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Perceptions and opinions of critical care nurses regarding family presence during resuscitation

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CHAPTER ONE

OVERVIEW OF THE STUDY

1.0 INTRODUCTION

Chapter one serves as an overview of the study. The reader is introduced to the background of the study. The problem statement, significance of the study, objectives and researcher assumptions are included. In addition to this, principles for ensuring trustworthiness are outlined. Research methodology and ethical considerations will also briefly be discussed.

1.1 BACKGROUND TO THE STUDY

Care refers to the willingness to act on behalf of one with whom one has a relationship (Beauchamp & Childress 1994:85). Nursing is based on caring, and the virtue of compassion is considered to be of importance for clinical practitioners (Mallia 2003:142). The intensive care is an area which is staffed by experts in intensive care however, care offered in the intensive care unit should be compassionate, ethical and focused on the patient as the most important person, and this focus should also extend to the patient's family (Langley & Schmollgruber 2006:64). Care should be individualized and patient centered and families should be kept informed and actively involved in decision making (Davidson, Powers, Hedayat et al. 2007:605). Intensive care clinicians should acknowledge the important role that the family plays in patient centered care, and family members

should be considered as an integral part of the multi professional intensive care team (Davidson, Powers & Hedavat et al. 2007:616).

Foote hospital in the United States developed the practice of family members witnessing resuscitation early in the 1980's following two family members requesting to be present during resuscitation (Mason 2003:190). Since then, according to international literature, more family members are requesting to be present with their loved ones during resuscitation (Fulbrook, Albaran & Latour 2005:558). In supporting this, various critical care organizations have released official position statements supporting family members being offered the option to be present during resuscitation, including the European Federation of Critical Care Nursing Associations and the European Society of Cardiology: Council on Cardiovascular Nursing (Fulbrook, Latour, Albarran, et al. 2007:251). With the increasing demand for witnessed resuscitation, numerous quantitative studies have been conducted in various parts of Europe and the United States of America to explore health care members and family members feelings towards this. Many of these studies have been conducted within the trauma casualty area (Walker 2008:348; Madden & Condon 2007:433), however this is pertinent and relevant in the intensive care unit, considering that 10-20% of patients admitted to the Intensive Care Unit die (Cook, Rocker & Heyland 2004:266). In the intensive care unit, end of life issues are an important aspect to the holistic care that intensive care unit nurses render (Cook, Rocker & Heyland 2004: 267). With the increasing need to care for patients and their families, issues such as allowing family members to witness resuscitation have come under the spotlight (Davidson, Powers, Hedayat et al.2007: 615).

South Africa is becoming increasingly westernised, and the role of the family in caring for the sick and dying patient in the ICU is being re-evaluated. The public are also being exposed to medical related issues and topics through television. People are exposed to surgery and graphic images of life support measures. This is increasing peoples' awareness of what is happening in hospitals, and what happens during resuscitation. In addition to becoming increasingly westernised, South Africans are increasingly aware of their rights. (Baldwin-Ragaven, de Gruchy & London 1999:213) The South African public health care systems are grounded in the principles of Batho Pele, which when translated means "people first", and these principles were introduced into the South African public services in order to improve service delivery (Muller 2005:8). The principle of openness and transparency may create an obligate for critical care nurses to offer family members a choice to witness resuscitation. Patients within the health care sector have rights as per the Patient's Rights Charter (Department of Health 1999:3), including the right to exercise choice within the health care system. This may give patient's families the right to be present during resuscitation. Despite this, family members are rarely offered the choice to be present during resuscitation.

1.2 PROBLEM STATEMENT

In the South African public health sector, family members are not offered the choice as to whether they would like to be present during resuscitation. It is presumed that family members should not be exposed to the traumatic experience of resuscitation. As a result, family members are escorted away from the resuscitation area, and made to wait in an allocated area.

In the institution where the study was conducted, the majority of critical care nurses are inexperienced with family witnessed resuscitation. In addition to this, it is often the critical care nurse who asks the family members to leave, or escorts the family members out of the resuscitation room. Therefore, the importance of exploring and describing critical care nurses' perceptions and opinions regarding family witnessed resuscitation.

1.3 AIM OF THE STUDY

The aim of the study is to explore and describe a select group of critical care nurses' perceptions and opinions regarding family witnessed resuscitation.

1.4 RESEARCH QUESTIONS

- What are critical care nurses' perceptions regarding family witnessed resuscitation?
- What are critical care nurses' opinions regarding family witnessed resuscitation?

1.5 RESEARCH OBJECTIVES

The objectives of this study are to explore and describe a select group of critical care nurses' perceptions and opinions regarding family witnessed resuscitation.

1.6 SIGNIFICANCE OF THE STUDY

The significance of this study is to uncover a select group of critical care nurses' perceptions and opinions towards family witnessed resuscitation. Thereby, to make a positive contribution to patient-family outcomes, healing and closure. In addition to this, to create awareness amongst South African critical care nurses of the international trends surrounding family witnessed resuscitation, and lastly, to contribute to the South African literature base on family witnessed resuscitation.

1.7 PARADIGMATIC PERSPECTIVES

1.7.1 Meta- theoretical Assumptions

According to Botes (1995) meta-theoretical assumptions are the researchers views on man and society.

Environment: This is the intensive care unit, a specialized area in which patients with critical illness or injury are admitted for medical management.

Nursing: The process of providing holistic bio-psycho-social care to the patient and the family within the environment, thereby maintaining a family centered approach to care rendered.

Health: A physical and mental state free of illness.

Patient: A physical, social and emotional being having critical illness with the potential to recover within the environment. A member of a family and a loved one to somebody.

End of life: The passage from a state of physical life to a state of physical death. Including the emotional changes and events that occur with this transition for the patient and the family.

1.7.2 Theoretical Assumptions

According to Botes (1995) the theoretical assumptions give form to the central theoretical statements of the research.

Operational Definitions

Operational definitions are derived from a set of procedures or progressive acts that a researcher performs to receive sensory impressions that indicate the degree of existence of a variable (Burns & Grove 2007:129). Definitions have been included to clarify what is meant by central concepts involved in this study.

Critical care nurse: According to the Australian College of Critical Care Nurses (2005) a critical care nurse is a person who provides competent and holistic care for the critically ill patient through integration of an advanced level of knowledge, skills and humanistic values.

Perceptions: A way of regarding or interpreting something, in this study this includes past experiences with regards to witnessed resuscitation and feelings with regards to these past experiences.

Opinions: A view or judgement of something, which may not be based on fact. In this study this includes if the participant feels that family witnessed resuscitation is a good or bad initiative and the reasons why.

Family member: "Those people who are important to the patient. This definition includes the patient's family, loved ones and close friends" (Fulbrook, Albarran, Latour et al. 2007:252).

Resuscitation: a set of emergency procedures aimed at the restoration of a patent airway, spontaneous breathing and effective blood circulation (Pertab 1999:38)

Conceptual definitions:

A conceptual definition provides the theoretical meaning of a variable, and is derived from a theorist's definition of a related concept (Burns & Grove 2007:129). The conceptual definition will be related to the study.

Family witnessed resuscitation: Signifies family presence during resuscitation (Walker 2006:380). In this study, this includes allowing family members to witness the resuscitation of a loved one.

Critical care: Is a humane, caring and healing environment in which critically ill patients are admitted for complex assessment and therapies, high intensity interventions and continuous vigilance (Alspach 2006:2).

1.7.3 Methodological Assumptions

According to Botes (1995) methodological assumptions give form to the research context, which influence the researchers decision about the research design.

- Critical care nurses subjective perceptions and opinions are regarded as a valid source of knowledge.
- A qualitative, exploratory, descriptive and contextual design was chosen as the most appropriate approach to gain the information required in this study.
- Qualitative research aims at exploring depth, richness and complexity inherent to a phenomenon, and the meaning of this phenomenon is only within a given situation or context (Burns & Grove 2007:62).
- In this study it is assumed that critical care nurses' perceptions and opinions regarding family presence during resuscitation would best be told by the critical care nurses themselves. According to Burns & Grove (2007) data obtained from qualitative research is subjective and incorporates the beliefs of the participant and the researcher alike.

