involves stress, confusion and uncertainty, a search for information, and attempts to fulfil the perceived needs of the patient and themselves (Terzi, Polat, Katran, Kıraner & Kol, 2022:22). However, when a patient is hospitalised with COVID-19, many of them are unable to communicate because of sedation, mechanical ventilation, confusion, and being in a coma. This results in much of the burden of decision-making and treatment choices falling to the patients' family members (Correia, Martins, Barroso, Valentim, Fonseca, Lopes & Pinho, 2022:1). This may affect the family members by increasing their risk of psychological and physical symptoms (Terzi et al., 2022:2; Khatri Chhetri & Thulung, 2018:3).

Nurses are at the forefront in healthcare settings and should support vulnerable populations, such as those affected by COVID-19. The nurses act as advocates for patients and their families (Jackson et al., 2020). During COVID-19, patients visited community health clinics, from where some were referred to healthcare facilities for admission unexpectedly. It is unclear how the families experience the hospitalisation of a close relative who was unexpectedly admitted to hospital with COVID-19, and how nurses should support the family in this scenario.

Nurses have professional responsibilities in providing for the psychosocial well-being of the family, and should provide holistic care that may include intervening, by evaluating family members physically and psychologically (Terzi et al., 2022:2).

The study by Prasopkittikun, Srichantaranit and Chunyasing (2020:77) reveal that nurses agreed that families have various needs, including the need to be fully informed daily about the condition of a relative.

From the problem statement, the following two research questions emerged:

- What are the experiences of families during COVID-19 when a close relative was admitted to a health facility?
- How can nurses support families during COVID-19 when their close relatives were admitted to a health facility?

1.6 Purpose of the study

The purpose of the study was to understand the support needed by family members in the Khayelitsha district, during COVID-19 when a close relative is admitted to any health facility in the Western Cape,Cape Town.

1.7 Objectives

The objectives of this study were to:

- Explore the lived experiences of families during COVID-19 when a close relative is admitted to a health facility.
- Describe the support of professional nurses to address the needs of families during COVID-19 when a close relative is admitted to a health facility.

1.8 Research design

A research design refers to the overall strategy chosen to integrate the different components of the study in a coherent and logical way, and thereby address the research problem through collection and analysis of data. A research design provides a plan of how the researcher will go about answering the research question/s. Clearly defining the problem as a researchable question is extremely important (Mbaka & Isiramen, 2021:28).

A qualitative descriptive phenomenological study was conducted between September 2021 and October 2021 to investigate the support needed by families during COVID-19 when a close relative is admitted to a health facility. Qualitative research aims to investigate feelings and thoughts of people (Bu-Shakra, 2019: 4), and was the method chosen to answer questions around the phenomenon of interest. Collecting and analysing narrative data from the participants was used to explore the lived experiences of by families during COVID-19 when a close relative is hospitalized (Hong & Cross Francis, 2020:381). In contrast, quantitative research would have employed the use of number of responses on e.g., an instrument (Polit & Beck, 2021; Rutberg & Bouikidis, 2018:209), while the researcher wanted to focus on human experiences.

1.8.1 Phenomenology

Husserl's descriptive phenomenology is popular in health research, as it provides a way to understand peoples' lived experiences (Northall, Chang, Hatcher & Nicholls, 2020). The goal of phenomenology is to describe the meaning of an experience, both in terms of what was experienced and how it was experienced (Neubauer, Witkop & Varpio, 2019). Phenomenology assisted the researcher to learn from the lived experiences of participants and not just to describe them. The goal of following this approach was to enter another person's (the family member's) world to gain an understanding thereof (Hanson & Abuijlan, 2020:48; Neubauer et al., 2019). A descriptive phenomenology design was followed in this study to investigate the lived experience of families during COVID-19 when a close relative is admitted to a health facility.

An exploratory design seeks to explore and find answers about the research problem, mainly focusing on "what" or "how" questions (Mbaka & Isiramen, 2021:29; Holloway & Galvin, 2017:93). In this study the lived experiences families during COVID-19 when a close relative is admitted to a health facility were explored (Brink, Van der Walt & Van Rensburg, 2022) in order to understand them.

A descriptive design was used to describe the support given to family members by nurses during a pandemic when a close relative was admitted to a health facility. A contextual design was followed, as the study was situated within the natural setting with contextual features in which the experiences were lived (Nuuyoma, Lauliso & Chihururu, 2023:3).

1.9 Setting

The study was conducted between September 2021 and October 2021 at two community health clinics (CHC) situated in Khayelitsha Eastern sub-district in Cape Town Metropole, Western Cape. Khayelitsha is a peri-urban area. The services provided by these clinics are primary healthcare orientated, and include an outpatient department, emergency trauma unit and maternity and obstetric unit. CHCs are among the busiest health clinics in the Khayelitsha peri-urban region.

1.10 Population and sample

A population is the entire group of persons, families, events or things that are of interest to the researcher and that meets the criteria of what they want to study (Andrade, 2021:86; Brink et al., 2018:116). In a qualitative inquiry, determination of the population considers the fact that the focus is on participants who can best share their lived experiences and thoughts to address the research aim (Stratton, 2021:373; Asiamah, Mensah & Oteng-Abayie, 2017). The accessible population in this study was family members who visited the two CHC clinics for various reasons such as appointment for child immunisation and collection of medication among other services in the Khayelitsha area of Cape Town.

Non-probability sampling was used, as the researcher selected participants who knew about the phenomenon and were able to articulate and explain nuances linked with the phenomenon (Mweshi & Sakyi, 2020:189; Brink et al., 2022). A purposive sampling technique was followed, with the deliberate choice of participants who had experience around the specific problem and context under investigation (Alshawish, Qadous & Yamani, 2020:75). It is a technique for the identification and selection of information-rich cases for the most effective use of available resources (Mweshi & Sakyi, 2020:189; Palinkas, Horwitz, Green, Wisdom, Duan & Hoagwood, 2015:534). Selecting a sample from the population began with identifying eligibility criteria. The participant needed to have had exposure or experience of having a close relative admitted to a health facility and residing in the Khayelitsha district. Eligibility criteria were used in selecting the sample (Chapter 2).

When pursuing interview-based research, attention to achieving data saturation is a key component in the process of answering the research question and achieving the study purpose (Mwita, 2022:414; Avella, 2016:317). The researcher continued conducting interviews until data saturation was reached at Participant 11.

1.11 Method

The method of data gathering was through phenomenological interviews, to gain an understanding of the lived experiences of families and the support they needed during

COVID-19 when a close relative is admitted to a health facility (Ruslin, Mashuri, Rasak, Alhabsyi & Syam, 2022:25; Neubauer et al., 2019).

1.11.1 Preparation of the field

After permission was obtained from the Research and Ethics committee of the Faculty of Health and Wellness Sciences at a Higher Education Institution (CPUT/HW-REC 2021/H13) (Annexure G and H) and the City of Cape Town in the Western Cape Province (Ref. 28242) (Annexure I). The nurse managers of the CHCs were contacted telephonically for permission to conduct the research at the sites. The researcher explained the purpose and process of the study. The researcher got permission and asked staff working at the clinics to refer voluntary selected participants after their consultations to a private room in the facility for an interview. A notice (Annexure F) was placed at the door entrance of the CHC with telephone number for the participants willing to participate to be able contact the researcher to arrange a time and date to meet. The participants agreed on convenient dates and times. The research purpose and informed consent, coupled with their right to withdraw from the research (Annexure A – information sheet) were explained to the participants. The researcher explained the consent form that informed participants that they may withdraw from the study at any point of the research process should they wish to do so (Lobe, Morgan & Hoffman, 2020:5). The interviews were conducted in a private room without disturbances after participants had provided informed written consent (Annexure B).

1.11.2 Pilot interview

The researcher started by interviewing one participant to ensure that the research questions would provide answers that addressed the purpose of the study. Data collected during this process would not be included in the main study if the research questions had to be changed. The individual interview was conducted to view if the participant understood the questions that were posed. The interview was seen to be credible, and the data of the interview was included in the main study.

1.11.3 Data collection

Data collection describes the way in which the researcher approaches the answering of the research question (Brink et al., 2022). In-depth individual phenomenological

interviews were conducted in both isiXhosa and English and digitally recorded. Field notes were taken. The researcher used an interview guide, starting with general demographic questions and then allowed participants to describe their lived experiences based on two semi-structured questions that were posed, followed by probing. Phenomenological interviews provide ‘deeper’ ideas or understanding of social issues or phenomena and are the most appropriate method when researchers know little about a phenomenon (Islam & Aldaihani, 2022:5). The researcher probed into unclear information to obtained better insight into the sharing of lived experiences. Each interview took between 30 and 45 minutes.

1.11.4 Data analysis

Qualitative data analysis requires the researcher to use inductive thought processes and reasoning to make inferences, offer conclusions and interpretations, or descriptions (Dyar, 2022:196). Positioned in Husserl’s phenomenology, Colaizzi’s (1978) approach offered an approach to analyse the data and obtain trustworthy findings (Northall et al., 2020). The steps in the Colaizzi (1978) descriptive phenomenological approach were followed, namely familiarisation with the data, identifying significant statements, formulating meanings, clustering themes, developing an exhaustive description, producing the fundamental structure and Seeking verification of the fundamental structure. The data analysis process is described in Chapter 2.

1.12 Trustworthiness

Trustworthiness or the rigour of a study refers to the degree of confidence in the data and their interpretation, and methods used to ensure the quality of the data (Dyar, 2022:198). The researcher ensured high quality and rigour by adhering to the criteria for trustworthiness, which included credibility, transferability, dependability, and confirmability. Trustworthiness is discussed further in Chapter 2.

1.13 Ethics

Ethics is a broad term that covers the study of the nature of morals and specific moral choices to be made (Rashid, 2022:1; Varkey, 2021:17). Conducting research must take place in a responsible and morally defensible way as permitted by research ethics

related to studies with human subjects (Pietila, Nurmi, Halkoaho & Kyngäs, 2020:49). Ethical aspects include principles of participant protection and conducting research based on ethical standards. Ethical clearance to conduct the study was obtained from a Health and Wellness Sciences Research Ethics Committee (CPUT/HW-REC 2021/H13) of the academic institution. Permission was obtained from the research and ethics committee of the City of Cape Town (Ref. 28242) to enter the Khayelitsha CHCs. The nurse manager of each of the CHCs was then contacted telephonically for an appointment to explain the study and request permission to enter the site. During the appointments, the method and benefits of the study were explained, and the proposal was handed in with a copy of the information sheet and consent form to the nurse manager, at each of the two clinics. The researcher indicated that he would present health talks to patients at the clinics around the topic of COVID-19 and related problems on the arranged days, in-between interviews. The ethics pertaining to this study will be discussed in full in Chapter 2.

1.14 Significance of the study

The research study could contribute to providing an in-depth understanding of the lived experiences of families during COVID-19 when a close relative was admitted to a health facility. It can assist the broader community of nurses in providing with recommendations on the support needed by families during COVID-19 when a close relative is admitted to a health facility.

1.15 Outline of the study

The report is organised as outlined below.

Chapter 1

This chapter provides the introduction to and background of the study, as well as the design and method that were followed. The purpose of the study was to understand the support needed by family members in the Khayelitsha district, during COVID-19 when a close relative is admitted to any health facility in the Western Cape, Cape Town.during COVID-19 when a close relative is admitted to a health facility.

Chapter 2

In this chapter the research methodology is discussed in detail. The reason for using a qualitative approach was described and the limitations of using this approach are highlighted. A phenomenological research design was used to explore the lived experiences of families during COVID-19 when a close relative is admitted to a health facility and how nurses can support these families during COVID-19 (a pandemic) when their close relatives are hospitalized. The details of the study design, population, sample, method, data collection and data analysis were presented and the measures used to ensure trustworthiness and ethics in the research process are described.

Chapter 3

This chapter outlines and discusses the research findings. The participants' demographic data as well as themes that emerged from the data were addressed. Quotes from the transcripts of the interviews were included to give a direct voice to the participants. The findings of the study were supported by supporting literature.

Chapter 4

This chapter discussed the conclusions and recommendations of the study, as well as the implications for further research as well as the limitations of the study.

1.16 Conclusion

A qualitative research approach was used in this study, where individuals were interviewed using an individual semi-structured interview guide with participants who visited two CHCs in the Khayelitsha district. The introduction in this chapter spelt out the orientation of the study, and the background outlined statistics related to the origin and progress of the COVID-19 pandemic. A clear problem statement was given from which the purpose and objectives of the study were formulated. The methodology was focused on using phenomenological interviews and the processes that were followed regarding the design and method.

CHAPTER TWO
METHODOLOGY

2.1 Introduction

Methodology is the general research strategy that outlines the way in which a research project is to be undertaken and, among other things, identifies the methods to be used (Sileyew, 2019:1). When choosing a methodology to address a research problem, it is important that the researcher selects an approach that aligns with their philosophical assumptions, the study purpose, the current state of knowledge in the area under investigation, and the desired outcome of the research project (Burns, 2022:1). In this chapter the researcher explains the different steps taken to attain the purpose of the study (Mishra & Alok, 2022:1). The main aim of this study was to understand the support needed by family members needed by families during COVID-19 when a close relative was admitted to a health facility in the Khayelitsha district, and how nurses could support families during COVID-19 when their close relatives are admitted to a health facility.

2.2 Paradigm

A paradigm is defined as a philosophical framework for understanding the world at its most basic level. The adoption of a paradigm supported the researcher in conceptualising his beliefs about the nature of knowledge and selecting the methods best suited to address the research questions (Allemang, Sitter & Dimitropoulos 2022:39). In this study, a postmodern paradigm was followed to understand the lived experiences of participants around the phenomenon under study (Hatch, 2018:386), namely, of families during COVID-19, when a close relative was admitted to a health facility in the Khayelitsha district. It helped the researcher to shape the research approach (qualitative), that should address the research problem and offered suggestions on how to address it, and how the research should be conducted within the scope of the given worldview (post-modern) (Mulisa, 2022:118). This research paradigm provided the researcher the methodological foundation for conducting the study (Mulisa, 2022:119).

From an ontological perspective, postmodernism, assumes “there can be no “objective” or final truth” and rejects objectivity, as there are different of reality (Bolaño

Quintero, 2022:18). In contrast, the positivist paradigm is associated with the quantitative research approach, where the purposes are to predict, control and generalise the findings through e.g., surveys or experimental methods (Kamal, 2019:1393).

2.3 Research approach

A qualitative approach was followed that investigated human experiences through the lens of research participants in terms of a phenomenon that took place in a specific context (Brink et al., 2022). Quantitative research, in contrast, employs numerical values derived from observations to explain and describe the phenomenon under investigation (Taherdoost, 2022:54). The qualitative approach of this study used non-numerical data to understand the phenomenon through exploring participants' lived experiences. The process was an attempt to get close to people within their contexts, to understand meaning (Small, 2021:568).

Both qualitative and quantitative research approaches are designed to describe a phenomenon, but each concentrate on distinctive forms of data gathering and analysis (Taherdoost, 2022:54). Quantitative research focuses on quantity or the extent of occurrences, using statistical methods to draw conclusions and test hypotheses (Rehman, 2021:188). This qualitative study employed Colaizzi's (1978) seven-step method to data analysis (Praveena & Sasikumar, 2021:914), on the experiences of having a family member admitted to a health facility with COVID-19.

Quantitative research tests hypotheses and theories to generalise results (Mulisa, 2022:117). This qualitative inquiry explored, narrated, and made sense of the multifaceted reality of family members, during COVID-19, and then generated hypotheses (Renjith, Yesodharan, Noronha, Ladd & George, 2021:1). As mentioned by Renjith et al. (2021:1), a qualitative study evolves from a generally stated question about human realities, in their natural environment, that provides rich, descriptive data, to assist in understanding those experiences. This nature of qualitative research is such, that it more difficult to analyse than quantitative data (Mehrad & Zangeneh, 2020:2).

The qualitative approach followed in this research, values the depth of meaning of human subjective experiences, through inductive reasoning to generate meaning and produce rich, descriptive data (Newhart & Patten, 2023:124). In contrast, quantitative research, if chosen, would value generalisability, objectivity, and deductive reasoning to obtain evidence in supporting specific theories and assumptions.

This study employed the qualitative approach, within a postmodern framework, through a descriptive, phenomenological design to obtain the research purpose set for the study.

2.4 Design

The research design is intended to provide an appropriate framework for a study and entails an outline of how to plan and conduct research (Sileyew, 2019:2). The selection of an appropriate design to answer research questions should be clearly explained and reasoned by the researcher (Doyle, 2020:444). The researcher began to think about the population of interest and the sampling method to employ for the investigation (Mweshi & Sakyi, 2020:183). A flexible research design which offers the opportunity for allowing the various aspects of a problem to emerge was considered, and descriptive phenomenology was found suitable for the purposes of this research study (Mishra & Alok, 2022:8).

The term ‘phenomenology’ refers to the study of phenomena where an occurrence is whatever that seems to a person in their mindful experience (Gill, 2020:1). It describes the crux of a phenomenon by exploring it from the angle of those who have lived it (Ataro, 2020:20; Neubauer et al., 2019:91).

The researcher needed knowledge of the basic assumptions of the design, in order to make important methodological decisions. A *descriptive phenomenological design* was followed that is different from the interpretive phenomenological design. Edmund Husserl (1859-1938) is the founder of the phenomenological philosophy, and his work directly informs ‘descriptive’ phenomenological methodologies, which seek to describe the core of experiences (Gill, 2020:2). In Husserl’s’ approach to phenomenology (descriptive phenomenology), experiences are described, and the views of the researcher are put aside (bracketed), to investigate the phenomenon without any

presumptions being in place (Rodriguez & Smith, 2018:2). This approach focuses on the awareness of the experience by the person in terms of "What is the meaning of the experience of the phenomenon under study?" (Prosek & Gibson, 2021:169).