1.8 RESEARCH METHODOLOGY

1.8.1 Research Design

This study has employed a qualitative approach. A qualitative approach is a systematic, subjective approach used to describe life experiences and give them meaning (Burns & Grove 2007:61). It focuses on the whole, which is consistent with the holistic philosophy of nursing, by exploring depth, richness and complexity of a phenomenon (Burns & Grove 2007:12).

This research is of an exploratory, descriptive and contextual design.

Exploratory studies set out to explore a relatively unknown field, of which the purpose is to gain new insights into the phenomenon under study, clarify central constructs and concepts and determine priorities for further research (Uys & Basson 2000:38). In this study the researcher set out to explore and gain insight into critical care nurses' perceptions and opinions of family witnessed resuscitation.

Descriptive research is used to gain more information about characteristics within a particular field, and to provide a picture of a situation as it naturally occurs (Burns & Grove 2007:18). In this study the researcher aims to describe the current clinical practice involved in family witnessed resuscitation, and critical care nurses' perceptions and opinions thereof.

This research is of contextual design, and refers to the context about and in which the participants were interviewed. According to the Concise Oxford English dictionary (2006) context can be described as the circumstances that form the setting for an event statement or idea. This study was conducted within a tertiary level academic hospital in Gauteng. Critical care nurses employed at this institution practice within the Scope of Practice as set out by the South African Nursing Council (Nursing Act 50 of 1978).

1.8.2 Research Method

The research method describes how the research was conducted and usually includes the study sample, setting and data collection process (Burns & Grove 2007:323). The research method chosen was used in order to best bring out critical care nurses' perceptions and opinions regarding family witnessed resuscitation. The population included critical care nurses at the tertiary level academic hospital under study. From this population, critical care nurses were purposively selected using inclusion criteria. Data was collected using semi-structured one on one interviews with the participants. Interviewing is considered the primary method of data collection in qualitative research (De Vos, Strydom, Fouche et al. 2006:287). Data collection and analysis occurred concurrently, and the data analysis process was guided by Tesch's method of qualitative data analysis (in Creswell, 2009:186).

1.9 MEASURES TO ENSURE TRUSTWORTHINESS

Lincoln and Guba (1985) state that a study is credible when it presents faithful descriptions of how the theme was derived from the original texts. Four constructs for ensuring trustworthiness in a qualitative research report have been identified:

Lincoln & Guba (1985) refer to credibility instead of truth-values and internal validity. Credibility is enhanced when researchers describe and interpret their experience as researchers, and self-awareness of the researcher is essential (Koch 2006:92).

Dependability is a way in which another researcher can clearly follow the decision trail used by the investigator and arrive at the same or comparable, but not contradictory conclusions (Koch 2006:92).

"Confirmability requires one to show the way in which interpretations have been arrived at via the enquiry" (Koch 2006:92). Confirmability captures the traditional concept of objectivity, and if results of the study can be confirmed by another (Lincoln and Guba 1985:290).

Transferability can be used instead of the term applicability (Koch 2006:92). This can also be referred to as fittingness. A study meets the criterion of fittingness when the findings are applicable to contexts outside the study situation and the audience views it as meaningful and applicable in terms of their own experiences (Koch 2006:92).

These four constructs to ensure trustworthiness and their application in this research will be discussed in detail in chapter three.

1.10 ETHICAL CONSIDERATIONS

The following authorities have granted ethical approval for this study:

- The Post Graduate Committee of the Faculty of Health Sciences of the University of the Witwatersrand.
- The Medical Human Research Ethics Committee (HREC) of the University of the Witwatersrand.
- The Gauteng Department of Health.
- The CEO of the institution where the research was conducted.

(Please see appendix 1 for copies of permission granting letters)

The ethical principles that have guided the progress of this study are as follows:

Informed Consent

- Written consent to participate in the study was explained and signed. All participants received written information and consent forms relating to the study, and could withdraw at any time without any adverse consequences.
- Participants were made aware of the audio taping device, and the purpose thereof. Written consent was obtained for the use of the tape recording device. In addition, verbal consent (captured on audiotape) was obtained.

(Please see appendix 3 for copy of consent form)

Anonymity and confidentiality

- No names were used in the writing up of the report, this ensured the anonymity of the participants.
- Hard copies are being held under lock and key, and only the researcher and her supervisors have access to the hard copies.

These ethical guidelines will be discussed in more detail in chapter three.

1.11 PLAN OF THE STUDY

The remainder of the research report has been divided into the following chapters:

Chapter Two: Literature review

Chapter Three: Research design and research method

Chapter Four: Results and findings

Chapter Five: Recommendations and limitations

1.12 CONCLUSION

Chapter one has outlined the background to the study. Thereafter, the problem statement, purpose, research questions and objectives were outlined. The significance of the study was then discussed. Paradigmatic perspectives were then outlined, followed by a brief description of the research design and method. Thereafter, measures to ensure

trustworthiness were briefly outlined followed by the relevant ethical considerations of the study. In the following chapter, the literature review will be discussed in detail.

CHAPTER TWO

LITERATURE REVIEW

2.0 INTRODUCTION

This chapter serves to provide a review of the literature surrounding family witnessed resuscitation. Family witnessed resuscitation will be discussed from differing perspectives. Firstly, an introduction to critical care in South Africa will be provided. Thereafter, family witnessed resuscitation from the perspective of healthcare providers will be explored. Following this, family members perceptions of family witnessed resuscitation will be outlined. Thereafter, patient's perspectives on family witnessed resuscitation will be discussed. Lastly, this chapter will conclude with a discussion about family witnessed resuscitation in South Africa, a developing country perspective, and the context in which this study was undertaken.

2.1 THE STAGE FOR FAMILY WITNESSED RESUSCITATION: CRITICAL CARE IN SOUTH AFRICA

The intensive care unit is an area in which critically ill or injured patients are admitted and involves the holistic care of these critically ill patients using a team based approach (Department of Health Modernization of Tertiary Services Report 2004). Intensive care units are staffed by experts who are able to care provide specialized care for critically ill patients (Langley & Schmollgruber 2006:58).

The public health sector in South Africa has an ICU patient to bed ratio of 1:20 000, (Bhagwanjee & Scribante 2008:4). South Africa has a deficit of critical care nurses in the region of 7 920 nurses (Bhagwanjee & Scribante 2008:5). This is largely due to migration of nurses, moving to other clinical and non-clinical areas, illness and nurses working shifts in units in which the nurse is not permanently employed (Bhagwanjee & Scribante 2008:5). Currently, a minority of critical care trained nurses (35%) work within the public sector, and the majority of these nurses are relatively inexperienced within critical care (Scribante, Schmollgruber & Nel 2005:111).

Critical care nursing in South Africa is a relatively young discipline, having being established in the 1960's (Scribante, Schmollgruber & Nel 2005:111). During this time, education systems were established for the training of nurses in critical care. At present, critical care nurses' practice within the Scope of Practice as set out by the Nursing Act 50 of 1978. Within this Act, the critical care nurses' scope of practice includes end of life issues.

According to Nelson & Danis (2001) around 20% of patients admitted to the ICU die. Hence, conversation surrounding end of life issues within the intensive care unit is common (Langley & Schmollgruber 2006:59). Despite cultural and language barriers in South African intensive care units, attempts are made to involve family members in decision making and to communicate with family members as soon as possible following admission to the intensive care unit (Crippen 2008:25). The importance of effective communication between health care workers and families cannot be overstated (Faith & Chidwick 2009:79). With the incorporation of family centered care within the intensive care unit, family members involvement with the health care team as an integral part of the

decision making team has become of increasing importance (Davidson, Powers & Hedavat et al. 2007:616). In view of this, with the emerging international trend of family witnessed resuscitation, South African critical care nurses are now in a position to acknowledge these international trends.

2.2 THE HEALTH CARE TEAMS PERSPECTIVES ON FAMILY WITNESSED RESUSCITATION.

There has been an increased focus on end of life issues particularly within the United States (USA) amongst health care workers. (Ciccarello 2003:216, Brosche 2003:179, Jurokovich, Pierce, Pananen et al. 1999:165). An interest in family witnessed resuscitation started in 1982 when the concept of allowing family members to witness resuscitation was brought under the spotlight at Foote hospital, following a reported positive experience of family presence in the emergency room (Mason 2003:190). Following this, several researchers published reports on family witnessed resuscitation including the opinions of American critical care professionals (McClenathan, Torrington & Catherine 2002:2204) and emergency department personnel (Macy, Lampe, O Niel, et al. 2006:74). However, this remains a highly controversial and debated topic amongst health care providers (Nibert 2005:38).

Traditionally, health care workers have been against the prospect of having family members present during resuscitation (York 2004:85). This may be attributed to a variety of factors as perceived by health care providers. One reason may be attributed to a lack of experience of family witnessed resuscitation. Badir & Sepit (2007) recently surveyed 409 Turkish critical care nurses to determine their experiences and opinions regarding family

witnessed resuscitation. More than half the sample population had no experience of family witnessed resuscitation. In addition to this, most of the nurses interviewed did not want family members to witness resuscitation as they felt that it could be offensive to them (Badir & Sepit 2007:83). This study indicated that these Turkish critical care nurses were not familiar with family witnessed resuscitation or with international literature regarding this.

In addition to lack of previous experience attributing to negative opinions surrounding family witnessed resuscitation, there are other perceived disadvantages to family witnessed resuscitation according to health care providers. These include fear of the family interference, limited space available, lack of trained staff to accompany the family and fears of long term negative effects on the family (Grice, Picton & Deakin 2003:821). In addition to these perceived disadvantages, some believe that family witnessed resuscitation would increase litigation (Macy, Lampe, O Niel et al. 2006:74). However, health care workers opinions that allowing family presence would increase law suits are unfounded (Mason 2003:191). According to Foote hospital, and Parkland hospital, the number of litigation cases did not increase (Mason 2003:191). In addition to a perceived increase in law suits, having family members present during resuscitation can make health care workers nervous and uncomfortable, which could have detrimental effects on patient outcomes. In addition not enough is known on the psychosocial impact on family members following witnessing resuscitation (Mason 2003:191). Also controversial, is the psychological consequences on family members that are removed from the resuscitation, and hence Mason (2003) advocates allowing families to have the option to be present during resuscitation.

On the opposite end of the spectrum, family witnessed resuscitation, and the support thereof is documented in the literature. In 2002, the Royal College of Nursing in the United Kingdom (UK) released their official position statement in support of family witnessed resuscitation, with certain guidelines to direct the practice. Other associations have also documented advocacy of family witnessed resuscitation. The 2005 American Heart Association guidelines for Emergency Cardiovascular Care and Cardiopulmonary Resuscitation support family witnessed resuscitation (American Heart Association 2005: IV9).

Studies have shown support for family witnessed resuscitation. McLean, Guzzetta, White et al. (2003) surveyed USA critical care nurses and emergency department personnel, and found that 36% had taken family members to the bedside during resuscitation. Grice, Picton & Deakin (2003) had results of 66% of nurses who would take family members to the bedside, and were in favor of the practice. Reasons offered as to the positive effects of family witnessed resuscitation include allowing the family to see that everything possible was being done, and to assist in the grieving process of the family (Grice, Picton & Deakin 2003:820). The literature does not support that witnessed resuscitation will increase the stress on the resuscitation team (Hadders 2007:227).

Doctors are traditionally the 'gatekeepers' for medical management within the hospital, as they are ultimately responsible for the outcomes of patients. Therefore, it is important to be aware of doctors' perceptions of family witnessed resuscitation. It seems that doctors and nursing personnel do not agree on their feelings regarding family witnessed resuscitation (Mason 2003:190). McClenathan, Torrington & Catherine (2002) have reported that 80% of doctors in their large sample survey of USA and international doctors are against the

practice of family witnessed resuscitation. Conversely, in the study by Meyers, Eickhorn & Guzzeta (1998), doctor's who participated in the study became supporters of family witnessed resuscitation and eventually backed the Parkland hospital's policy development of permitting the practice of family witnessed resuscitation.

2.3 FAMILY MEMBERS PERSPECTIVES ON FAMILY WITNESSED RESUSCITATION

The majority of families want to be present with their loved one during resuscitation (York 2004:85). In a recent Norwegian publication, Hadders (2007) emotively describes a woman who was denied viewing the resuscitation of her husband by the nursing staff. He goes on further to explore her feelings of sadness and anger of this incident. The article discusses the concept of family witnessed resuscitation in the ICU setting, including the benefits thereof. In addition to this, in the Trondheim University hospital's procedure manual, family members are not mentioned, and there are no guidelines as to whether family members may be present or not during resuscitation of a family member (Hadders 2007:227).

In the UK, the public demand for family witnessed resuscitation is notable, with 47% of family members wishing to remain with their loved one during resuscitation, and this was largely to ensure that everything possible was being done for their relative and to provide support (Grice, Picton & Deakin 2003:823). This may be due to 91% of the UK public being exposed to resuscitation from of media coverage (Grice, Picton & Deakin 2003:824). Family demand to be present during resuscitation is not isolated to the UK, as it occurs in Singapore and areas of the USA (Ong, Chung & Sng 2007; Mazer, Cox & Capon 2006).

Generally, family members want to be present during resuscitation, however, Van Der Woning (1999) showed that family members could find family witnessed resuscitation detrimental. In this study, five relatives were interviewed to recall and relate their experiences of witnessing resuscitation. Overall, the experience was described as been negative and stressful, and three of the five participants regretted the experience of witnessing resuscitation.

In South Africa, little is known on family wishes for family witnessed resuscitation. However, public sector intensive care doctors in South Africa question whether families would want to be involved in end of life decision making in the ICU (Crippen 2008:25).

2.4 PATIENTS PERSPECTIVES ON FAMILY WITNESSED RESUSCITATION

Studies available on patients' perspectives on family witnessed resuscitation are minimal (York 2004:86). Grice, Picton & Deakin (2003) explored this in their study, and surveyed 55 patients. Of these, 29% wanted to have their family witness their resuscitation should this occur. Reasons cited for this were to provide support, to see that everything possible was done and to lessen the traumatic effect on the family by them having seen what had happened (Grice, Picton & Deakin 2003:821). However, in this study 71% of patients did not want their family in the room, citing that it would be too distressing for the family (Grice, Picton & Deakin 2003:822).

Albarran, Moule, Benger et al. (2009) interviewed resuscitation survivors as well as patients admitted to the emergency department who had not had the experience of

resuscitation. These patients were asked about their preferences regarding family members presence during resuscitation (Albarran, Moule, Benger et al. 2009:1070). Both groups were broadly supportive of the practice, and both groups of patients stated that staff should seek the patients' preferences of family witnessed resuscitation following admission (Albarran, Moule, Benger 2001:1072).

2.5 FAMILY WITNESSED RESUSCITATION AND SOUTH AFRICA

South Africa is a country that since 1994 has focused extensively on the Rights of it's people, and equity of these rights. The principles of human rights and health care professional ethics, have as their common aim as the respectful and dignified treatment of people (Baldwin-Ragaven, De Gruchy & London 1999:8). Upholding the human, constitutional and patient rights of patients and family members is of high priority (Baldwin-Ragaven, De Gruchy & London 1999:207), and therefore health care workers in South Africa need to be sensitive to the rights of the patients and the family members that they serve. In addition to this, family members and patients are also becoming more aware of the rights that they have as customers of health care.

Little is known about family witnessed resuscitation in South Africa, and very little research is available on this topic. In the South African context, the researcher came across one study, a qualitative study, conducted with regards to family presence during resuscitation. This study was conducted by Goodenough & Brysiewicz (2003) at level one emergency departments in Kwa-Zulu Natal, South Africa, which revealed that emergency department nurses disliked family witnessed resuscitation, as it was perceived to be a harmful experience to the family. This is in contrast with the international critical care

community who are exploring trends surrounding family witnessed resuscitation, and there are several research articles available on family witnessed resuscitation. Therefore, highlighting the need for South African based literature with regards to family witnessed resuscitation.

2.6 CONCLUSION

This chapter has provided a review of the literature regarding family presence during resuscitation. This concept was explored from the perspective of that unique to South Africa. In addition to this, views on family witnessed resuscitation from the perspective of the health care provider, the family and of the patient were explored. In the following chapter, the research design and research method will be discussed in detail.

CHAPTER THREE

RESEARCH DESIGN AND RESEARCH METHOD

3.0 INTRODUCTION

This chapter serves to describe the research design and method of the study in detail. Following this, the measures to ensure trustworthiness will be outlined. Lastly, in concluding this chapter, ethical considerations pertinent to this study will be outlined.