Heideggerian (1889-1976) or interpretive phenomenology in its ontological form of questioning, aims to reveal vital facets of phenomena that are seldom reported on, and allow one an opportunity to understand the lived experience of being in the world (Burns & Peacock, 2019:1). This design aims to explore the lived experience of a happening, at an individual level of analysis, knowing that social contexts are rooted within an individual's being (Frechette, Bitzas, Aubry, Kilpatrick & Lavoie-Tremblay, 2020:5). In this case, a researcher would pose a question to understand the nature of being human in a specific situation and what is unknown, to inform actions for change (Burns, Bally, Burles, Holtslander & Peacock, 2022:7). This approach would foreground the subjectivity of the individual and how it played a role in shaping one version of the truth (Rangarajan, Onkar, De Kruiff & Barron, 2022:7).

Choosing the descriptive approach meant that the researcher accepted the idea of a blank slate, which used individual experiences to describe the essence of the phenomenon under investigation (Gumarang Jr, Mallannao & Gumarang, 2021).

2.4.1 Exploratory design

This is a design that explores how a phenomenon is displayed and is especially useful in uncovering the full nature of a phenomenon that is little understood to date (Kokorelias, McCallum & Howes, 2019). A qualitative exploratory design allowed the researcher to explore a topic with limited coverage within the literature and allowed the participants in the study to add to the development of new knowledge in a specific context (Kokorelias et al., 2019). It was not aimed at providing conclusive evidence, but at having a better understanding of the problem (Mbaka & Isiramen, 2021:29). An exploratory design has the advantage of discovering the full nature of a phenomenon in terms of what is really going on and how the phenomenon is experienced (Nuuyoma et al., 2023:3).

2.4.2 Descriptive design

The most frequently proposed rationale for the use of a descriptive approach to is to provide straightforward descriptions of experiences, particularly in areas where little is known about the topic under investigation (Doyle, McCabe, Keogh, Brady & McCann, 2020:444). A descriptive design “may or may not use a theoretical framework” to guide a study (Hong & Cross Francis, 2020:381). In this study, the assumptions of the basic needs of family members departed from the framework adapted by Molten (1979).

A qualitative descriptive design was appropriate in this study, as it recognised the subjective nature of the problem, and the various experiences that participants had, and the findings could be presented in a manner that directly resembled the language used in the research question (Doyle et al., 2020:444).

2.4.3 Contextual design

Contextualised understanding of human experiences is derived during undertaking qualitative research (Nuuyoma et al., 2023:3). Contextual inquiry is part of the contextual design process (Holtzblatt & Beyer, 2019), and is a combination of observation and discussion with the participants and gaining more insights through probing questions about a specific context (Duda, Warburton & Black, 2020:1). It is a certain view of the world “about how to treat each other and how to work together” (Duda et al., 2020:1). The researcher can become familiar with the intents and desires of participants. This study addressed the participants’ natural situation that was the clinics where interviews were conducted.

2.5 Study setting

The “nature, context, environment, and logistics” of a study setting can have an effect on how the study is carried out (Majid, 2018:3). South Africa has a population of 60,414,495 (Worldometer, 2023) who live within nine provinces and 52 health districts. The Khayelitsha Township served as the study's location. Located in the Cape Flats of Cape Town, Khayelitsha is a low-income neighbourhood established in 1983, the township was intended to house approximately 120,000 African residents of Cape Town in modest, two-bedroom dwellings.

Khayelitsha Township is the largest township in Cape Town, a dense, rapidly expanding, low-income residential area in the Cape Flats, about 30 km from Cape Town city centre. The Khayelitsha health district is primarily a low-income health district in the Western Cape Province of South Africa, with 73.0% of its population not having completed secondary schooling, and 75.0% living in informal dwellings, and most of the population (90.5%) is black African (Western Cape Department of Health, 2023). The name ‘Khayelitsha’ originates from the isiXhosa language and means ‘Our new home’. Creation of this township was a result of the influx of the African population from the Eastern Cape in search of employment (Lusinga & De Groot, 2019:202). The population is estimated at 2,400,000 people, with the largest single concentration of informal settlements (there is a minimum of 22 separate settlements) in Cape Town, located on land that is unsuitable for housing due to susceptibility to flooding (Western Cape Department of Health, 2023).

Khayelitsha has South Africa's highest concentration of poverty and unemployment (Mnguni, Schietekat, Ebrahim, Sonday, Boliter, Schrueder, Gabriels, Sigwadhi, Zemlin, Chapanduka & Ngah, 2022:4). It is argued that people in these low-income areas experience socio-economic problems and face urban environmental health challenges, like poor sanitation, lack of water, overcrowding, and high levels of poverty, crime, unemployment, gender-based violence, and femicide (Williams & Zacheous, 2022:2).

Khayelitsha health district has 11 CHCs and one district hospital (Khayelitsha District Hospital – KDH), and refers patients to the Metro East tertiary hospital, and Tygerberg Academic Hospital, as needed (MacQuene, Du Toit, Hugo, Alexander, Ramasar, Letswalo, Swanepoel, Brown & Chu, 2023:1173).

Two CHCs, ‘Town Two CHC’ and ‘Mathew Goniwe CHC’, were purposefully selected in the Khayelitsha health district. They are situated in the largest sub-locations of Khayelitsha health district with the highest patient intake.

Figure 2.1 Housing in Khayelitsha

The first case of COVID-19 in a South African township occurred in Khayelitsha (Mnguni et al., 2022:4). The literature reveals that low-income areas such as those around Khayelitsha, are created by new migrants; in some cases, these are created in the city, and keep attracting more migrants and people due to cheap and affordable rental accommodation, particularly for low-income earners (Williams & Zacheous, 2022:2).

2.6 Population and sample

2.6.1 Population

In research the term population refers to a well-defined set of units of analysis that are the focus of the study (Van Haute, 2021:247), and all members of a well-defined class of people or events (Ary et al., 2018:171). The population in this study was family members that visited the two CHCs in Khayelitsha health district, Cape Town. It was not feasible to recruit the entire population of interest (Majid, 2018:3) for this study. The target population is the group of people who share a common condition (disease process) or characteristic that the researcher is interested in studying (Capili, 2021:64). In this study, the target population was the family members(participants) who visited the two CHC clinics and had a relative who had been admitted to any health facility in the Western Cape, Cape Town. The accessible population is the

geographically and temporally classified subset who are available for recruitment as participants in the study (Capili, 2021:64). Since researchers generally do not have access to the full population of interest for a research project (the target population), the researcher relied on studying a subset of that population (the study sample or sample population) (Curtis & Keeler, 2021:53). The sample population in this study was family members(participants) who visited the two CHC clinics and had a relative is admitted to a health facility, which also served as the accessible population.

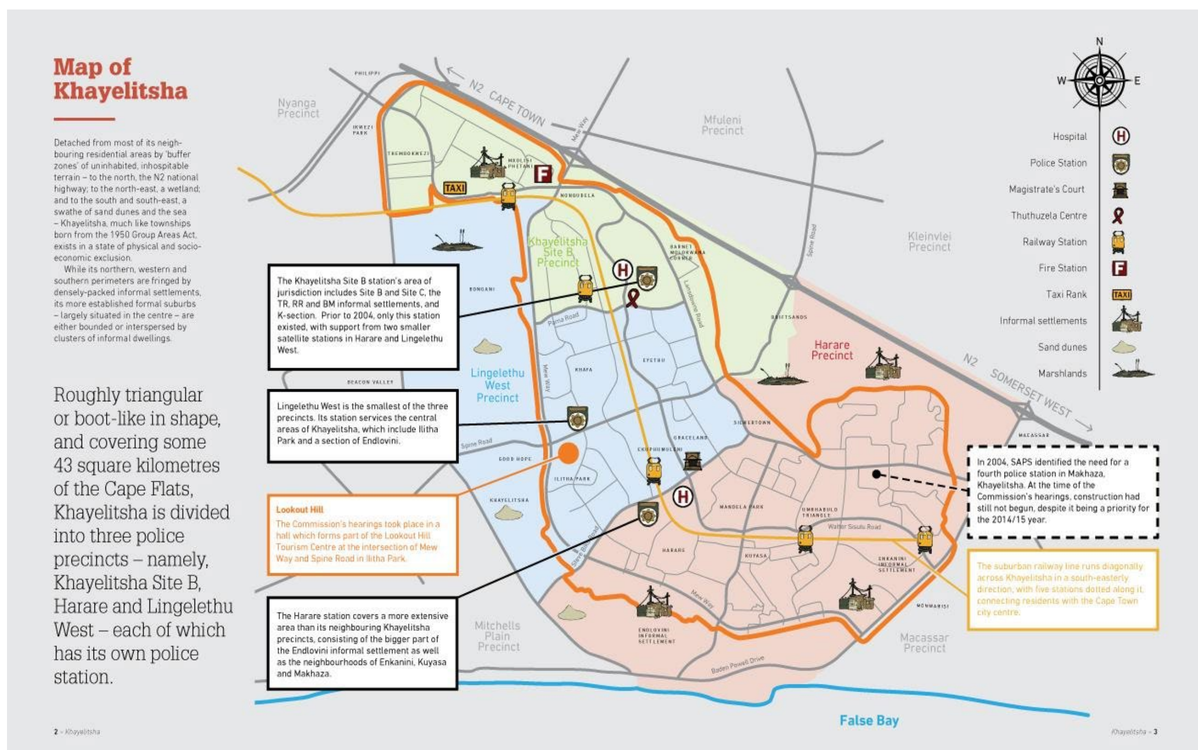

Figure 2.2 Map of Khayelitsha

2.6.2 Sampling

Sampling is described as the act, process, or technique of selecting a representative sample of a population to observe and analyse the characteristics of the entire population (Rahman, Tabash, Salamzadeh, Abduli & Rahaman 2022:45). The process for participant selection should be integrated into the overall logic of any study (Campbell, Greenwood, Prior, Shearer, Walkem, Young, Bywaters, & Walker, 2020:653). The two main types of sampling techniques are probability sampling and non-probability sampling (Rahman et al., 2022:46). Probability sampling refers to persons having an equal chance of being selected for a study, by using randomisation

(Pandey & Pandey, 2021:46). The primary purpose of probability sampling, if used, would have been to obtain a sample that is representative of the population from which it was taken (Rahman et al., 2022:47).

However, non-probability sampling was followed in this study, where the chance or probability of each participant/person being selected was not known or confirmed (Rahman, 2023:48; Rahi, 2017:3). The non-probability sampling was based on the researcher's judgement (judgemental sampling), or selection of those who were available and assumed to be able to answer the research question of this study (Stratton, 2019:228). This means participants are often intentionally chosen due to having the most suitable features related to the topic, being 'information-rich' cases, or those most willingly available (Nikolopoulou, 2023; Whitehead & Whitehead, 2020:119). Purposive sampling was thus the best approach to follow, as it focused on a confined number of individuals, recruited in two CHCs, who had the characteristics that the researcher wishes to study (Rahman, 2023:49). Homogeneous sampling reduces variation among participants, who share similar specific characteristics such as lived experiences, and make it possible to describe a particular subgroup in depth (Nikolopoulou, 2023).

A small purposively selected sample with rich and diverse lived experiences of the phenomenon is most coherent with the main objective of phenomenological studies of uncovering the unknown layers of a phenomenon within its context (Frechette et al., 2020:6). In qualitative research the sample size tends to be small, to support the in-depth analysis of the investigation (Hennink & Kaiser, 2022). The adequacy of the sample size was determined by the concept of data saturation, meaning that the researcher reached the point at which there was an adequate sample size, where:

- data continuously informed sampling, continually bringing new participants into the study until no new information emerged,
- it excluded redundant or replicated data (Aguboshim, 2021:180),
- all the important insights were extracted from the data, signifying that the conceptual categories were 'saturated', to answer the research question comprehensively with well-grounded data,

- the iterative process of simultaneously conducting sampling, data gathering, and data analyses was completed (Hennink & Kaiser, 2022); and
- the last transcript of a series of individual interviews indicated similar findings, and data collection was stopped (Silva, Agampodi, Evans, Knipe, Rathnayake, & Rajapakse, 2022:9).

2.6.2.1 Inclusion and exclusion criteria

Suitability/eligibility criteria are what the researcher uses to determine whether the person qualifies to join the study through specified requirements (Su, 2023:5; Polit & Beck, 2021).

The *inclusion criteria* describe potential study participants who could best provide an answer to the research question (Capili, 2021:64). In this study participants were selected on the following basis:

- had a close relative admitted to a health facility with COVID-19 symptoms,
- the close relative was either a brother, sister, husband, wife, or person staying in the same household as the parent of the house, regardless of sharing blood, and
- the participant was older than 18 years.

The following criteria excluded persons from taking part in the study:

- those who had previously had COVID-19.

A total of 11 males and females older than 18 years were selected, and one-to-one semi-structured interviews were conducted with them.

2.7 Method

An inquiry method was followed, seeking information by questioning. Research methods include all the techniques and methods which have been taken for conducting research whereas research methodology is the approach in which research troubles are solved thoroughly (Mishra & Alok, 2022:1). The methods, describe the means of data collection used to arrive at the desired result (Busetto & Gumbinger, 2020:40).

2.7.1 Interviews

Interviews were used, and is the most appropriate method, as little was known about the phenomenon, and they could provide a ‘deeper’ understanding of the phenomenon(Islam & Aldaihani, 2022:5). This method is also suitable for researchers when the topic is sensitive and participants want to express their opinions or ideas verbally (Islam & Aldaihani, 2022:5).

In this study the method of data gathering was through phenomenological interviews to gain an understanding of the lived experiences of individuals, that contributes to understanding the phenomenon (Neubauer et al., 2019). Phenomenological semi-structured interviews were the best way to probe the lived experiences of individuals whose answers help to understand the phenomenon. These interviews gave the researcher the opportunity to gain insight into the participants' world and access to their lived experiences (Alshawish et al., 2020:75).

As individuals do not always understand words or labels the same way, the researchers do not ask participants to explain their beliefs or behaviours—rather, they study the participants' own terms in an organic fashion. Phenomenological interviews intent to explain an occurrence as it exists, according to the realisation of the individual, who revisit the occurrence in her/his own words as it happened and reflect her/his own awareness to the occurrence as it took place, to the researcher (Ray & Locsin, 2023:3).

Semi-structured interviews were used as the researcher wanted to collect qualitative, open-ended data; explore participants’ thoughts and feelings about their experiences on the their loved ones admission to a health facilities during COVID-19; and to deeply explore personal and sometimes sensitive issues (Henriksen, Englander & Nordgaard, 2022:13; DeJonckheere & Vaughn, 2019:2). In contrast, a structured interview is a set of predetermined questions that is presented in a definite order (Henriksen et al., 2022:13). The semi-structured interview gave greater flexibility in terms of asking questions. Two main questions were formulated (Annexure D), and probing questions used, that could not be presented in a specific order (Henriksen et al., 2022:13). While starting with a set of semi-structured questions asked of participants, this method

could also be viewed as a semi-organised conversation, that is guided by new information obtained as the interactive discussion unfolds (Ahlin, 2019:2).

The semi-structured interview typically follows an interview guide, that allows participants to respond openly to a predetermined set of questions; the researcher can choose how much to engage the participant in their responses (Flory & Jacobs, 2023). However, there is the flexibility to ask any questions in any order, follow any tangents that arise, or seek further clarification of previous answers or elaboration of responses (Whitehead & Whitehead, 2020:125).

The flexibility that this type of interview offered could lead to collection of more and clearer data (Mwita, 2022:415). The main value of the semi-structured interview was, that it allowed the interviews to be focused and the researcher was able to independently explore pertinent ideas that could come up during the interview (Adeoye-Olatunde & Olenik, 2021:1360).

The semi-structured interviews were conducted with an interview guide with questions aimed at addressing the research objectives (Adeoye-Olatunde & Olenik, 2021:1362). An interview guide was developed to aid in the researcher's understanding of the participants' life experiences (Hung, Chan & Liu, 2022:3) during the COVID-19 pandemic. The interview guide included two questions that allowed participants to share their individual experiences and was flexible to allow the interviewer to probe and ask unplanned questions to encourage participants to provide more detail (Fiest, Krewulak, Jaworska, Spence, Mizen, Bagshaw, Burns, Cook, Fowler, Olafson & Patten, 2022:1250). The interview guide was piloted with one participant, and no changes to questions were needed. The guide was not meant to be read verbatim; it provided structure and focus to the natural flow of the conversation for each unique interview (Adeoye-Olatunde & Olenik, 2021:1362). In this study the first question that was started with was: 'How was it for you when your close relative was admitted to health facility with COVID-19?'

2.7.2 Preparing the field

In a time of unprecedented change and disruption due to COVID-19, qualitative researchers faced unique opportunities and challenges (Lobe et al., 2020:1). The

researcher prepared, by spending time planning how to approach the field, identifying potential problems, thinking of any additional materials and how to use them, and obtaining comments from the supervisor (Wolshon & Pande, 2018:110).

Permission to undertake the study was obtained from the Research and Ethics Committee of a Faculty of Health and Wellness Sciences at a University in Cape Town (CPUT/HW-REC 2021/H13) (Annexure G) and from the City of Cape Town (Ref. 28242) (Annexure H). The researcher could only visit the clinics after permission was granted by the Cape Town Muncipality. The nurse manager of each of the CHCs were then contacted telephonically for an appointment to explain the study and request permission to enter the site. During the appointments, the method and benefits of the study were explained, and the related proposal was given to the clinic manager of each of the CHCs.