3.1 RESEARCH DESIGN

In this study a qualitative approach has been followed. This study is of an exploratory, descriptive and contextual design that explores and describes critical care nurses' perceptions and opinions regarding family witnessed resuscitation.

Qualitative research

Qualitative research is a systematic, subjective approach to research that is used to describe life experiences and give them meaning. It focuses on understanding the whole, and is a means of exploring the depth, richness and complexity inherent to a phenomenon (Burns & Grove 2007:12). Secondly, it provides rich description that enables the reader to make sense of the clinical reality (Morse & Field 2002:15). In this study, critical care nurses' perceptions and opinions of family witnessed resuscitation were explored in order to gain an understanding of their subjective experiences of family witnessed resuscitation.

Exploratory research

Exploratory studies set out to explore a relatively unknown field, of which the purpose is to gain new insights into the phenomenon under study, clarify central constructs and concepts and determine priorities for further research (Uys & Basson 2000:38). In this study the researcher set out to explore and gain insight into critical care nurses' perceptions and opinions of family witnessed resuscitation. This was done to enable the researcher to gain an understanding of the topic from the perspective of the critical care nurse.

Descriptive research

Descriptive research is used to gain more information about characteristics within a particular field, and to provide a picture of a situation as it naturally occurs (Burns & Grove 2007:240). A descriptive design may also be used to develop theory, identify problems within current practice, justifying current practice, or to determine what others in similar situations are doing (Burns & Grove 2007:240). In this study the researcher aims to describe the current clinical practice involved in family witnessed resuscitation, and critical care nurses perceptions and opinions thereof.

Contextual research

According to the Concise Oxford English dictionary (2006) context can be described as the circumstances that form the setting for an event statement or idea. The context for this study is a tertiary level academic hospital in Gauteng. This hospital has various intensive care units, including a general unit and those assigned by specialty, for example cardiac.

The critical care nurses that were interviewed in this study were employed in different intensive care units.

The critical care nurses interviewed were of varying cultures and ethnic groups. However, all nurses were qualified specialist critical care nurses, and had undergone a period of at least 12 months of critical care nursing education in formal programs, in order to be registered with the South African Nursing Council as critical care nurses. In this study only critical care nurses who met the inclusion criteria of having a post basic qualification in critical care and having had worked in this capacity for longer than six months were included in the study.

3.2 RESEARCH METHODS

The research method chosen was used in order to best bring out critical care nurses perceptions and opinions regarding family witnessed resuscitation. All of the critical care nurses interviewed were selected purposively using inclusion criteria. Data were collected using semi-structured one- on- one interviews with the participants.

3.2.1 Entrance to the field

At the time of data collection, the researcher was employed at the institution where the research was conducted. This allowed for the researcher to have easy access to the field. Permission to conduct the research was obtained from the Provincial Department of Health and the acting Chief Executive Officer of the hospital. During the process of data collection, the researcher did a working rotation through the different units that would be

included in the study. By this, the researcher worked in her capacity as a nurse in these different units doing shift work. This was done to allow the researcher to get to know the participants and the context of each particular intensive care unit, and to allow for the establishment of a trust relationship between the researcher and the participants.

3.2.2 Population and Sample

The population of this study were all the registered critical care nurses at a tertiary level academic hospital in Gauteng. The monthly duty list was used as a sample frame. Purposive sampling was used to select the participants. Purposive sampling may sometimes be referred to as judgmental or theoretical sampling and involves the conscious selection of certain subjects by the researcher (Burns & Grove 2007:344). This type of sampling is based entirely on the judgment of the researcher, in that the sample comprises of elements that contain the most characteristic and representative attributes of the population (De Vos, Strydom, Fouche et al. 2006:202). Participants were consciously selected by the researcher based on the inclusion criteria, which were as follows:

- Critical care nurses' with post basic qualification and registration in Critical Care Nursing
- Critical care nurses having had worked clinically in this capacity for at least 6 months

Participants were approached by the researcher personally and asked if they would want to participate in the research study. Participants were also selected based on their willingness to engage in an interview with the researcher. Participants were selected until the point of

saturation of themes was attained. Saturation point was reached after nine participants were interviewed. Interviews ten and eleven were used as a means of control to ensure that saturation point had in fact been reached.

Morse & Field (2002) describe two principles of sampling that need to be met in qualitative sampling. These are appropriateness and adequacy.

Appropriateness can be described as the identification and utilisation of the participants that that best inform the research according to the theoretical requirements of the study (Morse & Field 2002: 65). In this study the process of interviewing critical care nurses on their own perceptions and opinions would be the most suitable method of obtaining this information.

Adequacy refers to there being enough data to develop a full and thick description of the phenomenon and that the stage of saturation had been reached, and that no new data or themes would emerge from conducting further interviews (Morse & Field 2002:65). In this study, after nine interviews the researcher was able to identify that no new themes were emerging from the interviews. Thereafter interview ten to eleven were used as a means of control.

3.2.3 Data Collection

Data were collected using one on one face to face interviews with the participating critical care nurses. The semi-structured interview is used when the researcher knows the questions she would like to ask but allows the respondent the freedom to answer in their

own words (Morse & Field 2002:76). Probes were also used to elicit additional information from the participants. All of the participants were asked the same questions, however the phrasing of the questions was altered in order to elicit a good response. Initially the question asked was:

What are your perceptions of family witnessing resuscitation?

However, following the first interview, the researcher realized that there was ambiguity in this question and it was difficult to direct the interview to obtain the necessary information. This may have been due to the fact that the majority of nurses' did not have English as their first language. Thereafter, the researcher paraphrased the question in the following manner:

As a critical care nurse, if your patient was being resuscitated, and the family members requested to be present, how would you feel?

This elicited the critical care nurses' perceptions and at times discussion of their past experiences of family witnessed resuscitation in the ICU. Most nurses were very willing to talk about their experiences, and prompts were not needed as they answered questions before they had been asked. In addition to this, another question was added to the set of questions:

Is there a policy in place in this institution regarding family witnessed resuscitation?

This added valuable information on nurses' knowledge of policies, and their feelings surrounding this.

Participants were offered to have the interview conducted in a setting of their choice, in order to allow the participant to feel comfortable (Morse & Field 2002:72). Written consent was obtained for participation and the usage of the tape recording device. Interviews were recorded on micro cassette and then transcribed for the purpose of analysis. Each interview lasted between 20-40 minutes. Each interview was accompanied with field notes. Field notes are written accounts of the things that the researcher hears, sees, experiences and thinks in the course of the data collection or reflection (Morse & Field 2002:91).

3.2.4 Data Analysis

Data were collected and analyzed concurrently, as interviews were immediately transcribed after they had taken place. This allowed the researcher to become immersed in the data whilst data collection was taking place. Tesch's method of qualitative data analysis (in Creswell, 2009:186) was utilised in guiding the data analysis process in this study. In brief, the steps for analysis are as follows:

- Read and re-read all transcripts and get a sense of the whole.
- Pick one document and look for underlying meaning. Go though the document and ask oneself, "What is this about?" Think of the underlying meaning of the interview. Write down thought in the margin.

- Complete this task for several participants, and make a list of all the topics. Cluster similar topics together. Form these topics into columns, arrayed as major topics, unique topics and leftovers.
- Go back to the original data. Abbreviate topics as codes in the text. See if new and codes emerge.
- Find the most descriptive wording for topics and turn them into categories. Try grouping topics that relate together.
- Make a final decision on the abbreviation for each category.
- Assemble the data material belonging to each category in one place and perform a preliminary analysis.

These steps of data analysis will be discussed in greater detail in chapter four.

3.3 MEASURES TO ENSURE TRUSTWORTHINESS

Four constructs for ensuring *Trustworthiness* in qualitative research studies have been identified as by Lincoln and Guba (1985) and have been chosen for use in this study. These four constructs are as follows:

- Credibility
- Dependability
- Confirmability
- Transferability

Credibility

Lincoln & Guba (1985) refer to credibility instead of truth value and internal validity. Credibility is enhanced when researchers describe and interpret their experience as researchers, and self awareness of the researcher is essential (Koch 2006:92).

The researcher has watched how family members were received during resuscitation with keen interest over her years of critical care nursing practice, allowing for prolonged engagement and observation. This assisted in formulating this research in the researcher's mind as the perceptions and opinions of critical care nurses were explored. This research is relevant to critical care nursing, and it has not been researched in this particular setting.

Investigator triangulation was used to remove the potential for bias that can occur in single researcher studies (Burns & Grove 2007:544). A critical care nurse specialist and a psychiatric nurse specialist were consulted during this research, and read though the narratives that were had. In addition to this, they shared their views and helped direct the analysis process.

Table 3.1 Measures used to ensure Credibility

CONSTRUCT	MEASURES USED TO ENSURE CONSTRUCT
Credibility	• Prolonged engagement and observation • Frequent member checks and peer reviews with regard to relevant literature searches, data collection and analysis. • Searching for disconfirming evidence and negative cases • Investigator and theory triangulation

Transferability

Transferability can be used instead of the term applicability (Koch 2006:92). This can also be referred to as fittingness. A study meets the criterion of fittingness when the findings are applicable to contexts outside the study situation and the audience views it as meaningful and applicable in terms of their own experiences (Koch 2006:92). The researcher has provided thick description of the specific research setting and process to allow readers to assess the study applicability in their own contexts.

Dependability

Dependability is a way in which another researcher can clearly follow the decision trail used by the investigator and arrive at the same or comparable, but not contradictory conclusions (Koch 2006:92).

In this study a decision trail was kept. Decisions, choices and subjective interpretations of the data have been documented and kept.

Table 3.2 Measures used to ensure Dependability

CONSTRUCT	MEASURES USED TO ENSURE CONSTRUCT
Dependability	• Inquiry audit of raw data, data reduction and analysis products • Decision trail

Confirmability

Confirmability captures the traditional concept of objectivity or neutrality, and if results of the study can be confirmed by another (Lincoln and Guba 1985:290). "Confirmability requires one to show the way in which interpretations have been arrived at via the enquiry" (Koch 2006:92).

In this study, an audit trail was kept by keeping track of all references used, and keeping the recordings of the interviews under lock and key. A member check was conducted during the eleventh interview as the participant was questioned about the findings and asked to comment on them. Accuracy and completeness of the findings were confirmed during this interview. Peer review were conducted throughout the analysis process, as findings, conclusions and themes were discussed with an intensive care nurse specialist and a psychiatric nurse specialist.

Table 3.3 Measures used to ensure Confirmability

CONSTRUCT	MEASURES TO ENSURE CONSTRUCT
Confirmability	• Provided an audit trail, by keeping track of all references used; audiocassettes made • Peer review • Member checking

3.4 ETHICAL CONSIDERATIONS

3.4.1 Permission

Permission do conduct this study was obtained from the following relevant authorities:

- The Post Graduate Committee of the Faculty of Health Sciences of the University of the Witwatersrand.
- The medical Human Research Ethics Committee (HREC) of the University of the Witwatersrand.
- The Gauteng Department of Health.
- The hospital Chief Executive Officer where the research was conducted.

(Please see appendix 1 for copies of approval letters.)

3.4.2 Informed Consent

Each participant willingly agreed to participate in the study. Informed consent was obtained from each participant after a brief description of the study was given to the participant. Each participant signed a consent form to participate in the study. In addition to this, each participant gave written and verbal consent to allow for the interview to be recorded on micro cassette.

(Please see appendix 3 for a copy of the consent form)

3.4.3 Anonymity

No names were used in the final report in order to ensure anonymity. All of the participants were also reassured of their anonymity in their participation in this study. All hard copies recordings will be destroyed after they are no longer needed for the purpose of this study.

3.5 CONCLUSION

In this chapter the methodology of the study was described. The design, population and sample were outlined. Following this data collection and analysis have been discussed. Methods to ensure trustworthiness were described and related to this study and ethical considerations explained. In the next chapter, chapter four, the findings of the study will be presented.

CHAPTER FOUR

RESULTS AND FINDINGS

4.0 INTRODUCTION

At the beginning of this chapter the research questions are briefly revisited to act as a guide for the chapter. Thereafter a profile of the participants is described. The data analysis process is then outlined in detail and this is followed by a presentation of the findings of this study.

4.1 RESEARCH QUESTIONS

To orientate the reader, the research questions of this study are repeated. The research questions are as follows:

- What are critical care nurses' perceptions regarding family witnessed resuscitation?
- What are critical care nurses' opinions regarding family witnessed resuscitation?

4.2 PARTICIPANTS

The population of this study consisted of all critical care nurses in a tertiary level academic hospital in Gauteng. The monthly duty list was used as a sample frame. Participants were

consciously selected by the researcher based on the inclusion criteria, which were as follows:

- Critical care nurses' with a post-basic qualification and registration in critical care nursing.
- Critical care nurses who have been working clinically in this capacity for at least 6 months.

A total of eleven participants were interviewed. The eleven participants all comprised of qualified critical care nurses from three different intensive care units in a tertiary level academic hospital in Gauteng. All of the interviews were conducted in English; however, for all but two of the nurses interviewed, English was not their first language. All of the nurses interviewed were female.

Table 4.1 includes a breakdown of the profile of the participants.

INTERVIEW NUMBER	YEARS POST CRITICAL CARE TRAINING	ENGLISH AS FIRST LANGUAGE
1	>20	No
2	1-5	No
3	1-5	No
4	11-15	Yes
5	11-15	No
6	16-20	No
7	>20	No
8	11-15	No
9	11-15	No
10	1-5	No
11	>20	Yes

4.3 DATA ANALYSIS

Data collection and analysis occurred concurrently and Tesch's method of qualitative data analysis guided the data analysis process for this study (in Creswell, 2009:155). In this study a co-coder was utilized. The co-coder is a senior critical care nursing lecturer and intensive care nursing specialist. The researcher and co-coder were guided by these eight steps for analyzing qualitative data as outlined by Tesch. An explanation of each step is presented below to allow the reader to understand how the results were obtained.

- Getting a sense of the whole. Reading all transcripts carefully. Perhaps jotting down any ideas as they came to mind.

Each interview was conducted and recorded on micro-cassette. Directly following the interview, the micro-cassette recording was transcribed directly onto the computer. The researcher then wrote a description of each of the participants; including the researcher's own feelings during the interview and observations and comments surrounding the interview. Reading through each transcript, and the field notes allowed the researcher to get an overview of the interviews. Important ideas were jotted down in the margin of the transcript.

- Picking one document. Going through the document and asking oneself, "What is this about?". Thinking about the underlying meaning of the interview. Writing down thoughts in the margin.

The researcher and co-coder picked out the most interesting interview, and whilst reading through this interview, the question of what this interview was about was asked. Any thoughts and ideas were jotted down in the margin.

- Completing this task for several participants and make a list of all of the topics. Clustering similar topics together. Forming these topics into columns, perhaps as major, unique and leftovers.

After having read several of the participants' narratives, a list of all the topics was made. Similar topics were clustered together. The topics were then formed into columns and tentatively arranged.

- Taking this list and go back to the data. Abbreviating the topics as codes next to the appropriate segments of the text. Trying this preliminary organizing scheme to see if new codes emerge.

The topics were abbreviated as codes, and each code was abbreviated next to the appropriate text in the interview. The categories were then merged from the codes.

- Finding the most descriptive wording for the topics and turning them into categories. Finding ways of grouping the topics that relate to each other. Perhaps drawing lines between categories to show relationships. Identified categories were used to refine probing questions in further interviews. This allowed for the saturation of categories to occur.

The most descriptive wording for the topics was considered and then these were turned into categories. Relationships between categories were explored.

- Making a final decision on the abbreviation for each category and arranging codes alphabetically.

Abbreviations were decided upon and codes were alphabetically arranged.

- Assembling the data material belonging to each category in one place and performing a preliminary analysis.

Categories were explored in the literature to identify their meaning in the literature. Similar and opposing views were taken into consideration in drafting the proposed findings. A discussion was held between the researcher and the co-coder to discuss and come to an agreement on the themes and sub-themes identified.