The researcher indicated that he would present health talks at the clinics with patients around the topic of COVID-19 and related problems, on the days in-between interviews. All nursing staff members then received information about the study and its advantages, for the clinics and the larger community from the nurse manager, in charge of the clinic. In order to identify and suggest potential study participants to the researcher, they were also educated about the inclusion and exclusion criteria for study participants. Potential participants were referred to the researcher after consultation, with the interview held in a private interview room. The researcher saw the importance of conducting the interviews in a natural setting, with all participants feeling comfortable with being interviewed in the private room that was allocated.

The researcher developed a notice (Annexure F) to display in the clinic, with the topic, purpose of the study, and benefits for the community. It indicated the times at which the researcher would be at the clinic and invited clients to contact the researcher personally to take part in the study. The researcher met with participants at the clinics or arranged a time and date to meet with those who agreed to take part in the interviews. The interviews were set to be conducted at the two clinics in a private room that the participant was comfortable with, while adhering to the rules and regulations of the COVID-19 lockdown.

2.7.3 Pilot interview

A pilot study is a mini version of a research study or a trial run before conducting the full-scale study, and may be conducted specifically to pre-test a research instrument (Aung, Razak & Nazry, 2021:603; Dikko, 2016). Piloting of an interview was an integral aspect and useful in the process of conducting qualitative research, as it highlights any need for changes before the major study is carried out (Majid, Othman, Mohamad, Lim & Yusof, 2017:1073). In this study, the researcher started with one pilot interview with one participant, to ensure that the semi-structured interview resulted in answering the research questions that addressed the purpose of the study. The pilot interview data was included in the final data analysis, as the experiences shared by the participant indicated that an individual interview was the appropriate method to follow, and the questions posed were understood by the individual. There were no gaps in the data collection process regarding, for example, time keeping; the interview schedule (Annexure C) was complete; a climate of open discussion was created; and no risks were perceived. The aim of conducting the pilot study was to increase the quality and trustworthiness of the study (Malmqvist, Hellberg, Möllås, Rose & Shevlin 2019:3).

2.7.4 Data collection

This descriptive phenomenological study used interviews conducted in September 2021 and October 2021 with key family members of patients admitted to a health facility during the severe visiting restrictions associated with COVID-19. Interviews were conducted in a quiet and private space, where the participants could talk freely without the risk of being overheard or seen by others. The researcher started with greetings, self-introduction from both interviewer and interviewee, and then explained the information sheet to the participant (Annexure B), and the objectives of the interview session.

In the first part of the interview the researcher built a relationship with the participant to put him/her at ease (Flory & Jacobs, 2023). To establish a good rapport, the interviewer needs to be sincere in listening to the participant, be interested in his/her experiences and acknowledge the importance he/she attaches to the experiences (Henriksen et al., 2022:22).

Two research questions were asked using the interview (Annexure D):

- How was it for you when your close relative was admitted to health facility with COVID-19?
- How can support you when your family member is admitted to health facility with COVID-19?

Probing questions were posed to obtain an in-depth understanding of the problem. Probes are questions that ask participants for additional information after answering a closed question, or for clarification (Meitinger & Kunz, 2022:2; Norouzadeh, Abbasinia, Tayebi, Sharifipour, Koohpaei, Aghaie & Asgarpour, 2021:2). These questions uncovered more details and obtained an in-depth understanding of the phenomenon (Ellis, 2019: 48). Examples of probing questions were 'What do you mean?' and 'Can you tell me more about it?'.

The researcher employed English and the native language IsiXhosa in the study location, so that participants who could not speak English could express themselves freely. Understanding verbal and non-verbal cues helped the researcher in remembering, and absorbing what had been covered, while keeping points to probe and follow up, and taking notes whenever possible (Ruslin et al., 2022:26). The non-verbal signs by participants which were observed included gestures, body language, facial expressions, and tone of voice. The researcher aimed to respond appropriately to the participants in terms of knowing when or not to ask certain probing questions (Henriksen et al., 2022:26).

Recording of the interview was done by using a digital recorder, which was tested beforehand to ensure that it was in proper working order to digitally record each session. It was important to record the data so that the researcher could go back to what was said, to discover or confirm information about what was said. According to Aung et al. (2021:604), an interview session takes between 30-45 minutes, and the same principle was applied in this study.

Taking field notes was an integral part of documentation of the data (Brewer & Scandlyn, 2022:3). These notes provided a rich source of data for examining the meaning of participants' words and actions in their context (Flick, 2018:2); the

interviewer also took field notes to capture non-verbal cues (Brewer & Scandlyn, 2022:3). Field notes were written by the researcher, which was either by hand during the interview or immediately after the interaction in the research setting. Field notes may address or be informed by other raw data sources but are a raw data source in and of themselves (Flory & Jacobs, 2023). The field notes in this study offered a complete picture of the interview, by describing observations made throughout the interviews and recording non-verbal indicators e.g., gestures, voice tone, and repetition.

The researcher summarised the interview session and allowed the participant to answer questions, or provide suggestions or further thoughts (Aung et al., 2021:604). Finally, the researcher expressed his appreciation and pleasure for the participant taking their time to participate in the study.

2.8 Data analysis

Qualitative data analysis includes the interpretation, identification, and examination of patterns and themes in textual data, and determines how these themes and patterns help to understand an issue or phenomenon in a deeper way, for answering the research questions at hand (Islam & Aldaihani, 2022:6). Analysis of data involves the integration and synthesis of narrative, non-numeric data, which is reduced to themes and categories with the help of a coding procedure (Brink et al., 2018:46). Rigorous analysis gives voice to people’s lived experiences (Raskind, Shelton, Comeau, Cooper, Griffith & Kegler, 2019:32).

Data analysis started during data collection, and data was interpreted and coded along with the field notes. Interviews carried out in the local language of isiXhosa were translated into English by the researcher and back translated by an editor who spoke both languages, to ensure the integrity and accuracy of the data. The researcher listened to the voice recordings and checked them against the transcribed text. The data was carefully listened to and transcribed in the same words as used originally, and field notes were carefully checked several times for accuracy (Lee, Lee, Sang & Morse, 2022:865).

Reading and rereading the transcribed text from an interview provides an understanding of context, situations, events and actions related to the phenomenon of interest, before the data can be analysed for concepts and themes (Ravindran, 2019:41). It helps to become familiar with the corpus of data so that a researcher is aware of the limitations or gaps in the collected data (Lester, Cho & Lochmiller, 2020:99). The independent coder and the researcher had a consensus meeting on the themes and categories that emerged from the data.

Colaizzi's (1978) descriptive phenomenological method was used for the analysis. It contains seven steps (Bordeos, Lagman & Cruzet, 2022), the first of which was familiarisation with the data. The researcher firstly acquainted himself with the data by reading over the records of experiences shared by the participants numerous times. In the second step, all important statements in the explanations provided by participants that were directly applicable to the phenomenon, of families with a relative admitted to a health facility with COVID-19, were identified. In the third step, meanings were formulated. Careful deliberation of important statements evolved as meanings relevant to the phenomenon were identified. The researcher had to place his own beliefs and ideas apart (bracket them) and stayed focused on the phenomenon as shared by the participants – although complete bracketing is never possible.

In the fourth step themes were clustered. The researcher clusters the important statements into themes that emerge as similar through all the transcripts. It was essential for the researcher to aim to bracket his own ideas, that could be influenced by known theories. This led to the step of developing an exhaustive description of the data. In step five the researcher wrote a comprehensive account of the phenomenon of families with a relative with COVID-19 in a health facility, integrating all the themes discovered in step four.

Step six was aimed at producing the fundamental structure of the study findings. The researcher consolidated the extensive description into a brief, dense statement that contained only identified aspects thought to be important to the structure of the phenomenon.

The last step was to seek verification of the fundamental structure. The researcher returned the fundamental structure statements to two participants, by holding

conversations, and confirmed that their experiences were captured correctly. It was not necessary to modify any of the earlier steps in the analysis in the light of this feedback.

2.8.1 The role of the researcher

The study used inductive reasoning as a process of departing from past experiences or facts towards new assumptions. It gathers different ideas to provide evidence for a more general conclusion. In contrast, deductive reasoning would have made wide generalisations from specific examples. During inductive reasoning, the researcher obtains an understanding of the experiences of the participants and may draw conclusions from them. It is a way of describing conclusions by going from the specific to the general findings (Doyle, 2020).

The ability to conduct a qualitative interview required a set of skills. The researcher needed to be organised and focused on what questions to ask, how to ask the participant, and how to interact with the information provided by the participant by comprehending verbal and non-verbal cues, recalling and absorbing what had been covered, keeping an eye out for opportunities to probe and follow up, and taking notes whenever possible (Ruslin et al., 2022:26).

The researcher bracketed or set aside any assumptions or biases throughout the study (Dyar, 2022:190).The researcher documented his personal beliefs, experiences, and values that might impact the interpretation of data. Bracketing is the most important feature that differentiates Husserlian phenomenology from the hermeneutic phenomenology (Ataro, 2020:22) and is believed to have scientific rigour, in that researcher puts aside his preconceptions. It demonstrates the validity of the research process through permitting the researcher to set aside preconceived knowledge, values, beliefs, and experience while conducting the phenomenological analysis (Ataro, 2020:22). The researcher had to set aside his preconceived notions, and any beliefs or biases (Zahavi, 2021:269). This method reduces the possibility that researcher bias may affect the interpretations of the themes that emerged from the interviews (Bartoli et al., 2022:50).

2.9 Trustworthiness of the study

Trustworthiness in qualitative research refers to the systematic rigour of the research design, the credibility of the researcher, the believability of the findings, and applicability of the research methods. Rose and Johnson (2020:3) refer to trustworthiness as the quality, authenticity, and truthfulness of findings of qualitative research. To ensure the quality of this study, the researcher relied on the five criteria offered by Lincoln and Guba (1985) to establish trustworthiness, by ensuring credibility, which corresponds to its validity, dependability, confirmability (reliability) and transferability of the findings (Lemon & Hayes, 2020:605).

2.9.1 Credibility

Credibility refers to the meaningfulness of the findings and whether these are well presented (Awan, Yahya & Arif, 2023:69). Credibility refers to the accuracy of the findings and whether the researcher attempted to present a true picture of the phenomenon being investigated (Lincoln & Guba, 1985). An independent coder who was an expert in qualitative analysis, conducted coding separately from the researcher. Experience in the field of nursing research and were credentials the appropriateness as an independent coder They then met to reach consensus on the themes and categories that emerged from the data. Credibility was ensured through triangulation, involving the use of different data collection methods (interviews, field notes) to ensure consistency of the findings.

Triangulation is a general approach to check and establish the credibility of qualitative findings, by analysing a research question from more than one perspective (Amin, Nørgaard, Cavaco, Witry, Hillman, Cernasev & Desselle, 2020:4). Benefits of triangulation are an increase in the credibility of the findings as well as a providing a richer and more elaborate understanding of the phenomenon under investigation (Amin et al., 2020). Triangulation enriches findings, with data explaining differing aspects of the phenomenon of interest (Noble & Heale, 2019:67).

The researcher also ensured that data was credible by relying on the participants' direct statements, with complementing data from the field notes, which included observations of the participants' interactions and their responses to questions.

2.9.2 Dependability

Dependability refers to the soundness of the research, particularly in relation to the appropriate methods being chosen, and the ways in which those methods were applied and implemented in a qualitative research study (Rose & Johnson, 2020:4) The interview schedule contained the same research questions which were similarly posed to all participants, that assisted in ensuring a consistent process of data gathering (Zhang & Wildemuth, 2016:324). Coherent themes and categories were found across transcripts. Dependability was ensured by using an independent coder who co-analysed the data and reached consensus with the researcher. Dependability refers to the stability of findings over time, and the researcher returned to two participants to ensure that the data provided was a correct interpretation and representation of what they had said (Korstjens & Moser, 2018: 121).

2.9.3 Transferability

Transferability indicated the degree to which the research findings of this inquiry could be transferred to similar settings and applied by other persons (Megheirkouni & Moir, 2023:849). However, the method used does not guarantee transferability (Sundler, Lindberg, Nilsson & Palmér, 2019:737). This study provided a thick description of the methodology that was followed and the recommendations formulated, that made it potentially useful for evaluating the relevance and applicable of the study to other contexts, situations, and populations (Armour & Williams, 2022:71, Brink et al., 2022). The data will be kept in a password-protected and secure place for five years, in case it is necessary to go back to the original documents.

2.9.4 Confirmability

Confirmability refers to the degree to which the research findings are a true reflection of participants' input, as opposed to the researcher's own perceptions (Stahl & King, 2020:28; Connelly, 2016:435). Qualitative research is subjective, and the researcher made sure to bracket his own feelings and opinions; thus the findings reflected the voices of the participants. Confirmability establishes whether the research data and interpretations of the findings are the researcher's imagination or derived from the experiences shared by the participants (Megheirkouni & Moir, 2023:849). The

researcher conducted critical reflexivity after interviews, which enabled him to avoid his own opinions being included in the data analysis (Amin et al., 2020:1478). The process of allowing the participants' voices to be heard, triangulating the field notes and data notes analysis, and following up with the participants to clarify their notes answers (member checking) all contributed to the results' confirmability. The independent coder agreed with the researcher on the coding that was completed. To subject one's research to auditing (confirmation), there must be some objective reality present (Stahl & King, 2020:28). Interviews were recorded and field notes were taken, that allowed the researcher to confirm the data that was gathered, as did including direct quotes from the participants in the final report (Aguboshim, 2021:183).

2.9.5 Authenticity

This is the extent to which researchers fairly indicate various realities and convey details of the participants' lives (Polit & Beck, 2021; Connelly, 2016:435). Authenticity refers to the fair selection of participants, which was ensured by using purposive sampling, and providing a rich description of the data.

2.10 Ethics

Ethics is a broad term that covers the study of the nature of morals and specific moral choices (Rashid, 2022:1; Varkey, 2021:17). Conducting research must occur in a responsible and morally defensible way, as outlined by research ethics related to studies with human subjects (Pietila et al., 2020:49). Ethical standards are needed to protect all parties – the participants, researchers, and their institutions – and the reputation of research (Alderson & Morrow, 2020:3). The interviewer also performed all prevention protocols according to the guidelines of the Provincial Advisory COVID-19 Committee (Norouzadeh et al., 2021:2).

2.10.1 Permission to conduct the study

All gatekeepers were asked for ethical clearance to conduct this study, and this was also obtained from the Research and Ethics Committee of a Faculty of Health and Wellness Sciences at a higher education institution in Cape Town (CPUT/HW-REC 2021/H13). Permission was also obtained from the Research and Ethics Committee of the City of Cape Town (Ref. 28242), and the researcher could only visit the two

clinics requested, after this permission was granted. The nurse managers of the CHCs were then contacted telephonically for an appointment to explain the study and request permission to enter the site (Annexure E), during which the method and benefits of the study were explained, and the proposal was given to each of the nurse managers of the clinics.

The researcher indicated that he would present health talks at the clinics, with patients around the topic of COVID-19 and related problems on the days of and in between interviews.

2.10.2 Informed consent

Every scientific research study conducted with human beings must have a clear and relevant justification, and participants must be freely and properly informed about the research, including its risks, benefits, and consequences, and their agreement to participate must be given without them being coerced or convinced (Taquette & Borges da Matta Souza, 2022:1). Participants were informed of the study's objectives and method, and that individual interviews would be conducted to gather data (Annexure A). All participants agreed to have their interviews digitally recorded and that the researcher could take field notes.

2.10.3 Prevention of harm

It is a moral obligation that researchers prevent any harm from coming to research participants (Kumar, Aranha, Rajgarhia, Royal & Mehta, 2021:3844). Participants were given the assurance that there were minimal risks associated with their participation. The researcher had a positive attitude and good intent towards the participants to fulfil the purpose of the study. The participants were informed about the benefits of the study for the broader community, and that results would be available on request.

The researcher told participants that if they became uncomfortable at any point, they should inform him, and the interview could be ended. If necessary, the participant could be referred to a psychologist who was available near the site. Prior to the

interviews, participants signed written informed consent forms, and were made aware that their participation was to be voluntary and that they could choose to withdraw from the study at any time, should they wish to do so (Annexure B). The study was designed to minimise any possibility of harm, and to provide full information on the benefits to themselves and the community that would potentially result from the findings (Kumar et al., 2021:3844).

2.10.4 Justice

Justice is generally interpreted as fair, equitable, and appropriate treatment of persons (Varkey, 2021:20). All participants had the right to fair selection and treatment. Fair selection was ensured in this study based on whether a particular participant met the inclusion criteria.

2.10.5 Anonymity

In this study, no name appeared on the interview schedule, and recordings and transcripts were all numbered, with no name mentioned on them. Anonymity applied to the reporting of research findings and participates information was kept anonymous.

2.10.6 Privacy and confidentiality

The researcher ensured that the interviews were conducted in a quiet environment (private room), where there would be no noise or disturbance All of the information that was provided by the participants was kept securely and seen by no one other than the researcher, supervisors, and the independent coder. Only the researcher and supervisors had access to the information, which are kept under lock and key (typed data is electronic data password-protected on the computer) for five years after the report has been published, then hard copies will be shredded, or electronic files deleted. The researcher ensured confidentiality by avoiding linkage of data gathered during the study, and participants were informed that their names would not be revealed in the study analysis.

2.10.7 Respect for the person

In light of the sensitive matter under investigation, the researcher made every effort to treat each individual with respect and care. The researcher endeavoured to treat each

person with respect and sensitivity in view of the sensitive subject being probed. The participants' privacy and the confidentiality of their information were always respected, in order to protect their integrity on a social, mental, and physical level. The researcher aimed to stay within the timeframe allocated for the interview.

2.11 Summary

Phenological interviews were conducted to obtain data from a purposively selected sample of 11 participants (including the one pilot interview). The interviews, allowing participants to give detailed descriptions voluntarily. Participants were able to provide more in-depth descriptions and narratives during interviews because the researcher employed open-ended questions. In order to be eligible for participation, individuals had to be between the ages of 18 and older and be males or females and had a close relative is admitted to a health facility during Covid-19.

The data collection method through individual interviews suited the nature of this study was followed, with a phenomenological data analysis. The researcher adhered to all COVID-19 prevention protocols according to the guidelines of the Provincial Advisory COVID-19 Committee (Norouzadeh et al., 2021:2), during the study.

The research methodology, including the population, sample, data collection tools, and strategies to maintain ethical standards as well as the study's validity and reliability, has been covered in this chapter. To ensure the study's credibility, the lead researcher and the independent coder came to a consensus prior to the generation of the final themes.

CHAPTER 3
FINDINGS

3.1 Introduction

This chapter addresses the first objective of the study, which was to explore the lived experiences of families during COVID-19 when a close relative is admitted to a health facility. The purpose of this study was to explore and describe the lived experiences of families in the Khayelitsha district with close relative with COVID-19 admitted to a health facility. Data indicates the accuracy of the data analysis and provides answers to the research questions. In qualitative data analysis, patterns and themes found in textual data are interpreted, recognised, and examined to ascertain how these themes and patterns contribute to a deeper understanding of a problem or phenomenon and address the research issues at hand (Islam & Aldaihani, 2022:6).

3.2 Participants

Eleven participants took part in semi-structured interviews, which were held during September 2021 and October 2021. Each signed a written informed consent form. Most of the participants had visited the clinics before. They were identified in the waiting area as they waited to be attended to by a nurse or doctor, given information about the study, and asked if they were prepared to be interviewed after they had done what they came to the clinics to do. In this way, the study avoided any disruption of clinical services.

Participants were males (n=2) and females (n=9) 18 years and older, including the participant in the pilot interview. Table 3.1 shows the demographic characteristics of all 11 participants, and their relationship with the person who had been admitted to a health facility with COVID-19. They will each be referred to by a number in the following way, for example, Participant 5 is referred to as P5.

The mean age of the participants was 38 years, and their ages ranged from 21 to 55 years. All participants had had a family member admitted to a health facility with COVID-19, however, only three participants' have relatives who survived after being admitted to the facility. Nine participants had children that they had to take care of during the admission of a relative.

Table 3.1: Demographic characteristics of the participants (n=11)

Participant	Race	Gender	Age (years)	No. of children	Employment status	Relatives in hospital	Housing
1 (pilot)	Black	Female	24	1 (infant)	Unemployed	Mother, sister	Stayed with aunt
2	Black	Female	28	2	Khayelitsha	Mother	Lived with mother
3	Black	Female	55	2	Working	Sister	Sister
4.	Black	Female	28	0	Working	Mother	Lived with boyfriend
5	Black	Female	38	2	Working	Sister	Sister
6	Black	Female	48	2	Working	Sister	Sister
7	Black	Female	52	3	Working	Sister	Sister
8	Black	Male	42	1	Self-employed	Father	Father
9	Black	Female	48	3	Working	Mother, father, brother	Mother, father, brother
10	Black	Female	21	0	Studying	Mother	Mother
11	Black	Male	38	0	Unemployed	Mother	Mother

Seven participants were working, two of the participants were attending school or a college, one was self-employed, and another was unemployed.

3.3 Themes and categories that emerged

Four themes were identified from analysis of the data, as indicated in Table 3.2. These themes were: Authentic information should regularly be made available to relatives to establish a trusting relationship with staff; Essential needs of family members must be identified to assist in relieving their pain; The need of families for ‘nearness’ should be understood, and means more than physical proximity to a close relative; and Comfort

Table 3.2: Themes and categories that emerged from the data

Themes	Category	Sub-category
1. Authentic information should regularly be made available to relatives to establish a trusting relationship with staff	1. A sense of loss of reality during an indefinite timespan with insufficient information	
	2. Family members being uninformed as novices in an uncertain health environment	
	3. Trustworthy and straightforward information should be provided to family members	
2. Essential needs of family members must be identified to assist in relieving their pain	4. The family members take ownership of their own circumstances	
	5. The need to accept the great family tragedy	
	6. The desire to feel secure in knowing what to expect	
3. The need of families for 'nearness' should be understood, and means more than physical proximity to a close relative	7. A chain of connection, attachment and reliance on the family member was broken	
	8. Abrupt alienation from the sick family relative in an unfamiliar situation	
4. Comfort should be given to the family members through comprehensively supporting them, to diminish 'the waves' of hurt created by the unforeseen impact of COVID-19	9. Assessment of the unrelieved presence of sadness, from being emotionally wounded by the suddenness of loss	
	10. Addressing adequate resources to treat ill patients	
	11. Giving reassurance to relieve fear resulting from the hard-hitting transformation in the lives of families	Sub-category: Communication and being with others helps ease the pain Sub-category: Professional support

should be given to the family members through comprehensively supporting them, to diminish 'the waves' of hurt created by the unforeseen impact of COVID-19. A common

thread was that participants had experienced a sudden disruption to their family structure, leading to a measure of adjustment, which could be hard to deal with.

The 4 themes had 11 categories in total (Table 3.2).

3.3.1 Theme 1: Authentic information should regularly be made available to relatives to establish a trusting relationship with staff

The impact of the COVID-19 pandemic depends on the actions of individual citizens and, therefore, the quality of the information to which people are exposed (Pennycook, McPhetres, Zhang, Lu & Rand, 2020).

Providing dedicated information and communication is key in family-centred care (Zante, Camenisch, Jeitziner, Jenni-Moser & Schefold, 2020:336). An important aspect of COVID-19 is the facts provided to relatives when their family member is admitted to a health facility. Trust in information sources about COVID-19 may influence public attitude toward the disease and the restrictions imposed, thus determining the course of the COVID-19 pandemic in any given country (Rožukalne, Kleinberga, Tīfentāle & Strode, 2022:1).

Therefore, to build a setting of a trustworthy relationship with the family members, genuine information should constantly be made available by the healthcare facilities (Zante et al., 2020:336).

3.3.1.1 Category 1: A sense of loss of reality during an indefinite timespan with insufficient information

A sense of losing touch with reality over an indefinite period when there was inadequate knowledge about a relative was outlined by most of the participants during the interviews. Psychological stress was experienced due to them being concerned about their family members.

Perceptions of a lack of personal control can be strongly interconnected with the justified concerns experienced by individuals during a crisis, for example, worrying about one’s own life and livelihood or the safety of loved ones (Wnuk, Oleksy & Maison, 2020:3). Before the pandemic struck, patients and their relatives were counselled about relevant clinical information and updated about their condition in

person during visiting hours (Rana, Sharma, Kulshrestha, Khanna, Bhatla, Kumar & Trikha, 2022:122). During the pandemic, however, visiting restrictions of different extents were implemented.

A participant mentioned that she was mentally confused as to how to act, as the circumstances around her mother were unclear:

> *"At that time, my mind was all over the place for instance when I couldn't get hold of her, I thought she had passed on."* (P2)

The participant mentioned that her "mind was all over the place", meaning that she was confused, disorganised and unable to think properly. She seemed to be anxious. Serious emotional disturbances, insecurity, anxiety, and depression could be associated with social isolation and fear of uncertainty (Mistry, Ali, Akther, Yadav & Harris, 2021:1).

Another participant felt regretful that she had no physical contact with her mother before, after a short period of time, she passed away:

> *"The unfortunate part was that I was not able to go visit her to see how sick she was. Two days later I received a call informing me that she had passed on. So, it happened in a short period of time."* (P6)

It seemed that even though the participant knew that she was not allowed to visit, she still felt unprepared for the unexpected and sudden happening. The restricted visitor guidelines for family members enforced by many hospitals resulted in feelings of severe distress, even suffering, among family members who found themselves unable to visit or participate in the care of their loved one (Bartoli et al., 2021:926).

Anguish was openly shown during what was mentioned as an exhausting period of simultaneously managing a critically ill parent and the burial of the other parent:

> *"So, I was hurt I don't want to lie, it happened so quickly and the worse part while my mother was fighting for her life, we had to prepare for the funeral of my father."* (P9)

The participant seemed to be distressed in carrying the burden of two unexpected traumatic events. Psychological distress is described as the result of the imbalance

between stressors and coping resources (Padilla-Fortunatti, Munro & Gattamorto, 2022).

It is known that psychosocial distress is likely to impact those directly affected by COVID-19, through either contracting the disease or having to take care of a family member who has been infected with COVID-19 (Apostol-Nicodemus et al., 2022:2).
It was interpreted that the participant was shocked and did not believe the information given to her by other family members. Either the way messages were conveyed or the way they were received by the participant made them sound unreal.

It was noted that another participant was shocked to learn that her sister had been hospitalized with COVID-19. She did not process the information until receiving a call from the hospital from one of the staff members confirming the sad news that seemed to be an illusion, later to discover it was the reality:

> *"When I first heard I was in disbelief; I thought they were just joking only later to find out that it was indeed true. I got a call from hospital informing me that my sister had been admitted to hospital and that she had tested posited for COVID-19."* (P5)

The participant was overwhelmed and experienced a sense of loss of reality, dealing with a health situation that threatened the life of her sister. Admission of a family member to a high- risk unit in a hospital is often an unexpected and overwhelming experience for family members, and may lead to psychological distress (Chen, Wittenberg, Sullivan, Lorenz & Chang, 2021).

The distress could be made worse by inadequate information; people viewed COVID as a death sentence because it was often paired with death when portrayed in the media. It seems likely that people internalised this association, particularly if they belong to groups portrayed as vulnerable (Jimenez, Restar, Helm, Cross, Barath & Arndt, 2020:2).

Another participant expressed that she did not know what was happening, because the last time she spoke to her mother, her mother sounded very sick, and no one

informed her about her prognosis; therefore, she was expecting any form of news, whether good or bad:

> *"I only got a call I think three days later, which is I didn't know whether she was still alive because the last time I spoke to her she was out of breath, so I didn't know what was going on."* (P2)

Family members' anxiety also stemmed from their inability to feel connected to the patient and informed about their care (Apostol-Nicodemus et al., 2022:13). Direct access to knowledge about their loved ones – seeing, touching, and perhaps talking to them – was cut off, making the family members of patients hospitalised with COVID-19 utterly dependent on the healthcare professionals' efforts to collaborate and communicate (Bernild, Missel & Berg, 2021a:5).

Participant 8 developed many emotions, such as stress, concern and sorrow, but had hope that his father would survive. Unfortunately, that did not happen:

> *"I was stressed and worried when he got admitted but then again, I had hope that he was going to fine, little did I know that he was going to leave us 2 days after. I became worse after hearing that he had passed on. I was shocked and I couldn't believe it, I could not understand how it happened."* (P8)

It could be understood that there was a need for more attention to be paid to the relatives' emotional wellbeing, by comforting them through providing authentic information. Fear has been one of the emotions most frequently associated with the COVID-19 pandemic. Uncertainty, worry, health anxiety, media exposure, personal health, and the risk to loved ones are the predictors of fear for this disease (Mistry et al., 2021:2).

Studies show that family members of patients admitted to a health facility often encounter a psychological crisis and experience stress and depression, and therefore have elevated needs in terms of support, information, assurance from the healthcare practitioners, as well as proximity to the patient (Bernild et al., 2021a:2).

In many cases, patients died without saying goodbye to their loved ones (Fernández-Basanta, Espremáns-Cidón & Movilla-Fernández, 2022:659). The circumstances in which patients were admitted and/or died was emotionally intense for participants, leaving them with an uncertainty that placed a heavy emotional burden on them.

3.3.1.2 Category 2: Family members being uninformed as novices in an uncertain health environment

The COVID-19 pandemic was expected to have profound and enduring effects on mental health, but until we have data, we will not know the form, extent, duration, or distribution of these (Pierce, McManus, Jessop, John, Hotopf, Ford, Hatch, Wessely & Abel, 2020: 567). Patients, families, nurses, physicians, and other team members all felt the stress on the healthcare system, as the COVID-19 pandemic was new to everyone. However, while workflow and tasks of staff can change, the principles of family engagement and patient- and family-centred care should remain a priority for all involved (Care, 2020:441).

Apart from dealing with the uncertainty of the pandemic and the new disease, there were a lot of questions that were left unanswered and created mistrust. As participant 8 stated about the passing away of his father:

> *"I had a lot of questions that couldn't be answered."*(P4)

When a patient passes away in a healthcare setting, the grieving process may be especially challenging, as family members did not have the opportunity to ask the necessary questions of the patient or participate in the steps that are vital in end-of-life care rituals (Kentish-Barnes, Chen-Solal, Morin, Souppart, Pochard & Azoulay, 2021:7).

A female mentioned that she was uninformed about COVID-19 at the time it started, and she felt, or it made her terrified to hear about the many people dying in the hospitals:

> *"I was worried and thinking about death because at that time we had no information about COVID-19 because it was still new. I was scared because even on the news you could see a lot of people dying of COVID-19."* (P3)

Fear can be disabling during an unprecedented pandemic and may adversely affect mental wellbeing (Mistry et al., 2021:7). Family members struggled to trust the

healthcare environment as they were not informed about the care being given to patients (Apostol-Nicodemus et al., 2022:13).

Participant 11 was initially informed that her mother's health status critical, and never received any further information about her mother condition and was uncertain:

> *"I didn't know what was happening with my mom and first thing that came to my mind was that she was going to die because I was told once by hospital staff that she was critically ill, and I never heard anything about her ever again."* (P11)

The lack of information from the healthcare environment to relatives was not only applicable to nurses, as family members were also unable to meet the treating doctors in order to obtain updates on the condition of the patient, adding to their anxiety (Rana et al., 2022:122).There was a need for family members to be update about the condition of their loved ones.

3.3.1.3 Category 3: Trustworthy and straightforward information should be provided to family members

According to Fernandez-Martinez, Mapango, Martinez-Fernandez and Valle-Barrio (2022:1), it is important to ensure the credibility and accessibility of information about COVID-19. The relationships that were built between families and nurses prior to the start of the first wave of COVID-19 changed, due to the difficulties in maintaining contact and rapport between families and nurses. This was also because of the implementation of in extremis nursing care that prohibited and/or limited family access to the healthcare facilities and restricted physical and temporary contact with relatives. (Salcedo-Pérez-Juana, García-Bravo, Jimenez-Antona, Martinez-Piédrola, Fernán-dez-De-Las-Peñas & Palacios-Ceña, 2022:8). Findings indicate that for healthcare professionals, had the additional responsibility of making challenging surrogate medical-related decisions during an unfamiliar time in healthcare was difficult (Harlan, Miller, Costa, Fagerlin, Iwashyna, Chen, Lipman & Valley, 2020:2).

A vital element is family involvement in communication with nurses, and the ability to build a trusting relationship based on appreciation of the role of the patient's family

(Frivold, Ågård, Jensen, Åkerman, Fossum, Alfheim, Rasi & Lind, 2022:451). Accurate information dissemination about COVID-19 has beneficial effects on society and provides guidance on avoiding transmission of the virus and pursuing effective treatment. However, fake news and rumours may have a negative impact on society, such as provoking the choice of ineffective treatment options and evoking fear, stress, anxiety, and depressive symptoms (Patwary, Bardhan, Browning, Disha, Haque, Billah, Kabir, Hossain, Alam, Shuvo & Salman, 2021:2).

One participant was anxious because she was unable to speak to or see her admitted relative (mother) to obtain conformation of her true condition. She did not trust the vague answers given to her by staff in the hospital about the condition of her mother:

> *"I was stressed because I couldn't see my relative that was admitted we couldn't speak to her. They could just lie, maybe sometimes and they could say "no she's fine "only to find out she was not because I couldn't go there personally and speak to her directly."* (P4)

Because the COVID-19 pandemic was still in its early stages, the provision of accurate information was difficult to obtain, even for healthcare professionals (Lee, Zhong, Zhou, He, Kong & Ji, 2021:213). The lack of reliable information about COVID-19 is of particular concern, given its role as a prerequisite for mitigating the health impacts of the virus (Patwary et al., 2021:2).

Participant 8 felt that untrustworthy information was provided by nurses regarding the prognosis of his father in hospital with COVID-19, when he had to contact the hospital about his father's condition:

> *"I had to call the hospital to ask how he was doing, one of the nurses told me that "his condition remains ill and unchanged but stable. They never gave a clear picture of what was going on."* (P8)

The confidence that the community had in nurses prior to the start of the first wave of COVID-19 changed due to difficulties in maintaining contact and poor rapport between families and nurses, that created mistrust, which was worsened by the restricted physical contact with family members (Salcedo-Pérez-Juana et al., 2022:8).

A female participant mentioned that she lost hope because of not having reassurance, as a doctor did not give straightforward answers, leaving her feeling down (demonstrated by her sighing):

> *"The doctor said, "She was fine but cannot promise anything "we couldn't speak to her because she was out of breath, and we couldn't visit and all that so yeah…" [Taking a deep breath]* (P2)

Effective doctor-patient communication is the key to provision of information to resolve fear, stress, and anxiety among relatives of an ill patient (Rana et al., 2022:122). Due to isolation and because family members could not physically be with patients, communication between professionals and family members was diminished (Venturas, Prats, Querol, Zabalegui, Fabrellas, Rivera, Casafont, Cuzco, Frías, Olivé & Pérez-Ortega, 2021:5). This seemed to affect trusting interrelationships.