4.4 THEMES AND SUB-THEMES EXTRAPOLATED FROM THE INTERVIEWS

4.4.1 'Wavering'

Central to the findings in this study was that there was uncertainty amongst the participants as to whether family witnessed resuscitation is acceptable or unacceptable and the reasons for this. Therefore, a central concept identified in this study is wavering, and can be defined as uncertainty or ambivalence. Most of the participants interviewed wavered during their interviews as to whether they would encourage family presence at the bedside during resuscitation, or if they would not.

4.4.2 Exclusion of the family from viewing resuscitation efforts

Four participants in this study felt that family witnessed resuscitation is an unacceptable practice. However as mentioned, these nurses wavered in their decisions with this regard. One nurse revealed her uncertainty in the following statement, she said, *"No, I wouldn't be quite comfortable with it (allowing family members to be present)…(Pause)…But, you know, I don't mind (having family members present)"*. Another nurse expressed her view of family witnessed resuscitation and stated the following during her interview, *"Personally I think that they should not be present"*. Another nurse said, *"I wouldn't like it (to have family members present)"*.

In the study conducted in Turkey by Badir & Sepit (2007), of which 94.3% of the respondents were female intensive care nurses, the majority (81%) did not feel that family witnessed resuscitation is acceptable. However, in contrast, critical care nurses in the study

conducted in Canada by Fallis, McClement and Pereira (2008), of which 93.3% of the respondents were female, the majority (92%) felt that family witnessed resuscitation is an acceptable practice. This indicates that critical care nurses have opposing opinions regarding the acceptability of family witnessed resuscitation.

In this study views of family witnessed resuscitation and it's acceptability were divided. Four participants felt that it is not acceptable to have family members at the bedside during resuscitation. However, there was some degree of wavering amongst the participants with this regard with a few conceding that in some cases family witnessed resuscitation may be helpful for the family and could be contemplated.

4.4.3 Attitudes surrounding the exclusion of family members from the resuscitation process

Reasons for excluding a family member from the bedside during resuscitation efforts were articulated by the participants of this study. These reasons as to why family members should not view resuscitation attempts include that family witnessed resuscitation is a traumatic event for the family. In addition to this, family members may misinterpret issues, family members may interfere in the resuscitation process, there are physical space constraints and nurses fear exposing their own inadequacies. Nurses also asserted that it is the norm to ask family members to leave the resuscitation area. That no formal policy has been promulgated may also hinder nurses' willingness to have family members present during resuscitation. Each of these will now be discussed in greater detail.

4.4.3.1 It's a traumatic experience

Nine out of the eleven nurses interviewed expressed a fear of traumatizing the family by allowing them to witness resuscitation. A cardio-thoracic intensive care nurse felt that resuscitation is too traumatizing for a family member to witness and as a result she said, *"That's a terrible thing…its not a nice sight to see your family member lying there motionless or in agony or see them struggling somehow…its not a nice sight"*. Another critical care nurse said, *"Some may be too traumatized"*.

Nursing is based on an ethos of caring and alleviating suffering (Muller 2005:3), and this could be extended to preventing undue suffering and the potential traumatic effects that witnessed resuscitation could have on the family. Resuscitation is not always a clean procedure, with the area becoming crowded with health care professionals and alarms sounding. To the family, this may appear to be chaotic and disorganized (Clift 2006:15) therefore, it may be presumed that this would be experienced as a horrific situation for family members to be exposed to. Osuagwu (1991) states that family witnessed resuscitation is non-therapeutic and traumatic enough to haunt family members and make them regret their participation for as long as they live. The study that was conducted in Saudi Arabia by De Beer (2005), examined the attitudes of nurses working within critical care towards family presence during resuscitation. 10% of the respondents in this study qualified in South Africa, and 72.9% of the respondents were female. In this study, 88.2% of the respondents reported that family witnessed resuscitation is traumatic for the family. However, in the study by Robinson, Mackenzie-Ross, Campbell Hewson et al. (1998) which aimed at discovering if UK family members experienced adverse effects from witnessing resuscitation showed that family members did not experience any adverse

psychiatric effects from witnessing resuscitation. No studies have been conducted in South Africa with regards to family wishes for witnessed resuscitation, or the effects of family witnessed resuscitation on family members.

In this study, nine out of the eleven participants felt that family witnessed resuscitation would be too traumatic for family members to experience. Therefore, in this study this is a reason as to why family members are not invited to be at the bedside during resuscitation efforts.

4.4.3.2 Family members may misinterpret issues

Critical care nurses in this study felt that family members may misinterpret issues or actions taken during resuscitation. Three critical care nurses were concerned that family members may not understand resuscitation treatments. One critical care nurse stated the following, *"So their whole interpretation of the thing (resuscitation), if they visualize it, if they see it, um, I don't think that its going to make any sense to them"*. Another multi-disciplinary critical care nurse expressed her concern by saying, *" They don't actually know what is happening, because a little knowledge is dangerous"*. However, in another nurse pointed out the following, *"Nowadays, people are more clued up from watching "911", "Greys Anatomy" (television shows). There are very few people who haven't 'witnessed' a resus"*. Another cardio-thoracic nurse pointed out the importance of eliminating misinterpretation by a chaperone giving accurate information to the family. She stated, *"The way that they would trust us, if that information that was given (by the chaperone) was honest. Like if we are battling, the person allocated should give an honest report of what is happening"*.

In a study conducted in Turkey, which surveyed Turkish critical care nurses' experiences and opinions regarding family presence during resuscitation, 88.5% of the nurses felt that family members may misinterpret issues by not understanding the need for specific interventions (Badir & Sepit 2007:88). However, 62.2 % of the nurses in this study agreed that if family members should be present during resuscitation, there should be a member of the resuscitation team whose role would be to look after the family (Badir & Sepit 2007:89). The presence of a chaperone can decrease misinterpretation by preparing the family member, answering any questions, providing support and not leaving a family member unattended (York 2004: 86).

Grice Picton & Deakin (2003) revealed in their study, that on the contrary, only 7% of nurses felt that family members would misinterpret issues. According to Van der Woning (1997) this may be due to television shows that have exposed the public to previously censored clinical scenes, and as a result the public have become more knowledgeable about resuscitation.

In this study, three nurses believe that family may misinterpret issues pertaining to the resuscitation effort. And the presence of a chaperone may decrease family misinterpretation (York 2004: 86). The South African public has also become more aware of what happens during resuscitation in part due to television shows that are been broadcast.

4.4.3.3 Family may interfere

Four nurses interviewed in this study felt that family members may physically interfere with the resuscitation process. One nurse expressed her fear related to family interference. During her interview she said, *"They may come in and interrupt"*. Another nurse said, *"They tend to interfere"*. Another nurse said, *"I am sure that there are people who do try to interfere"*. However, another nurse pointed out during her interview how the presence of a chaperone could prevent family from interfering in the resuscitation. She said, *"There should be a dedicated person who is going to explain to them what's happening, read the body language. If they are becoming too distressed, remove them, give them a cup of tea"*.

Resuscitation is naturally an emotional situation (Critchell & Marik 2007:311), especially for the family members of the person being resuscitated. This may be due to fear of an unsuccessful outcome and uncertainty of the family. Due to this, family members may interfere in the resuscitation process. Interference from family members can come in different forms. Meyers, Eichhorn, Guzzeta et al. (2000) noted that family presence can lead to medical personnel prolonging resuscitation efforts. On the contrary, Post (1989) found that family members could want the resuscitation called off early to prevent ongoing suffering to the patient. Nurses feel that resuscitation attempts may be hindered as family members would interfere (De Beer 2005:63; Badir & Sepit 2007:89). However, the survey of European nurses by Grice, Picton & Deakin (2003:821) had opposing views from the nurses. In their results only 12% of the nurses felt that family members might interfere in resuscitation attempts. Similarly, according to the study conducted by Fullbrook, Albarran & Latour (2005) few UK critical care nurses (12.2%) feel that family members would interfere in resuscitation efforts. In this study, 73.4% of the respondents were female, and it

was noted that a large portion (80.6%) of the respondents believed that family support from a chaperone is very important (Fullbrook, Albarran & Latour 2005:562).

In this study, four of the critical care nurses interviewed felt that family members may interfere in resuscitation efforts. This is therefore one of the contributing factors as to why these critical nurses would not feel comfortable with inviting family members to witness resuscitation unless there is a chaperone to accompany the family throughout.

4.4.3.4 Physical space constraints

In addition to nurses concerns that family members may interfere in the resuscitation, when considering the physical space that is available during resuscitation, three nurses felt that this space would not be adequate to allow family members to view resuscitation. One cardiac ICU nurse said the following, *"We find ourselves jumping around, we need space"*. Another nurse said, *"They are going to be in our way"*. Another nurse said, *"Bed space could be a problem"*.

Grice, Picton & Deakin (2003) revealed that only 12% of 50 UK nurses feel that family members may get in the way during a resuscitation attempt. However, on the contrary, Badir & Sepit's (2007) study in which Turkish nurses were surveyed, showed the large percentage of 70.9% of nurses that felt that bed areas are too small for family members to be present during resuscitation. Similarly, in the qualitative study which was conducted in level one emergency departments in Kwa-Zulu Natal, the nurses also felt that bed spaces are inadequate to allow for family presence during resuscitation (Goodenough & Brysiewicz 2003:59).

In this study three of eleven nurses interviewed mentioned space constraints as a reason not to allow family members to witness resuscitation. In the intensive care units in the hospital in which the study was conducted, the bed spaces are relatively spacious, and some rooms have windows through which family members could witness resuscitation. Therefore, in this study, this is a minor contributing factor as to why critical care nurses would be reluctant to allow family members to witness resuscitation.

4.4.3.5 Nurses' fear of exposing their own inadequacies

In addition to minor concerns related to physical space available during resuscitation, six nurses interviewed in this study felt that having family members present could pose a disadvantage to themselves. These nurses felt that allowing family members to witness resuscitation may expose their own shortcomings or faults to family members. One critical care nurse working in a general intensive care unit said, *"Sometimes if somebody is watching, you panic…When somebody else is watching you, you try to make things perfect"*. Another nurse commented on nurses fear of exposing themselves, she said, *"I actually feel that people who say no are insecure in themselves"*.

As resuscitation is a stressful event for the health care team, having family members watching may increase the levels of stress that the staff members experience (Grice, Picton & Deakin 2003:821; Critchell & Marik 2007:313). Stress on the resuscitation team could be attributed to the urgency of the situation, and the (at times) unplanned occurrence of the event. However, nurses with more self-confidence are more likely to invite family members to be present during resuscitation (Twibell, Siela, Riwitis et al. 2008:107).

Six of nurses interviewed in this study felt that by having family members at the bedside during resuscitation could expose their own shortcomings to the family. The reason for this was that nurses felt that due to their own lack of confidence in their own abilities, that their own shortcomings may be exposed to the family should family members witness resuscitation. Therefore, feelings of inadequacy and lack of self-confidence from the perspective of nurses would be a reason for not inviting family members to witness resuscitation.

4.4.3.6 It's the norm to ask family members to leave

Six of the nurses interviewed in this study felt that it would be better for the family not to be present at the bedside during resuscitation and it is the norm to ask family members to wait outside whilst the resuscitation is occurring. One nurse commented and said, *"We always ask them out"*. It is norm for family members not to be invited to witness resuscitation. This could be due to the lack of experience that these nurses have with witnessed resuscitation, and possibly habit. Only one of the participants interviewed had a previous experience of witnessed resuscitation. One nurse commented during her interview, *"We are inexperienced with this"*.

In the study conducted in Turkey by Badir & Sepit (2007), 63.7% of the sample was inexperienced with family witnessed resuscitation. Similarly, in the study by De Beer (2005) only 15.7% of the respondents had previously been involved in a family witnessed resuscitation. In addition to this, in the study conducted in Kwa–Zulu Natal level one emergency departments, only one of the participants had a previous experience of family witnessed resuscitation (Goodenough & Brysiewicz 2003:59). However, in contrast, the

majority Canadian nurses in the study by Fallis, McClement & Pereira (2008) have taken family members to the bedside during resuscitation in the past, thus showing that a large number (65%) of these nurses had a previous experience of witnessed resuscitation.

Six of the nurses interviewed in this study expressed that it is a norm to ask family members to leave the resuscitation area. This may be attributed to a lack of previous experience of family witnessed resuscitation. Therefore, this lack of previous experience of family witnessed resuscitation is a factor hindering nurses from including family members in the resuscitation.

4.4.3.7 Uncertainty regarding policy guidelines

Ten of the nurses in this study stated that no specific policy regarding decision making involving family presence during resuscitation had been formulated in the hospital in which this study was conducted. This in fact was true, as there is no current policy within the institution with regards to family presence during resuscitation. One nurse felt exposed without any policy guidelines, she said, *"I am not aware of any policy that is written, I think, …We always ask them out (of the room), and I am not aware of any policy that says that we should do either this or that"*. This showed that there was some uncertainty of the existence of a policy and its contents. This also shows uncertainty as to what actions should be taken without the guidance of a policy.

Literature supports the fact that few nurses work in institutions where a policy directing family witnessed resuscitation is in place, and many nurses do not know if a policy exists or not in the facility where they are employed (Fallis, McClement & Pereira 2008:26).

Most nurses would prefer that a policy be in place directing their actions (Fallis, McClement & Pereira 2008:27; De Beer 2005:43).

There is no policy at the hospital where the study was undertaken regarding family witnessed resuscitation Most of the nurses knew this, however on questioning during the interviews, some seemed unsure if there was in fact a policy, and if there was one, what the contents of this policy were. One nurse even stated that there is a policy, when in fact there is not a family presence policy in place. Nurses also feel exposed without the guidelines of policy, and this may be acting as a barrier to nurses inviting family members to witness resuscitation.

4.4.4 Inclusion of the family in viewing resuscitation efforts

In this study there was a degree of wavering amongst the participants who were accommodating to the possibility of family witnessed resuscitation. This wavering could be linked with certain conditions surrounding the resuscitation. One nurse explained, *" I am very sure that me personally, I would be happy to have families in, but there are conditions"*. Another nurse said, *" It would depend"*.

Participants in this study were divided in their perceptions as to whether family witnessed resuscitation is acceptable or not. Five of the eleven participants in this study felt that family witnessed resuscitation is acceptable. Two participants stated that they were unsure. One nurse commented during her interview, *"I have no problem to have family members there"*.

In the study by Fallis, McClement and Pereira (2008), in which 944 Canadian critical care nurses were surveyed on family presence practices and perceptions, the majority of nurses (92%) supported family presence during resuscitation. This was also true for nurses in the study by Grice, Picton & Deakin (2003) as 66% of a total of 50 UK nurses who filled in the questionnaire felt that witnessed resuscitation is acceptable. This is in contrast with the participants interviewed in this study, as five participants in this study felt that family witnessed resuscitation is an acceptable practice. However, the study by Badir and Sepit (2007), in which 409 Turkish nurses were surveyed, revealed that the majority of nurses (69.1%) do not feel that family witnessed resuscitation is acceptable.

Participants in this study were divided in their perceptions as to whether family witnessed resuscitation is acceptable or not. Five of the eleven participants in this study felt that family witnessed resuscitation is acceptable. Two participants stated that they were unsure.

4.4.5 Attitudes` surrounding the inclusion of family members in the resuscitation process

Reasons for and qualifiers for including family members in the resuscitation process were expressed by the some of the participants in this study. One qualifier for allowing family members to witness resuscitation is that family members are adequately prepared beforehand. In addition to this, the importance of a chaperone to assist the family is also noted. Benefits, that the participants associated with allowing family members to be present during resuscitation, included that the experience could offer an opportunity for

closure to the family should the resuscitation be unsuccessful. Nurses also expressed a need to offer the family the choice as to if they would want to witness resuscitation.

4.4.5.1 The importance of preparing the family

Three of the eleven nurses interviewed felt that family members should be adequately prepared psychologically beforehand should they wish to be present during resuscitation, by explaining to family members what they may witness during the resuscitation. One intensive care nurse said during her interview, *"They need to be psychologically prepared, otherwise it will be harder for them"*. However, another nurse pointed out the importance of a chaperone by saying, *"There should be a dedicated person (chaperone)"*.

Ryan (1988) has highlighted that relatives of patients admitted to the ICU need to be informed so that they can build up a foundation upon which they can face a situation without suffering. Therefore, family members need to be prepared psychologically before witnessing resuscitation attempts (Critchell & Marik 2007:314). The importance of this has been highlighted, and family members need to be prepared psychologically for what they may witness during the resuscitation process (Clift 2006:17). The importance of a chaperone for preparing the family member, answering any questions and providing support has been highlighted (York 2004: 86).