Some of the participants believed that telling them the truth would be the best course of action for them. One participant cautioned staff not to give the family members false hope by pretending that the patient's condition was improving when it was not, because this would worsen the intensity of the relatives' shock at a later stage:

> *"I think the best thing that they could do is to tell the truth. Don't lie to the family and say your family member is doing better when they're in the hospital because that gives you false hope because it come as a surprise if now today, tell you your relative has passed on. So, to us as a family member, that doesn't make sense, they must not comfort us with lies. They must just be honest and say it like it is."* (P4)

A study on family support in ICUs during the COVID-19 pandemic indicated that the experience of relatives was that when they were well informed, receiving a detailed medical update on the patient's clinical status, the family trusted the information and felt involved in the patient's health status (Klop, Nasori, Klinge, Hoopman, de Vos, du Perron, van Zuylen, Steegers, Ten Tusscher, Abbink & Onwuteaka-Philipsen, 2021:5). Participant 2 felt that regular, straightforward information about a patient could put the relative at ease, instead of giving them the urge to phone to try to follow up on authentic information about the state of the mother:

> *"It would be nicer to get someone from the hospital to keep the family updated maybe two-hourly just to let the family members know because it's not easy to have someone and not knowing anything about them. You keep calling their phones and they not answering and the last time you spoke to them they were out of breath."* (P2)

Many participants alluded to the importance of having someone from the hospital update them by daily telephone contact; in that way they felt part of the situation, as they felt recognised as a family member and taken seriously in their need for reassurance through communication (Klop et al., 2021:5).

This theme confirmed the theoretical assumption made in Chapter 1, that adequate and honest information should regularly be provided to the family within a professional-ethical framework, supported by the findings.

3.3.2 Theme 2: Essential needs of family members must be identified to assist in relieving their pain

Family members are the first line of support during times of sickness (Apostol-Nicodemus et al., 2022:1). Amidst the challenges of the pandemic, ensuring the needs of families are met at the patient's end of life will likely promote better short- and long-term mental and physical health outcomes for relatives (Hanna, Rapa, Dalton, Hughes, Quarmby, McGlinchey, Donnellan, Bennett, Mayland & Mason, 2021:1250).

3.3.2.1 Category 4: Family members taking ownership of their own circumstances

The magnitude of family resilience is determined by many factors, such as developmental age, educational status, pre-existing mental health condition, being economically underprivileged, or being quarantined due to infection or fear of infection (Gayatri & Irawaty, 2022:1).

Family resilience is not only about overcoming adversity, it is also about turning adversity into a catalyst for the growth of the family by supporting each other's individual needs (Rich, Butler-Kruger, Sonn, Kader & Roman, 2022:2).

Creating a daily practice of gratitude is important to build family wellbeing. It is essential to have good and healthy communication and to find positive activities for family members to do together, which can build a sense of togetherness, trust, cohesion, and happiness. A healthy relationship, communication, faith-based practices, a positive mindset, and building social support are adaptive coping mechanisms to respond to the crisis and adversity together (Gayatri & Irawaty, 2022:137).

A study of the impact of COVID-19 on the perspective of relatives found that relatives of family members not in treatment more often reported that worries about their family members' health affected their ability to take care of themselves, had a negative influence on their economic wellbeing, and made them worry more often about acting out or being violent (Mork, Aminoff, Barrett, Simonsen, Hegelstad, Lagerberg, Melle & Romm, 2022:9). This suggests that offering relatives psychoeducation and support, even when their family member is not in treatment, may be important, especially during a crisis (Mork et al., 2022:9).

During the COVID-19 pandemic, family members at home also were infected. They had to organise themselves by ensuring that prescribed treatment was taken, as they understood their collective role as a family for improving their health:

> *"I once also had COVID-19, so my husband took good care of me and assisted me with taking medication."* (P3)

Gayatri and Irawaty (2022:137) support the notion that the family members should collectively focus on solutions, by building a healthy relationship in assisting one another as a family.

Participant 2 spontaneously spoke about her distress since she did not have the encouragement of either healthcare professionals or other emigrated family members (who had emigrated). Feeling isolated, she had to show her own strength in moving forward during a painful situation:

> *"We are a divided family, as I said my other siblings are in the UK, so I'm the one who's here, however it was really hard. I didn't get any support and through*

the process I just had to be strong and even at work no one supported me." (P2)

It seemed that family members had to take ownership of their own circumstances. People had to start looking for new ways to support their families and survive, as well as adapting their living expenses (Rich et al., 2022:6).

A participant had to take ownership through taking on his future. Owing to quarantine he was not part of the last moments of his father passing away. He exercised self-control over a period of experiencing his own emotional pain:

> *"It took time for me to accept that he was gone forever because I never had a proper chance to say goodbye."* (P8).

Being isolated was associated with feeling trapped and being distressed about the deceased, with limited interactions with family and community involvement while living alone (Portacolone, Chodos, Halpern, Covinsky, Keiser, Fung, Rivera, Tran, Bykhovsky & Johnson, 2021:255).Therefore, to alleviate the agony of family members, it is necessary to identify their essential needs.

3.3.2.2 Category 5: The need to accept the great family tragedy

The catastrophic and unstoppable nature of COVID-19 had a series of devastating effects from an economic, social, and psychological point of view at a global level (Coppola, Rania, Parisi & Lagomarsino, 2021:1). The results of a study on the mental health crises of the families of COVID-19 victims show that the bereaved families experience a much deeper sense of loss and emotional (Mohammadi, Oshvandi, Shamsaei, Cheraghi, Khodaveisi & Bijani, 2021:2). Indeed, it has been reported that COVID-19 may cause many psychological problems that could potentially be even more detrimental in the long run than the virus itself (Jarvis, Oyegbile & Brysiewicz, 2021). Family support as a second cornerstone of family-centred care needs to be adapted to the current COVID-19 pandemic (Zante et al., 2020:336).

The fact that some participants never got a chance to say goodbye properly meant that it took time for them to come to terms with the fact that their loved ones were gone forever. Since visitors were not allowed, one participant mentioned that he didn't even

get to see his father before he passed away. The participant’s life seemed to have been tragically affected by COVID-19, and he is still healing from its repercussions.

The sudden painful loss of a family members was difficult, as it was overwhelming to process all at once. As P6 said:
“I was devastated, but then I didn’t expect that she would leave us so soon.”

Zante et al. (2020:336) point out that a sudden tragedy in a pandemic such as COVID-19 may disrupt the process of bereavement in terms of arranging funerals and other ceremonies. The time frame in accepting the tragedy may cause a high prevalence of anxiety, depression, and PTSD among family members. After the crisis relatives should hold ceremonies to remember their loved one, and culturally sensitive bereavement services held in hospitals may be helpful for closure and to show respect for the dead (Selman, Chao, Sowden, Marshall, Chamberlain & Koffman, 2020:84).

One participant stated that the admission of their relative to a health facility was not related to a death-threatening condition. She mentioned that she was expecting her mother to come home after she had gone for a follow-up appointment at the local clinic, only to discover later that her mother had been referred to hospital for admission:

> *“She didn’t leave home as a person who was going for admission, she left in morning and told us she was going to the clinic for check-up. A few hours later she gave us a call to say that she had been admitted to hospital.”* (P2)

Family members witnessed their relatives being referred to a heath care facility to be admitted when least expected . A relatives hospitalisation to a healthcare institution due to an unforeseen illness causes physical and mental detachment (Bartoli at el., 2021:929)

A participants did not know the diagnosis of her mother when she was admitted, and no one understood what was wrong with her because she did not exhibit what was expected as COVID-19 symptoms. The medical professionals anticipated that it would

not be COVID-19. It was discovered after she passed away that she was positive for the virus. Family members could not believe the unexpected diagnosis received from staff, that the passing of their mother was due to COVID-19, and a participant mentioned:

> *"When she was admitted we didn't know what was wrong with her. Only later, after she passed on, the results came back stating that she was positive for COVID-19, So when she was initially admitted, no one knew what was wrong with her because she didn't really have the COVID symptoms. The doctors didn't think she could be having COVID-19."* (P4)

Family members find it difficult to accept a tragedy that came about unexpectedly. It was confirmed that uncertainty of family members about the patients' future, the course of illness, his/her survival, and the unfamiliar environment of a hospital may all have an impact on the relatives' psychological condition (e.g., anxiety, stress, depression, sleep disturbances) (Zante et al., 2020:336). The death of a family member usually causes emotional shock and trauma to the other members of the family, who need to receive emotional support from relatives and even the society to adapt to their sense of loss (Mohammadi et al., 2021:2).

Due to the pain of the tragedy, a participant got physically ill, as she longed to be connected to her loved one:

> *"I was not alright I just became sick, even now you asked to interview me, I just thought of her and miss her (emotionally down while sharing)."* (P9)

The families have had difficulties in coming to terms with and processing the losses, due to having been confined to their homes – a traumatic and abnormal situation. Families were prohibited from experiencing the reality of the worsening health and subsequent death of their family member (Hernández-Fernández & Meneses-Falcón, 2021:1229).

The participants were heartbroken because of the COVID-19 regulations which prohibited them from visiting hospitalised family members or taking their body home. One participant expressed how she did not find comfort, because under normal

circumstances in most South African cultures, the body of the deceased would be brought home a day before the funeral. Part of the reason for this is to allow close family members to see the body to get closure:

> *"I was so hurt because with COVID-19 you are unable to see your family member while they are admitted to hospital and when they die you can't even see you family member because the body was not allowed to be taken inside our home. So, I could not see her, it was so bad I didn't get closure. Due to COVID-19 restrictions I was unable to see her. It was painful."* (P7)

Funerals play a key role in mourning, bringing together those who remember the deceased to celebrate their life, and creating a supportive network for the bereaved family. Restrictions during the pandemic meant that funerals carried out in this time were unlikely to match the wishes of the bereaved or the deceased (Selman at el., 2020:84).

3.3.2.3 Category 6: The desire to feel secure in knowing what to expect

Understanding and acknowledging the challenges we face is a vital step in developing effective primary and secondary prevention efforts and other countermeasures to optimise mental health and functioning (Montauk & Kuhl, 2020:97).

Participant 2 emotionally expressed how she felt insecure, as she did not have vital information, there was a lack of communication about the relative, and she was not able to be at the bedside*:*

> *"… we couldn't call the doctor every hour to ask what going on."* (P2)

Fear of the unknown was described as worst at the beginning of the pandemic (Rwafa-Ponela, Price, Nyatela, Nqakala, Mosam, Erzse, Lalla-Edward, Hove, Kahn, Tollman & Hofman, 2022:9). The most common needs were for more timely and regular care updates, and exceptions to allow face-to-face visits, despite isolation policies and visitation restrictions (Chen et al., 2021:873).

The absence of information created an environment of uncertainty and increased the anxiety of this participant and his bad habit of smoking:

> *"I couldn't get out of my mind the thought of knowing that my mother was in hospital and couldn't image my life without her. I was thinking about it all the time hence I used to smoke a lot to try and distress. I even cried bro." (P11)*

Results of another study indicated that participants expressed difficulty in coping with COVID-19 infections affecting either themselves or their family (Rwafa-Ponela et al., 2022:6).

A child was distressed about the implications if the parent would die, and in essence could not focus on studying. Being unable to reach the mother and get information felt dreadful:

> *"I was worried and feared that my mother was going to die and leave us. I could not cope at all. During that time, I was studying at home online because classes were suspended. I could not concentrate; all I thought about was my mom who had been admitted. The saddest part was sometimes when I called the hospital and couldn't get hold of her and that made me very anxious." (P10)*

During the COVID-19 pandemic bereaved relatives perceived healthcare teams as instrumental in ensuring connectedness between patients and their family at end of life, through proactive measures such as video and telephone calls, providing relatives with ongoing updates about their dying family member's declining health, and enabling opportunities for relatives to 'say goodbye' when death was imminent (Hanna et al., 2021:1250).

This theme confirmed the theoretical assumption (Chapter 1) that the basic needs of the family members of a close relative had to be assessed, so that they could be supported by nursing staff.

3.3.3 Theme 3: The need of families for 'nearness' should be understood, and means more than physical proximity to a close relative

In a culture where extended family ties are highly valued, South African families may also rely on other family members for social support, rather than seeking this from health professionals (Redley, Phiri, Heyns, Wang & Han, 2019:19). The separation of the family from the patient inhibits opportunities for family engagement, and begs the question – what can/should nurses do when caught in the dilemma of ensuring strict

compliance to COVID-19 regulations, while trying to meet the needs of patients' family members (Jarvis et al., 2021)? Family members of critically ill patients are vulnerable to intense psychological distress as well as immediate and long-term emotional suffering because of losing connection with their relative (Redley et al., 2019).

3.3.3.1 Category 7: A chain of connection, attachment, and reliance on the family member was broken

Emotional distress and negative emotions were evident as family members struggled to adjust their family structure without the patient, and relationships between family members were strained (Chen et al., 2021:871). Research shows that having visual contact with their loved one provides context and confirmation of reports from the clinical team, supports family decision-making, and promotes better communication with the clinical team (Dainty, Seaton, Molloy, Robinson & Haberman, 2023:4).

Family members experienced high levels of stress and anxiety after learning about the patient's diagnosis. While being concerned for the health and wellbeing of their loved ones, family members also felt vulnerable and worried about their own potential of contracting the virus (Chen et al., 2021:871).

The very first participant who was interviewed mentioned the negative impact of the passing away of a family member and breadwinner due to COVID-19, which led to her having to make sudden radical changes, for example having to take care of herself and her baby:

> *"My aunt used to take care of us now that she gone it's tough. She did not only take care of us, but she also took care our children as well. When I'm at school she used to take care of my child. She was a breadwinner because I'm not working."* (P1) *[Looking frail]*

This participant also described her aunt as part of her life, a strong person who people used to rely on to give a great deal of support and comfort, saying "She was the pillar of my strength."

Economic concerns during hospitalisation of the primary caregiver has been widely reported, as family members describe the financial concerns related to changes in their employment schedule (Blok, Valley, Weston, Miller, Lipman & Krein, 2023:7).

The shift of responsibility, by having to care for the family member that was once the primary caregiver, can lead to symptoms of insomnia and fatigue, with the added discomfiture of having to borrow money and ask for financial assistance from others (Ghezeljeh, Rezaei, Shahrestanaki & Milani, 2023:7). Other participants described the struggle of having to face the challenges of not having someone they use to depend on for financial support as catastrophic:

> *"My aunt has taken care of me since I was young from when my mom passed on."* (P1)

Participants expressed deep concern and trauma at being separated – often with little advance notice – from a loved one in medical distress, with limited options for contact (Dainty et al., 2023:4).

Because of this unexpected event, those who are left behind suffer and experience major disruptions and may fail to adjust in a positive way. As Participant 1 put it: *"Now that she has passed on, things aren't the same anymore, it's tough."*
Many families were unable to say farewell to their loved ones, and many were unable to attend funeral ceremonies to carry out their final grieving customs. These difficult circumstances upset not just the family members involved, but also resulted in distress of the person who is near death (Corpuz, 2021:281).

Indeed, trauma of detachment related to sudden hospitalization , as many of the participants mentioned that COVID-19 not only took away their family members, but also took away people they depended on for financial support:

> *"It has taken the life of a person we had depended on. She was our Bread winner. You see now I sometimes in need of a R50 for travelling to work of which if she was still around, she would give me. Things have changed now that my sister has died because of COVID-19. My sister was everything; she used to support us with everything, there is a gap now that she's no long here."* (P5)

The pandemic has changed the structure and routine of the family (Gayatri & Irawaty, 2022). COVID-19 and its associated lockdown restrictions impacted families in different aspects of life. Research evidence further suggests that there has been an increase in the unemployment rate, and economic uncertainty has been reported (October, Petersen, Adebiyi, Rich & Roman, 2021:3).

The changes in family structure due to the loss of a breadwinner in the household resulted in participants having to take on the responsibility of taking care of themselves and their families:

> *"She used to take care of use; I grow up knowing that she was my mother. She was like a mother to me. It's not easy things aren't the same anymore." (P5)*
>
> *"She was the breadwinner, so it was tough ever since and I had to take care of her children while she was in hospital. It's worse now that she has passed on, things have changed and it's difficult. I now must carry the burden and the responsibilities on my shoulders alone. At least when she was alive, we used to help each other."* (P6)

The COVID-19 pandemic disrupted everyday routines and brought with it social disruption such as financial insecurity, caregiving burden, and physical distancing-related stress (Gayatri & Irawaty, 2022). While the disease itself drove significant anxiety and fear, measures imposed by the government to curb the pandemic led to substantial financial and social strain and were equally important in contributing to poor mental wellbeing (Rwafa-Ponela et al., 2022:15).

The impact of COVID-19 affected the patients' wellbeing, as well as the emotional welfare of their family members, due to the implementation of social distancing. Families found it especially distressing to be regarded as an additional measure of support to the patient without being recognised as having their own individualised needs (Maaskant Jongerden, Bik, Joosten, Musters, Storm-Versloot, Wielenga, Eskes, & Group, 2021:7).

3.3.3.2 Category 8: Abrupt alienation from the sick family relative in an unfamiliar situation

The family is responsible for maintaining stability in society through socialisation and is central in the care and wellbeing of individuals so that they can function properly in society (Adebiyi et al., 2021:233). COVID-19 was an unfamiliar situation in which families were abruptly impacted, with individuals as well as societies affected (Adebiyi et al., 2021:233). Individuals across the world had to adapt and cope with unexpected difficulties (Rich et al., 2022:2). The pandemic influenced the way families interacted with one another and added constraints to the interactions between individuals and community members (Rich, Butler-Kruger, Sonn, Kader & Roman, 2022).

A participant mentioned that due to the COVID-19 restrictions they could not visit someone close to them when they became ill or were admitted to a health facility, and that was an unfamiliar situation:

> *"You know… the fact that when someone close to you get sick or get admitted to hospital it was expected that you would go to visit them but with COVID-19, "obviously" the family members now could not... ."* (P2)

The COVID-19 pandemic prompted extraordinary measures around the world to slow the pace of SARS-CoV-2 transmission and minimise the public health consequences of the disease (Govender, Cowden, Nyamaruze, Armstrong & Hatane, 2020:8). The inflexible visiting restrictions had a momentous impact on the families of patients admitted during the pandemic. Most could understand the rationale for restricted visiting, but they still had an overwhelming need to be with their critically ill relative (Bartoli et al., 2022:3).

One participant expressed how she could not understand why she could not view her family member from a distance, as it would have not meant such sudden and complete separation:

> *"For me personally… ,I just needed to walk into the hospital and see how she was doing."* (P4)

Families experienced significant psychological distress from being separated and struggled to adapt to visiting restrictions (Bartoli et al., 2022:3). Participants could not make sense of the situation and felt the need to be in close contact in order to feel informed about the care of their relative. It is therefore crucial to offer psychosocial assistance to family members who are close to patients during the epidemic.

It seemed that being unable to visit and not knowing what was going on with the family relative admitted to the health facility was rather a sudden and exhausting experience:

> *"When my aunt was admitted we were unable to visit her … we couldn't even see her to check on how she was doing."* (P1)

Abrupt alienation from the sick relative in an unfamiliar situation, isolation, and separation from their families are the toughest challenges that had to be dealt with over the past few years with implementation of the COVID-19 restrictions (Rich et al., 2022:4).

Families suddenly had to find new ways of adapting and coping with sick loved ones through building family resilience:

> *"It was a very stressful journey … in the hospital they were very busy. They can't always take calls from the patient's family, so it was a challenge."* (P4)

COVID-19 restrictions made it even more difficult for people to interact with others outside of the immediate family (Chersich Matthew, Gray, Fairlie, Eichbaum, Mayhew, Allwood & English et al., 2020). Furthermore, the restriction of interactions among family members was especially difficult when members became ill and ended up in hospital or being isolated, even though many tried to keep in touch via telephone or video calls (Rich et al., 2022:6).

A participant expressed difficulty in coping well with the fact that they couldn't see their relative because they were not allowed to visit:

> *"I think I would've felt a lot better if they answered my calls when I desperately needed to hear how my mom was doing. The worst part was that we were not allowed to visit due the COVID-19 restrictions."* (P10)

Abrupt alienation from the sick family relative in an unfamiliar situation and the restrictive visitation policy adopted in hospitals during the COVID-19 pandemic affected the coping of families (Mulaudzi, Anokwuru, Du-Plessis & Lebese, 2022:1). One participant could not deal with the unexpected news that her mother had been admitted to hospital:

> *"I couldn't cope because first of all when she* [mother] *left home, she didn't say she was not going to come back …." (*P2)

It seemed as if separation of the patient from their close family members was an unfamiliar situation, and even though the family members understood and agreed with the forced social separation, it still caused guilt, uncertainty and powerlessness, with ambivalent feelings towards the visiting restrictions.

Theme 3 thus supported the theoretical assumption (Chapter 1) that closeness to the patient does mean more than standing at the bedside of a close relative.

3.3.4 Theme 4: Comfort should be given to the family members through comprehensively supporting them, to diminish 'the waves' of hurt created by the unforeseen impact of COVID-19

Comfort is a multi-dimensional structure within the context of four experiences – physical, environmental, psychospiritual, and socio-cultural – and defined as a condition for meeting basic human needs for relief, ease, and transcendence of suffering (Terzi et al., 2022:7). The unrelieved presence of sadness of the participants, indicated that they were wounded emotionally, by the suddenness of the death of a close relative. The absence of being able to say farewell to a loved one, both before and after the death, caused severe grief. Grieving is associated with disbelief, denial and a lack of acceptance and coming to terms with the loss (Hernández-Fernández & Meneses-Falcón, 2022:1230).

3.3.4.1 Category 9: Assessment of the unrelieved presence of sadness from being emotionally wounded by the suddenness of loss

Even though death is unavoidable, COVID-19-related fatalities tend to have a more detrimental impact on families and acquaintances (Yoosefi, Lebni, Irandoost, Safari,

Xosravi, Ahmadi, Soofizad, Ebadi Fard Azar, Hoseini & Mehedi, 2022:2). It seems that the absence of a final goodbye, sudden death or the uncertainty caused by not knowing how a loved one was faring while admitted to hospital, were elements that provoked a complete sense of disbelief and unreality in the mourners, making it difficult to adequately digest and come to terms with the news.

> *"Yoh it was sad … I am still very hurt even now (emotional."* (P1)
>
> *"I'm still devastated every time I think about it."* (P1)

The global devastation caused by the COVID-19 pandemic and its mental health impact is undeniable (Bröcker et al., 2021). The absence of being able to say farewell to a loved one, both before and after the death, is a complicating factor in grief, as it is associated with disbelief, denial and a lack of acceptance and coming to terms with the loss (Hernández-Fernández & Meneses-Falcón, 2022:1230).

It was obvious from the facial expression of a participant that she was in a state of mental distress as she shared her experience, saying:

> *"It has brought sadness into our lives."* (P5)

Family members reported suffering immensely after being separated from their ill relatives at a time when family connection was most needed (Digby et al., 2023:358). Another common experience was a sense of a void left by the departed, not only in terms of a radical change in everyday life habits, but also concerning the loss of an important resource which the mourner could formerly rely on, or what seemed a part of oneself (Cipolletta, Entilli & Filisetti, 2022:988).

Participant 9 described the event as the most tragic experience, causing suffering extreme stress, and had lost three family members:

> *"My mom, my dad and my brother. They all died of COVID-19… . Yoh, it was the worse time in my life."* (P9)

Families had difficulties in coming to terms with and processing the losses, due to the limitations of home confinement that in and of itself was an abnormal situation and prevented them from connecting with the reality of the worsening health and subsequent death of their family member (Hernández-Fernández & Meneses-Falcón, 2022:1229).

COVID-19 posed a threat to one's very existence (or that of relatives), a kind of threat that, according to much research, is deeply interrelated with a lack of cognitive and emotional control (Wnuk et al., 2020:3). The separation of the family from their relative is particularly problematic and disruptive in terms of the coping and pain processes of families, for different reasons (Bartoli et al., 2021:926).

3.3.4.2 Category 10: Addressing adequate resources to treat ill patients

The worsening COVID-19 pandemic in South Africa posed multiple challenges for clinical decision making in the context of already scarce resources (Naidoo & Naidoo, 2021:1). Health professionals were in extraordinary situations where there was a high demand for care, often accompanied by a shortage or scarcity of resources, resulting in the health system operating at saturation point (Delgado, 2022:44).

One participant described how the shortage of equipment (oxygen) contributed to priority care due to lack of resources. She mentioned that patients had to be prioritised according to their oxygen saturation levels:

> *"At that time, the hospitals were full and there was not enough oxygen therapy at the facility she was admitted. At the hospital she was admitted they used to share oxygen, when one patient's oxygen saturation increased to near to normal then they would take them off oxygen and put it on someone who had low oxygen saturation."* (P9)

This participant continued and mentioned that the situation was out of the nurses' control, as there were no beds available to admit patients, apart from the shortage of oxygen therapy:

> *"I could see that situation was beyond their control, it was bad at the facility where my parents were admitted. Nurses tried their utmost best, but they could only do as much, sometimes there were no beds for to admit patients or patients sharing oxygen. Basically, everyone was burdened."* (P9)

The availability of healthcare providers and support staff played a significant role in the patients' clinical management. The study by (Delgado, 2022:44) noted inadequate and inequitable staff distribution as a healthcare system factor that contributed to COVID-19 mortality.

3.3.4.3 Category 11: Giving reassurance to relieve fear from the hard-hitting transformation in the lives of families

Visiting restrictions limited the presence of family members in the hospitals to provide emotional support for patients, restricted family-centred care, and reduced opportunities for formal and informal communication with the healthcare team (Rose, Cook, Onwumere, Terblanche, Pattison, Metaxa & Meyer, 2022:1157). There was a need for reassurance that the relative's loved one had not been abandoned and was being taken care of.

3.3.4.3.1 Sub-category: Communication and being with others helps ease the pain

Family-centred care, including communication, collaboration and (bereavement) support has always been a core element of ICU care, as the patients' situation is often critical (Klop et al., 2021:2). Previous studies of the COVID-19 pandemic have revealed that the psychological effects of infectious disease outbreaks can last long after the event, negatively impacting psychological well-being and causing post-traumatic stress disorder, depression, and stress among health-care workers (Alnazly et al., 2021:3).

Two participants needed others to support them at the time that their relatives were admitted to a health facility. This is what they had to say:

> *"Talking to friends and family encouraging me to stay positive."* (P3)
>
> *"I needed emotional support, like people calling and checking on me."* (P11)

A common impulse among those experiencing grief is to seek comfort in the arms of family, friends, and community (Selman et al., 2020:84). The rapid deterioration witnessed in many patients with COVID-19 who were admitted to hospital caused a high burden of stress, anxiety, and feelings of loneliness among relatives (Klop et al., 2021:2). Therefore, the support of relatives of patients with COVID-19 admitted to a health facility appeared to be extremely important.

It seemed that there was a need for liaison nurses as an important resource for some families. One participant mentioned that she expected the nurses to check-up on her

and her family to see how they were doing after her relative passed away from COVID-19, or to make a house visit to test the rest of the family members:

> *"During that time, I needed someone I could talk to. I thought they (nurses) would check up on us and see how we are doing or do a home visit and test the rest of the family members for COVID-19 since one of my family members died of COVID-19."* (P5)
>
> *"I wish that someone could just call me and let me know everything was going to be alright. I was not even allowed to see her in ICU because she was very sick, and people were not allowed to visit their family member in hospital."* (P11)

The need for reassurance and keeping the family members informed about the condition of their relatives were some of the crucial needs outlined by the participants to have been lacking.

The kind of support that the participants in this study seemed most in need of, and which they themselves valued most, was emotional support:

> *"The only thing I needed that that time was to see my sister and talk to her, but I couldn't because we were not allowed to visit. I think nurses can help support families during COVID-19 when their close relatives are admitted by also assisting those patients who are unable to answer video calls so that they can see because family members could not see, touch, or hold their loved ones."* (P6)

Another participant felt lonely, especially after realising that they would never see their loved one ever again:

> *"I think the support I needed when was more after he died than when he was still hospitalised. I just need to be around people because when I was alone, I am thinking too much and stressing a lot. I think nurses can help us by telling us about the condition of the patient whenever we call to ask." (P8)*

Whether or not a patient dies in hospital, clear and complete communication by healthcare providers improved the bereaved relatives' satisfaction with the end-of-life care, and families appreciate proactive, regular, accurate and sensitive communication (Selman, Sowden & Borgstrom, 2021).

Communication in end-of-life care is of critical importance, and health professionals should be educated to provide this type of support, which is pivotal for both the patients preparing for their own departure and their family members (Coppola, Rania, Parisi & Lagomarsino, 2021).

A participant mentioned that he experienced a lot of changes, because he used to depend on the family member that was admitted:

> *"Well, I needed financial support and emotional support. There was no one to talk to and I also had to take care of my siblings."* (P11)

It seemed that the loss of essential income can have a cascading effect after the loss of a breadwinner. The severe economic shockwaves of the COVID-19 pandemic have far-reaching impact for the financial security and wellbeing of families (Walsh, 2020:900).

3.3.4.3.2 Sub-category: Professional support

Nurses have professional and moral responsibilities in providing for the psychosocial well-being of the family. Nurses' understanding of providing holistic care requires them to intervene by evaluating family members physically and psychologically, and by determining risky conditions (Terzi et al., 2022:2).

One participant described how the counselling sessions helped her to cope and relieved her stress related to grief after the loss of a family member:

> *"I did get support at clinic from one of the professional nurses and as well as my family members were with me throughout the process. I also got support from my other sister who's a nurse also working in Joburg. She would call me to ask how I am doing. I've also went for a counselling session for 6 weeks at the clinic."* (P7)

In a culture where extended family ties are highly valued, South African families may also rely on other family members for social support, rather than seeking this from health professionals (Wang & Han, 2019:2819). The family, consists of self-defined members and is described as "two or more individuals who depend on one another for emotional, physical, and economic support" (Jarvis et al., 2021).

A few participants mentioned that they received psychological support which was incredibly by beneficial, and suggested that relatives who had a family member admitted with or who died of COVID-19 should seek professional assistance and guidance in resolving personal or psychological problems:

> *"I went for counselling which really which helped me a lot. I would recommend that to everyone who lost family member due to COVID-19 because it's an instant thing, it a lot to deal with you don't get closure it's a lot to digest at once. So, it helps to speak with someone, a psychologist it helps to deal with the trauma."* (P4)

Local support groups could be used in PHC settings and can help by significantly helping to combat the isolation and the disability that the study has identified as occurring in COVID-19 survivors and their family members/partners (Shah et al., 2021:11). While family, friends, and existing networks are the foundation of bereavement support – and for many people the only support needed – formal bereavement services play a central role in supporting individuals and families (Selman at el., 2020:84).

The theoretical assumption that the comfort of a family member should be viewed holistically was supported by the findings and easing of the impact of the situation around the close relative with COVID-19 was mentioned.

3.4 CONCLUSION

The pandemic has had unpredictable and uncertain impacts that could pose a threat to the well-being of families. It has caused mental health problems such as anxiety, stress, and depression. Short-term as well as long-term psychosocial and mental health impacts were experienced for all family members, especially when a family member was suddenly admitted to a health facility. Evidence from the participants showed that lack of preparedness among relatives and visitor restrictions led to unsatisfactory communication and difficulty in understanding the information provided by healthcare workers.

Some of the concerns of family members were related to the emotions of their loved ones regarding what thoughts and feelings they might have, and the treatment they were receiving while admitted, in the absence of communication with their family member. It was also interpreted that restrictions of visitors to the health facility caused anxiety among family members. The study showed that visits to the healthcare facilities that were subjected to restrictions evoked negative emotions, specifically among family members in the context of the COVID-19 pandemic.

Despite the sudden admission of a family member to a health facility, various financial demands and the extra stress of family issues that came with the loss of a family member left relatives trying to remain stable and trying to comprehend that there was still a future for them. The evidence shows that many of the participants require psychological intervention, such as counselling for emotional support.

CHAPTER 4
CONCLUSIONS, RECOMMENDATIONS, SIGNIFICANCE AND LIMITATIONS OF THE STUDY

4.1 Introduction

The COVID-19 pandemic has had a significant impact globally, and the research findings of this study assist in providing an in-depth understanding of the lived experiences of families in Khayelitsha, Cape Town, when a close relative was unexpectedly admitted to a health facility with COVID-19. The second objective of the study was, to describe the support of professional nurses to address the needs of families during COVID-19 when a close relative is admitted to a health facility.

4.2 Conclusions

The findings indicated that participants had a lack of authentic information around the condition of their relatives, which hindered establishment of a trusting relationship with staff in the healthcare setting. Admission of a relative to a health facility is an event that impacts the lives of the patients and their families.

Family members expected to receive authentic information and needed to have a trusting relationship with the healthcare staff. In this context, experiences shared indicated that at the start of the COVID-19 pandemic, there was an absence of consistent and structured communication between the family and the patient who was hospitalised. Such communication is regarded as one of the basic components of FCC (Kokorelias et al., 2019:8). Family members were uninformed novices in an uncertain health environment, as some of the participants were uninformed and uncertain about the health status of their relative who had been admitted to the health facility. This led to a sense of uncertainty, as in their reality they experienced an indefinite timespan with insufficient information, and only vague information available to them. Various feelings emerged among the relatives, including curiosity and anxiety, as they felt far removed from their family member. It was expected that nurses should keep family members informed of any change in the condition of their relative who had been admitted (Terzi et al., 2022:8).

Experiencing an indefinite period with little knowledge made the participants feel as though reality had vanished. Although participants were aware that no visiting was allowed, this was still an unexpected, sudden occurrence which they were unprepared for. Although hospitals had to put visitor guidelines in place for family members, not being able to visit their loved one led to feelings of distress, panic, anxiety and suffering among the family members.

This uncertain and life-threatening situation altered the normal family routine. In addition, it is lived in an unfamiliar environment that is often unwelcoming and involves a healthcare team that primarily focuses on the medical treatment of the patient, leaving the family on the side-lines. It could have been expected that during the COVID-19 pandemic the families of patients could be supported in nonphysical ways to promote FCC (Hart et al., 2020:94).

The lived experiences of some of the interviewed participants indicated that they needed to accept the family tragedy of losing a family member to COVID-19, resulting in serious psychological conditions (for example, anxiety, stress, depression, and sleep disturbances) among family members. Previous studies of the COVID-19 pandemic have revealed that the psychological effects of infectious disease outbreaks can last long after the event, negatively impacting psychological wellbeing and causing PTSD, depression, and stress among healthcare workers (Alnazly et al., 2021:3). The findings of this study indicated that the essential needs of family members were not assessed, although doing this could have assisted in relieving their suffering. Knowing the needs of family members could have been an opportunity for nurses to demonstrate their vision of quality integrated patient care, which should incorporate the experiences lived by the patient’s family (Silva et al., 2022).

Participants had the desire to feel secure in knowing what to expect. The family members had to take ownership of their own circumstances, by seeking new ways to support their families and survive the traumatic circumstances, such as adapting their living expenses. Family members found it difficult to accept the great distress that was inflicted on them unexpectedly and in a short timeframe. Not being able to say goodbye or the uncertainty caused by not knowing about the health status of a loved one are elements that can provoke a total sense of disbelief and unreality in relatives,

making it hard to digest and accept the difficult situation at hand (Hernández-Fernández & Meneses-Falcón, 2021:1228).

Families needed a 'nearness' that went beyond being physically close to a family member. Experiences indicated that sudden alienation from a sick relative in unfamiliar circumstances was traumatic; it was compared with a chain that was broken, as the participants and their relatives were disconnected. In a culture where extended family ties are highly valued, South African families may also rely on other family members for social support, rather than seeking it from health professionals (Brysiewicz & Bhengu, 2010; Redley et al., 2019:2819).

The hurt of the family created by the impact of COVID-19 should have been addressed through comforting them. Close family members of patients hospitalised with COVID-19 were in a vulnerable situation of unpredictability, and the sudden seriousness evoked fear of losing their loved ones (Bernild et al., 2021b). This fear was increased by the stay at home (lockdown) orders deployed across countries as a non-pharmaceutical public health intervention to control COVID-19 transmission (Hamadani et al., 2020:1381).

The unrelieved sadness of individuals who were emotionally hurt by the suddenness of loss was unattended to. It is important that healthcare professionals respond to any significant changing needs, priorities, and expectations in the community (Jordan et al., 2023:377).

This study also found that there were inadequate resources to treat the ill patients. Some participants mentioned that inadequate and inequitable staff distribution, as well as of resources such as the availability of hospital beds and oxygen in the healthcare system, are some of the factors that contributed to COVID-19 mortality. It should be noted that the COVID-19 pandemic overwhelmed health systems in both developed and developing nations alike (Tessema, Kinfu, Dachew, Tesema, Assefa, Alene, Aregay, Ayalew, Bezabhe, Bali & Dadi, 2021:1).

Relatives inevitably felt anxious, afraid, alone, and in need of professional support, yet this was an area in which hospital care was found to be lacking (Selman et al., 2020:83). It is crucial to develop reassuring activities to allay fear owing to the hard-

hitting transformation in families' lives. They need reassurance that their loved one has not been abandoned and is being taken care of holistically.

The personal emotional support given to the family members of patients is an integral part of professional holistic care (Terzi et al., 2022:2).

4.3 Recommendations

Recommendations are made to support professional nurses in addressing the needs of families who have a close relative with COVID-19 admitted to a health facility. These recommendations are for nursing practice, nursing management, nursing education and future research. These recommendations are not only limited to pandemic situations as good communication between healthcare practitioners, patients and family members is a basic general part of nursing care.

4.3.1 Recommendations for nursing practice

The following recommendations are made:

Authentic information is needed order to build a trusting relationship. This could be established in a number of ways:

- A trusting relationship can be established via communication between nurses and family members. It is important for nurses to dedicate time to telephone conversations or video calls, not only to respond to doubts but also to give a face to specific nurses delivering care to the family member. This can create a closer relationship between stakeholders (Lissoni et al., 2020:106).
- Trustworthy and straightforward information should be provided to family members through regular nursing care updates. In certain instances, exceptions could allow face-to-face visits, despite isolation policies and visitation restrictions (Chen et al., 2021:873), to ensure that the family feels secure in knowing what to expect.
- During in-service training sessions, staff should be informed that during stressful times accurate and in-depth information should play a key role in educating, empowering, and protecting other people from fatal diseases and their multi-dimensional consequences (Dutta, Dutta, Hasan, Sarkar & Sana, 2020:100).

- Trauma counselling should be available for family members so that they understand how to manage difficult experiences around loved ones. More opportunities and teaching moments should be established for the provision of trauma-informed care to staff, patients and family members.
- Healthcare professionals and institutions should be the most trusted sources of information in pandemics, with TV and radio broadcasts less trusted (Rožukalne et al., 2022:13).
- It is the duty of nurses to provide clear and appropriate information and compassionate care to families in circumstances where family members are critically ill and admitted for treatment.
- Strategies to encourage communication with and the wellbeing of the family should be outlined in policies and procedures for units, since It is an essential pillar for people in sharing the ideas, delegating responsibilities, management of a team, building up a healthy relationship, etc.

The essential needs of family members must be identified, to assist them at this critical time. This could be implemented by:

- Accurate assessment of family needs, as one of the first steps in providing appropriate care to patients and their families.
- Nurses themselves having a personal conversation with the family to get to understand their circumstances, with regular feedback about the progress that the patient is making. This could be through WhatsApp or emails, for example.

The need of families for ‘nearness’ should be understood and should extend to more than the physical proximity of the close relative. This could be established by;

- Nurses caring for ill patients should view them as holistic beings, with a spiritual bond with the family that is a partner in care delivery.
- Nurses establishing a chain of connection and attachment (reliance) with the family members by aiming to meet their needs. For instance, the family would appreciate a daily telephone call to make them feel part of the care delivered to their loved ones.
- Short programmes designed and offered at specific times, that can assist the family to cope with stress and address their mental health. Nurses are responsible for the family's psychological wellbeing in a professional and ethical

manner. Nurses' understanding of providing holistic care requires interventions, by evaluating the physical and psychological wellbeing of family members who could have risky conditions (Terzi et., 2022:2), such as severe anxiety.

- Psychosocial support for family members who feel the need to be near the patient, under impossible conditions (Azoulay, Curtis & Kentish-Barnes, 2021).
- Evaluating the needs for comforting of family members of patients in a pandemic, with multi-dimensional measurement tools to be developed for this purpose.
- Building social support with others, such as extended families, siblings, and neighbours, and talking to friends when family members reach out for help. Specific contact details should be provided by the family when the patient is admitted.

Comfort should be given to the family members through comprehensively supporting them to diminish 'the waves' of hurt created by the unforeseen impact of COVID-19, through:

- Assessment of the unrelieved sadness related to being emotionally wounded by the suddenness of loss, by referring them to a medical practitioner.
- Nurses' exploration of more creative means of communication between the nurse-patient-family triangle, through different types of messages or an information station monitored by a professional nurse of a ward. Specific communication strategies that increase family satisfaction could include empathic statements to assure others of non-abandonment, motivational discussions to establish feelings of comfort around how treatment is delivered, and provision of written information on the status of recovery of a patient (Selman et al., 2020:82).
- Creating reassurance through actions to relieve fear related to the hard-hitting transformation in the lives of families, by showing them video clips of similar situations, in a private area near the ward where the patient is.
- Good record-keeping, which is an integral part of skilled professional practice, that limits legal cases after a patient has passed away.
- Delivering a service within a professional-ethical-legal framework, with nurses complying with compulsory immunisation requirements of the employer, to offer the best family- centred care to patients, as in the COVID-19 pandemic.

4.3.2 Recommendations for nursing management

The following recommendations are made in terms of planning and policies, staff development, organising support, direction to staff, and controlling an effective, conducive environment.

4.3.2.1 Planning and policies

- In response to the COVID-19 pandemic, hospitals have to develop policies to mitigate the spread of infections between role players. These policies should include communication strategies, family- and patient-centred care, and visitor restrictions (including general visitor restriction statements, exceptions to the rules, and restrictions specific to pandemic patients), and these policies should be changed/updated over time.
- A policy on authentic information within a family-centred approach must align with unexpected situations such as the COVID-19 pandemic. When families are not able to visit patients, information and regular updates from healthcare professionals on the patients' condition are needed. A policy should outline expectations to be addressed and the extent of detailed and frequent communications with family members, similar to when such information could be provided during visits and face-to-face communication (Wammes et al., 2020).
- A checklist/procedure manual should contain processes on phone calls to the family members during epidemics/pandemics.
- If a patient is admitted, the responsible person on the shift must contact the family, and the same applies to handovers. The shift leader must communicate the patient's condition and prognosis across the team and to the family member/s of the patient. This will ensure that there is an early warning if there is the detection of a change in the patient's condition.
- A policy to rapidly address complaints by and support to relatives should be written and implemented where applicable.

4.3.2.2 Staff development

- There should be in-service training for staff on developing creative ways to ensure that the family is provided with adequate information, for example, allocating specific persons in a unit to this task.
- Continuous development should make professional nurses aware of their vital contribution as role models for students, to demonstrate the vital importance of communication to create a trusting relationship between service providers and clients.
- Staff should also attend counselling developmental courses so that they are able to support those in need of it during COVID-19 when a close relative is admitted to a facility.
- Invite a legal representative to give a presentation on the disciplinary hearings of the South African Nursing Council and the laws of the country regarding the implications of unprofessional behaviour.

4.3.2.3 Organising support

- Support services (for example, social services) should liaise with families. A study carried out in Melbourne in Australia in 2020 during the first wave of the COVID-19 pandemic looked at family experiences and perceptions of ICU care and communication during the COVID-19 pandemic. The results suggest that nurses routinely contacted family members by phone once or twice to explain the visiting process, answer their questions, and direct them to appropriate support if needed (Digby et al., 2023:8).
- Hospitals should allow visitation for relatives with seriously sick family members in critically important situations, such as where a patient needs to make a will. The presence of family members (with protective clothing) can also play a vital role in successful management and motivation of the recuperation of hospitalised patients. Family members may find that regular visits to a patient improves their health status, if the family understands the diagnosis that has been made (Creutzfeldt, Schutz, Zahuranec, Lutz, Curtis & Engelberg, 2021:746). The family should be involved in the care of the person in the inpatient setting (Correia et al., 2022:1).

- Each ward should have a smart phone since WhatsApp communication can increase family satisfaction. A daily SMS with encouraging words to family members will lighten the heavy burden they carry when isolated from a loved one. A letter of condolence from management if a patient passes away should be policy.
- It is important for a health system to provide staff with supportive childcare facilities and resources when a pandemic occurs (Naidoo & Naidoo, 2021:1).
- Involve family members in decision making. Active participation of relatives in patient care helps to build trust, allay anxiety, and allows room for structured communication with healthcare providers (Kumar et al., 2022:304). A variety of factors influence trust, especially during a crisis (Rožukalne et al., 2022:1).

4.3.2.4 Direction to staff

- Staff members must be knowledgeable about the correct guidelines for specific situations. Visitors must be advised on precautions and the use of appropriate measures and hand hygiene before leaving the patient room.
- Staff allocated within units must be aware of the role of the person assigned each day to oversee interaction with families and follow up on their wellbeing. This will ensure consistent and comprehensive communication with family members.

4.3.2.5 Controlling an effective, conducive environment

- The healthcare system and its professionals must adapt established strategies or create ones for new emergency circumstances, and be innovative in the use of technology, with a focus on the human beings that need to receive the best possible care or services in any circumstances (Delgado, 2022:48).
- The performance of staff during crisis situations should be evaluated in yearly appraisal sessions. Auditing reports should outline the quality of care delivered during a pandemic, and the actions needed to improve standards of service delivery.
- Addressing inadequate resources to treat ill patients is essential. There is overwhelming evidence that the quality of healthcare in South Africa has been compromised by various challenges that have a negative impact (Maphumulo & Bhengu, 2019:1). Therefore, monitoring of developments and programmes

to improve the efficiency, safety and quality of healthcare delivery and access for all users is necessary.

- Establish the effectiveness of the disaster management and rapid response teams. The responsibility to respond needs a well organised system with clear roles and responsibilities at all levels.
- Effective liaison should be established for key role players in an outbreak, including the hospital management, area nurse managers and professional nurses, representatives of the City of Cape Town, laboratories, clinicians, emergency services and the community.

4.3.3 Recommendations for nursing education

Recommendations for nursing education in terms of planning teaching moments, offering teaching moments and formal lectures, and evaluation of students are outlined below.

4.3.3.1 Planning teaching moments

- Learner nurses must be trained and prepared to participate in a pandemic outbreak when requested to do so by the broader health sector.
- Plan to incorporate communication with families, making use of effective interpersonal communication techniques, during a pandemic, through simulated roleplay with peers.
- During their clinical placements assign students to a trauma counselling centre, is important, to observe the management of a traumatised patient.
- An essential teaching method to incorporate in lessons is role play with students on counselling family members who have lost a relative to COVID-19, to develop characteristics of caring, support, and resilience. All of the nurses – including students –have the responsibility to play a role in treating COVID patients, irrespective of their position in the nursing hierarchy.

4.3.3.2 Offering teaching moments and formal lectures

- There should be teaching of students with regard to the accompaniment of a family member through the bereavement process, where caring should be demonstrated.

- The techniques of showing empathy and remorse are important interpersonal skills, and to be included as part of the emotional domain of the holistic being.
- Incorporate the topic of support needed by families during COVID-19 when a close relative is admitted to a health facility in the undergraduate curriculum.
- In the subject Nursing Sciences, the impact of trauma on the family must be emphasised. Students must be made aware that the physical distance between the family and their ill loved ones calls for emotional support from health professionals to the family members, placing new demands on healthcare professionals (Creutzfeldt et al., 2021).
- Students must be encouraged to use peer support and mutual self-help as key vehicles for establishing safety and hope, building trust, and enhancing collaboration, with community members,and serving as models of recovery and healing (Anderson, Burton, Draughon Moret &Williams, 2022:3), .

4.3.3.3 Evaluation of students

- Students should be competent to interpret policies applicable to a patient with COVID-19, and able to act correctly at the right time and place, for example, regularly providing correct and honest information to the family within a professional-ethical framework. This will enhance development of a trusting relationship between the family and professional staff.
- In teaching and learning there should be a focus on record-keeping of all events during the pathway of delivering care to a patient or advice to a family member.

4.3.4 Recommendations for future research

Ongoing research is required to understand how best those who have been most detrimentally affected by the pandemic can be supported, so that they may go through a healing process from the traumatic events.

A qualitative study can be conducted to explore what impact the COVID-19 pandemic had on the future life span of those traumatised by it. Research could also be undertaken on the effect of media coverage on (or the experiences around it) and COVID-19 or other pandemics. When there is an outbreak of a pandemic, international and local news networks play a role in creating both awareness and anxiety among the public, through live coverage of news briefings, press conferences, and so on.

Health officials and many others also post and explain health guidelines and governmental instructions on websites, in magazines and journals and on social media platforms, including Instagram, Facebook, and X (formerly Twitter).

Hypothesis can be formulated from the research findings, e.g.,

- There is no difference between the perceptions of female and male family members on having a feeling of closeness towards their loved ones being hospitalised for COVId-19.
- There is no relationship between the age of the family members and the need to receive information about the relative who is hospitalised with COVID-19 patients in a health facility.

4.4 Significance of the study

This qualitative research study was employed to obtain a deeper and nuanced understanding around support needed by families during the COVID-19 pandemic when a close relative was admitted to a health facility in the Khayelitsha district. The results of the study contribute towards knowledge that could contribute to improvement of the care rendered by nurses in supporting relatives. The main strength of this study is that it extends the body of knowledge on supporting families separated from sick relatives in unpredicted circumstances. The reason for restricting visitors was to limit the spread of the virus to vulnerable patients and essential staff members, but there were unintended consequences for family and patients which must be addressed (Digby et al., 2023:359). The results of the study indicate that individual circumstances must be considered in order to promote family-centred care.

4.5 Limitations

The study was qualitative in nature, and this implied purposive sampling with saturation reached, including a small number of participants. The study was in a specific context of Khayelitsha in Cape Town. The findings from the individual interviews will not be generalised to the broader population of Khayelitsha. The researcher translated the findings from Xhosa into English (he speaks both languages fluently), since not all participants could speak English. Fortunately, the independent coder was also able to speak the languages in which the interviews were conducted.

Although the findings cannot be generalised, the report of the research can be evaluated by other relevant sites, to incorporate findings where they are thought to be relevant.

4.6 Conclusion

The findings of this study indicated that the onset of the COVID-19 pandemic brought unique challenges to families, who needed authentic information about their ill relatives. Information should regularly be made available to relatives, to establish a context with a trusting relationship between staff and the community. This qualitative study followed a sound methodology, and the experiences of the participants, indicated the importance of a family-centred approach. Families have a longing for nearness to their relatives, that is more than the physical proximity to them. The underlying feelings of hurt that family members came to the surface in the individual interviews and emphasised the need for the family members of patients to be comforted. It was found that 'the waves' of hurt (sometimes feeling better and sometimes worse) of families that was created by the unforeseen impact of COVID-19 should be diminished through a more family-centered approach.

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APPENDIX A: INFORMATION SHEET

Ext 3:32 Inqilo Street,Mfulen,7100

Tel:0782706656

www.cput.ac.za

Email: 220165785@mycput.ac.za

Participant's Information Sheet

Title of the research project:

Support needed by families during COVID-19 when a close relative is admitted to a health facility in the Khayelitsha district

Dear participant

Introduction

I am a Master's student at the Cape Peninsula University of Technology (Health and Wellness Sciences, Department of Nursing). My supervisors is Professor Karien Jooster. I would like to ask you to offer me an opportunity to explain the research that I wish to undertake and to ask you to kindly participate in an individual interview. Please note that you are allowed to ask any question you may have at any time. It is important that you are satisfied and clearly understand what this research entails.

Purpose of the study

The COVID-19 pandemic has had a significant impact globally. Most affected, however, are those individuals and groups routinely disadvantaged by the social injustice created by the misdistribution of power, money, and resources (Xafis, 2020:223). This research will therefore assist in providing an in-depth understanding of the lived experience of families when unexpectedly, a close relative is admitted with COVID-19. The study will describe the support of nurses to the family members left behind during a pandemic. During the COVID-19 pandemic, family presence must be supported in non-physical ways to achieve the goals of family-centered care (Hart, Turnbull, Oppenheim & Courtright, 2020:94).

Description of the process

Individual semi-structured interviews will be conducted in a private room at the clinic with the participant as agreed. The interview will take between 30 and 45 minutes of your time to participate in during the research. The interview will be recorded with your permission. The reason for recording is to allow the researcher to analyse the interviewee's experiences to gain insight, to listen to the interview more than once, and share the data obtained with only the supervisor. The researcher will also take notes so that at the end of interview she can reflect on the interview to identify gaps that might need to be explored in a follow-up interview. The interview schedule will include questions such as: How was it for you when your close relative was admitted to health facility with COVID-19? (2)How can nurses support you when your family relative is admitted to hospital with COVID-19?

Privacy and Confidentiality

Your anonymity will be guaranteed. No names will be recorded anywhere during this research, only numbers on the consent form, and the audio recording will not be linked to your name. Only the researcher and supervisors will have access to the information. All your information will be kept under lock and key (electronic data password-protected on the computer) for five years after the report has been published, then it will be destroyed or deleted.

Conditions of participation

Please understand that taking part in this study is voluntary and you are not being forced to participate. The decision to participate is entirely up to you. However, I would appreciate it if you share your views with me. If you decide not to participate in the study, this will not affect any care at this clinic. You will get the treatment as needed. If you agree to participate and later decide to withdraw at any stage of the interview or study, you are allowed to do so. There will be no interruption of services during the research project as a private room will be

Ethical approval

Ethical approval has been obtained from the Health and Wellness Sciences Research Ethics Committee (HWS-REC) of the Cape Peninsula University of Technology.
The study will be conducted according to the ethical guidelines and principles of the International Declaration of Helsinki (1964) (Good clinical practice guidelines) and the Medical Research Council (MRC) Ethical Guidelines for Research (2019).

Benefits to the participant or others

Results will be available to the participants and published in an article. The results of the study will contribute towards more knowledge and insight into the experiences when a close relative is admitted with COVID-19.

Risks or discomfort

Should you decide to participate in the study, you may feel emotional about the admission your close relative, however, there will be no physical risk. In the event of any unforeseen circumstance, the interview will be stopped, and the necessary assistance will be offered by a counsellor that will be arranged to be available at the clinic.

Expenses

No, you will not be paid to take part in the study. There will be no costs involved for you if you do take part.

Researcher contact details:

You can contact the me on 0782706656 if you have any further concerns or complaints that have not been adequately addressed. You will receive a copy of this information and consent form for your records.

Supervisor's contact details:

Professor Karien Jooste
Head: Department of Nursing Science
Faculty of Health and Wellness Sciences Symphony Road
New Health Education Building B Block

Bellville
Cape Peninsula University of Technology
Tel: 021: 959 6274
Email: JoosteKa@cput.ac.za

APPENDIX B: CONSENT FORM

Ext 3,32 Inqilo Street,Mfulen,7100

Tel:0782706656

www.cput.ac.za

Email: 220165785@mycput.ac.za

WRITTEN INFORMED CONSENT

Letter of request to participate in the study

Project Title: Support needed by families during COVID-19 when a close relative is admitted to a health facility in the Khayelitsha district

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

Participant's signature……………………………….

I further agree that the interview be voice recorded.

Participant's signature……………………………….

I further agree that the researcher takes field notes.

Participant's signature……………………………….

Witness ……………………………….

Date………………………

APPENDIX C: INTERVIEW SCHEDULE

Ext 3,32 Inqilo Street,Mfulen,7100

Tel:0782706656

www.cput.ac.za

Email: 220165785@mycput.ac.za

Introductory questions

Welcome and explain the purpose of the study

Demographics of age gender career

Main Questions

How was it for you when your close relative was admitted to a health facility with COVID-19?

How can Professional nursessupport you when your family member is admitted to hospital with COVID-19?

What do you mean?

Tell me more…….

APPENDIX D: LETTER TO THE CITY OF CAPE TOWN

Email: 220165785@mycput.ac.za

The Head,
City of Cape Town
Cape Town,
8000.

The Head

Re: Request to conduct a research study at Khayelitsha Community Healthcare Clinic

I hereby request permission to undertake a qualitative study at the Khayelitsha district Clinics to Explore and describe the experiences of the community when family members are admitted to a health facility with COVID-19.

I am a Master's student at the Cape Peninsula University of Technology (Health and Wellness Sciences, Division of Nursing). My supervisors are Professor Karien Jooste. In fulfilment of this course, I am required to conduct a research project

The title of my study is:
The support by nurses to families during COVID-19 when a close relative is admitted to a health facility in the Khayelitsha district
The purpose of the study was to describe the support by the nurse to families in the Khayelitsha district, during COVID-19 when a close relative is admitted to a health facility.

The participant needs to have had exposure or experience with the content being investigated.

Inclusion criteria

The participants will be selected on the basis that.

- They had a close relative admitted to hospital with COVID-19 symptoms.
- The relative is either a brother, sister, husband, wife or person staying in the household
- they have not had the disease her/himself
- they are living in the same home as the close relative
- age of older than 18 years

Exclusion criteria

- Family members who had COVID-19 themselves

The participants will be interviewed by the researcher himself, using a prepared interview guide.

Ethical considerations will be strictly adhered to during the study. Approval for the study has been obtained from the Health and Wellness Sciences Research Ethics Committee (HWS-REC). The researcher will adhere to the rights of participants to privacy and confidentiality. In this study no names will be attached only numbers on the interview transcripts. The participants' names will not be linked to the research findings. The research will not harm a person in any way. Participants will be able to withdraw at any stage of the research process. In this study, the researcher will make use of semi-structured individual interviews and field notes to develop a comprehensive understanding of the phenomenon. The interviews will take between 30-45 minutes in a private room at the clinic. The researcher will record the views and experiences shared by the participants with their permission. The transcribed data of the interviews, together with the field notes, will be triangulated for analysis. Open coding will be used, and an independent coder (experienced researcher) will assist in this regard.

I am attaching the proposal, information sheet to participants and informed consent sheets for your information.

Looking forward to your favourable consideration.

My contact detail is:

E-mail address: 220165785@cput.ac.za

Cell no.0782706656

Tel no. at work: (021) 4618420

I am attaching the proposal, information sheet to participants and informed consent sheets for your information.

Thank you for considering my request.

Yours faithfully

Signature: …………… ………… Date: ………………………2021

Student: Mondli Chiya (Registered Professional Nurse)

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

Research Supervisor/ Health and Wellness Sciences

Prof. K. Jooste

Cape Peninsula University of Technology

P O Box 1906, Bellville, 7535

Telephone: (021) 959 2271

Email: kjooste1@gmail.com Signature…… ………………………………….

Date: 15 December 2023

APPENDIX E: LETTER REQUESTING CONSENT FROM THE CLINIC

Ext 3,32 Inqilo Street,Mfulen,7100

Tel:0782706656

www.cput.ac.za

Email: 220165785@mycput.ac.za

City of Cape Town

Community Health Clinic

PO Box 2815

Cape Town

8000

Dear Nurse manager

Re: Request to conduct a research study

I hereby request permission to undertake a quantitative study at the your CHC facility.

I am a master's student at the Cape Peninsula University of Technology (Health and Wellness Sciences, Division of Nursing). My supervisors are Professor Karien Jooste. The study is entitled: **The support by nurses to families during COVID-19 when a close relative is admitted to a health facility in the Khayelitsha district.**

The purpose of the study will be to describe the support by the nurse to the families during a pandemic when their family member is admitted. The participant needs to have had exposure or experience with the content being investigated.

Inclusion criteria

The participants will be selected on the basis that;

- they had a close relative admitted to hospital with COVID-19 symptoms.
- the relative is either a brother, sister, husband, wife or person staying in the household
- they have not had the disease her/himself
- they are living in the same home as the close relative
- age of older than 18 years

Exclusion criteria

- Family members who had Covid- 19 themselves

The participants will be interviewed by the researcher himself, using a prepared question guide. Ethical considerations will be strictly adhered to during the study. Approval for the study has been obtained from the Health and Wellness Sciences Research Ethics Committee (HWS-REC). The researcher will adhere to the rights of participants to privacy and confidentiality. In this study no names will be attached only numbers on the interview transcripts. The participants' names will not be linked to the research findings. The research will not harm the s in any way. Participants will be able to withdraw at any stage of the research process. In this study, the researcher will make use of semi-structured individual interviews and field notes to develop a comprehensive understanding of the phenomenon. The interviews will take between 30–45 minutes in a private room at the clinic. The researcher will record the views and experiences shared by the participants with their permission. The transcribed data of the interviews, together with the field notes, will be triangulated for analysis. Open coding will be used and an independent coder (experienced researcher) will assist in this regard. I am attaching the proposal, information sheet to participants and informed consent sheets for your information.

Looking forward to your favourable consideration.

My contact detail is:

E-mail address: 220165785@cput.ac.za

Cell no.0782706656

Tel no. at work: (021) 4618420

I am attaching the proposal, information sheet to participants and informed consent sheets for your information.

Thank you for considering my request.

Yours faithfully

Signature: …… ………………… Date: ………………………2021

Student: Mondli Chiya (Registered Professional Nurse)

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

Research Supervisor/ Head of Department Nursing Science, Health and wellness science:

Prof. K. Jooste

Cape Peninsula University of Technology

P O Box 1906, Bellville, 7535

Telephone: (021) 959 2271

Email: kjooste1@gmail.com

Signature…… …………………… Date: ………………… ….2021

APPENDIX F: NOTICE

Title of research project

Support needed by families during COVID-19 when a close relative is admitted to a health facility in the Khayelitsha district

Dear participant

Interviews held on how the COVID-19 has affected you while having a family member admitted to a health facility.

It will take 30-45 minutes for the session of sharing your experiences

Your responses to the questions will be kept confidential.

If you are willing to participate, please suggest a day and time that suits you and I'll do my best to be available.

If you have any questions, please do not hesitate to ask.

Phone Mondli at Tel:0782706656

APPENDIX G: ETHICS CLEARANCE RENEWAL CPUT

HEALTH AND WELLNESS SCIENCES RESEARCH ETHICS COMMITTEE (HWS-REC)
Registration Number NHREC: REC- 230408-014

P.O. Box 1906 Bellville
7535 South Africa Symphony
Road Bellville 7535
Tel: +27 21 959 6917
Email: sethn@cput.ac.za

13 June 2023

REC Approval Reference No: CPUT/HWS-REC 2021/H13(renewal)

Faculty of Health and

Wellness Sciences Dear

Mr. M Chiya (220165785)

Re: APPLICATION TO THE HW-REC FOR ETHICS CLEARANCE

Approval was granted by the Health and Wellness Sciences-REC to **Mr. M Chiya** for ethical clearance. This approval is for research activities related to research for **Mr. M Chiya** at Cape Peninsula University of Technology.

TITLE:

Supervisor:

Support needed by families during Covid-19 when a close relative is admitted to a health facility in the Khayalitsha district

Prof. K Jooste

Comment:

Approval will not extend beyond 14 June 2024. An extension should be applied for 6 weeks before this expiry date should data collection and use/analysis of data, information and/or samples for this study continue beyond this date.

The investigator(s) should understand the ethical conditions under which they are authorized to carry out this study and they should be compliant to these conditions. It is required that the investigator(s) complete an **annual progress report** that should be submitted to the CPUT HWS-REC in December of that particular year, for the CPUT HWS-REC to be kept informed of the progress and of any problems you may have encountered.

Kind Regards

Ms. Carolynn Lackay
Chairperson – Research Ethics Committee
Faculty of Health and Wellness Sciences

APPENDIX H: ETHICS RENEWAL CPUT

HEALTH AND WELLNESS SCIENCES RESEARCH ETHICS COMMITTEE (HWS-REC)
Registration Number NHREC: REC- 230408-014

P.O. Box 1906 • Bellville 7535
South Africa Symphony Road
Bellville 7535
Tel: +27 21 959 6917
Email: sethn@cput.ac.za

4 April 2022

REC Approval Reference No: CPUT/HW-REC 2021/H13 (Renewal)

Faculty of Health and Wellness

Sciences Dear Mr M Chiya

Re: APPLICATION TO THE HW-REC FOR ETHICS CLEARANCE

Approval was granted by the Health and Wellness Sciences-REC to **Mr M Chiya** for ethical clearance. This approval is for research activities related to research for **Mr M Chiya** at Cape Peninsula University of Technology.

TITLE: Support needed by families during Covid-19 when a close relative is admitted to a health facility in the Khayalitsha district

Supervisor: Prof K Jooste

Comment:

Approval will not extend beyond 5 April 2023. An extension should be applied for 6 weeks before this expiry date should data collection and use/analysis of data, information and/or samples for this study continue beyond this date.

The investigator(s) should understand the ethical conditions under which they are authorized to carry out this study and they should be compliant to these conditions. It is required that the investigator(s) complete an **annual progress report** that should be submitted to the HWS-REC in December of that particular year, for the HWS-REC to be kept informed of the progress and of any problems you may have encountered.

Kind Regards

Carolynn Lackay
Chairperson – Research Ethics Committee
Faculty of Health and Wellness Sciences

APPENDIX I: PERMISSION FROM THE CITY OF CAPE TOWN

CITY OF CAPE TOWN
ISIXEKO SASEKAPA
STAD KAAPSTAD

CITY HEALTH

Dr Natacha Berkowitz
Epidemiologist:
City Health

T: 021 400 6864 **F**: 021 421 4894
E: Natacha.Berkowitz@capetown.gov.za

Ref: 28242 2021-06-21

RE: Support needed by families during Covid-19 when a close relative is admitted to a health Facility in the Khayelitsha district

Dear Mr Mondli Chiya

Your research request has been approved as per your protocol. Please refer to the subsequent pages for the approval of any facilities or focus areas requested. Approval comments on any proposed impact on City Health resources are also provided.

Eastern & Khayelitsha:

Contact Person: Prof Vera Scott (Area East Manager)

Tel/Cell: 021 360 1258/082 308 8059

Email: Vera.scott@capetown.gov.za

Please note the following:

1. All individual patient information obtained must be kept confidential.
2. Access to the clinic and its patients must be arranged with the relevant Manager such that normal activities are not disrupted.
3. A copy of the final report must be uploaded to https://web1.capetown.gov.za/web1/mars/ProjectClosure/UploadReport/0/9414, within 6 months of its completion and feedback must also be given to the clinics involved.
4. Your project has been given an ID Number (9414). Please use this in any future correspondence with us.
5. No monetary incentives to be paid to clients on the City Health premises
6. If this research gives rise to a publication , please submit a draft before publication for City Health comment and include a disclaimer in the publication that "the research findings and recommendations do not represent an official view of the City of Cape Town "

Thank you for your co-operation and please contact me if you require any further information or assistance.

Kind Regards
Dr Natacha Berkowitz Epidemiologist: City Health

APPENDIX J: EDITOR DECLARATION

Leverne Gething, M.Phil., *cum laude*

PO Box 1155, Milnerton 7435; cell 072 212 5417

e-mail: leverne@eject.co.za

11 October 2023

Declaration of Editing of Master's of Nursing Science, CPUT:

Support needed by families during COVID-19 when a close relative is admitted to a health facility in the Khayelitsha district

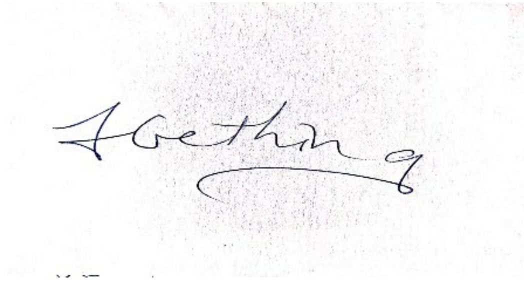
By Mondli Innocent Chiya

I hereby declare that I carried out language editing of the above dissertation on behalf of the author.

I am a professional writer and editor with many years of experience (e.g. 5 years on *SA Medical Journal*, 10 years heading the corporate communication division at the SA Medical Research Council), who specialises in Science and Technology editing – but am adept at editing in many different subject areas. I have previously edited many academic papers and theses for various higher education institutions and journals.

I am a full member of the South African Freelancers' Association as well as of the Professional Editors' Association.

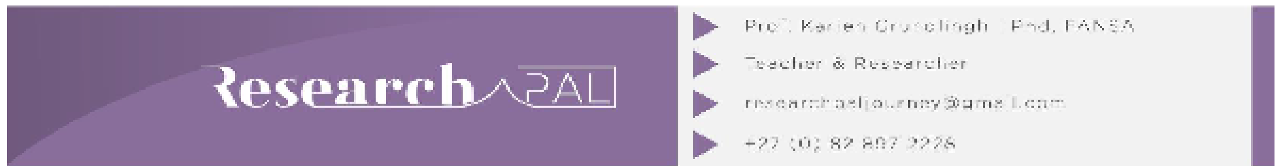
Yours sincerely



LEVERNE GETHING

leverne@eject.co.za

APPENDIX K: DECLARATION OF CODING



1 October 2022

INDEPENDENT CODING OF DATA ANALYSIS

TOPIC: Support needed by families during Covid-19 when a close relative is admitted to a health Facility in the Khayelitsha district

STUDENT: MONDLI CHIYA - CPUT STUDENT NUMBER: 220165785

It is hereby confirmed that the analysis of the data has independently been coded.

Regards

R Team

www.researchpal.co.za

APPENDIX L: SIMILARITY REPORT

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