Three nurses saw adequate psychological pre-preparation of the family as a pre requisite to allowing family members to be at the bedside during resuscitation. Preparation of the family, answering questions and providing support would be performed by a chaperone.

4.4.5.2 Opportunity to offer the family closure

Four of the eleven nurses interviewed said that allowing families to witness resuscitation attempts may offer an opportunity for closure to the family should the resuscitation attempt be unsuccessful. By this, an opportunity to mend misunderstandings or grievances can ease mourning in the future (Critchell & Marik 2007:314). One critical care nurse felt that allowing family members to be present could offer an opportunity for closure to the family. She said of her single previous experience of witnessed resuscitation, *"It gave them closure"*. Another nurse commented during her interview, *"There are some people who may get closure"*.

There are divided views from the perspective of nurses as to whether family witnessed resuscitation would offer closure or be a traumatic event for the family. In the study by Fullbrook, Albarran & Latour (2005) in which 235 European nurses were surveyed, the majority of nurses felt that family members may draw comfort from sharing the last moments with their loved one. Few nurses felt that family members will experience long term negative psychological effects from witnessing resuscitation (Grice, Picton & Deakin 2003:821), in fact, most nurses feel that witness resuscitation will offer closure by offering assurance to the family that everything possible had been done for the patient (Fullbrook, Albarran & Latour 2005:562). A traditional African perspective of death prefers for a person to die surrounded by family, so that any last wishes or feelings can be expressed (Stellenberg & Bruce 2007:943).

Four of the nurses in this study feel that allowing family members to be at the bedside during a resuscitation attempt could be beneficial to family members by allowing them an

opportunity to draw closure from the experience. However, more participants in this study were concerned of the potential traumatic consequences for the family should they witness resuscitation.

4.4.5.3 Offering the family the choice

Three of the nurses interviewed stated that family members should be involved in decision making and should be offered the choice of whether they would want to view resuscitation efforts or not. One nurse, who had a previously positive experience of witnessed resuscitation, said during her interview, *"We must always give the family the choice"*. Another nurse stated, *"I think it is up to that person, I think that it could be offered to them, this is what's happening would you like to be present?"*

Despite cultural and language barriers in South African intensive care units, attempts are made to involve family members in decision making and to communicate with family members as soon as possible following admission to the intensive care unit (Crippen 2008:25). The importance of communication between health care workers and families cannot be overstated (Faith & Chidwick 2009:79). Various organizations internationally, including the American Heart Association (2005) and the American Association of Critical Care Nursing (2004), advocate for offering family members the choice to witness resuscitation. Interestingly, in studies on family witnessed resuscitation the majority of nurses did not feel that it was necessary to extend an offer to family members to witness resuscitation (Badir & Sepit 2007:88; Fullbrook, Albarran & Latour 2005:561).

Three nurses interviewed in this study would be open to extend an offer to family members to witness resuscitation efforts. One of these nurses had a single previous experience of witnessed resuscitation. Thus highlights the importance of involving family members in the decision making process, and extending an offer to them as to if they would want to witness resuscitation of their loved one.

4.5 SUMMARY OF FINDINGS

In this study results were divided as to critical care nurses' perceptions of the acceptability of family witnessed resuscitation. Nurses wavered with regard to this, and only one of the participants had a previous experience of family witnessed resuscitation within the hospital where the study was undertaken.

Four of the participants in this study felt that family witnessed resuscitation is unacceptable. However, as mentioned, these four nurses did waver during their interviews. Two other participants seemed unsure, and wouldn't give a concrete answer to their opinions regarding family witnessed resuscitation. These nurses felt that it would, for the most part, be unacceptable due to the potential disadvantages that family witnessed resuscitation posed to the family and to themselves.

In this study, nine nurses felt that family witnessed resuscitation would be too traumatic for family members to experience. Therefore this is a contributing reason as to why family members are not invited to the bedside during resuscitation efforts. In addition to this, three of the nurses in this study believe that family members may misinterpret issues pertaining to the resuscitation effort. This may in part be due to the explicit nature of medical

television shows that are been broadcast. The importance of chaperone in minimising misinterpretation is also noted. Therefore, it would appear that participants concerns for family misinterpretation are a contributing factor for nurses' reluctant attitude towards family witnessed resuscitation. In addition to this, three nurses felt that bed space would be inadequate to accommodate a family member. This is therefore a reason for the participants' reluctant attitude towards family witnessed resuscitation.

Four nurses in this study felt that family members may interfere in resuscitation efforts. It would appear that this is a contributing factor why these critical care nurses would not feel comfortable with inviting family members to witness resuscitation. In addition to this, six nurses interviewed in this study felt that having family members at the bedside during resuscitation could expose their own shortcomings to the family. The reason for this could be a lack of confidence in their own abilities, that their own shortcomings may be exposed to the family should family members witness resuscitation. Therefore, feelings of inadequacy and lack of self-confidence from the perspective of nurses is a reason for not inviting family members to witness resuscitation.

Six of the nurses interviewed in this study expressed that it is a norm for family members to be asked to leave the resuscitation area. This could be attributed to a lack of previous experience with family witnessed resuscitation, or habit and further could be preventing nurses from inviting family members into resuscitation in the future. Therefore, this may be a factor hindering nurses from including family in the resuscitation process.
In this study it can be stated that there is no policy in place with regards to family witnessed resuscitation. Ten of the eleven nurses' knew this, however on questioning during the interviews, some seemed unsure if there was in fact a policy, and if there was

one, what the contents of this policy was. One nurse even stated that there is a policy, when in fact there is not a family presence policy in place. Some participants felt exposed and uncertain without the guidelines of a policy, and this may be acting as a barrier to nurses' inviting family members to witness resuscitation.

In contrast, in this study there are nurses who favour family witnessed resuscitation, despite the lack of experience that these nurses' had with witnessed resuscitation. Five of the nurses' in this study had accepting attitudes towards family witnessed resuscitation. The one nurse who had a positive previous experience of family witnessed resuscitation was amongst these. Two nurses were unsure if family witnessed resuscitation is acceptable or not.

Three nurses interviewed in this study felt that should family members witness resuscitation, it is important for the family member to be psychologically prepared beforehand. These three nurses' saw this as a pre requisite to allowing family members to be at the bedside during resuscitation. Preparation of the family, answering questions and providing support would be the role of a chaperone Four of the nurses in this study feel that by allowing family members to be at the bedside during a resuscitation attempt could be beneficial to family members by allowing them the opportunity to draw closure from the experience should the resuscitation attempt be unsuccessful. However, it should be noted that in contrast more participants in this study were concerned of the potential traumatic consequences for the family should they witness resuscitation. Three nurses interviewed in this study would extend an offer to family members to witness resuscitation efforts. This could be attributed to a lack of previous experience of family witnessed

resuscitation and decreased awareness of the international trends surrounding family witnessed resuscitation.

4.6 CONCLUSION

At the beginning of this chapter the research questions guiding this research were stated. Thereafter a detailed profile of the population and participants was given. Following this, an explanation was given for the data analysis process. Thereafter, an in-depth discussion of the findings of this study was given. The limitations of this study and recommendations for future studies will be discussed in chapter five.

CHAPTER FIVE

RECOMMENDATIONS AND LIMITATIONS

5.0 INTRODUCTION

In this chapter the summary of the study will firstly be described. Thereafter, the methodology of the study will briefly be outlined. The main findings of the study will thereafter be described followed by the limitations of this study. Lastly, recommendations for future research, education, management and clinical practice will be discussed.

5.1 SUMMARY OF THE STUDY

5.1.1 Research Questions

The aim of the study was to explore and describe a purposefully selected group of critical care nurses at a tertiary level academic hospital in Gauteng's perceptions and opinions regarding family witnessed resuscitation. Therefore, the research questions of this study are as follows:

- What are critical care nurses' perceptions regarding family witnessed resuscitation?
- What are critical care nurses' opinions regarding family witnessed resuscitation?

5.1.2 Research design

This study has employed a qualitative approach. It focuses on the whole, which is consistent with the holistic philosophy of nursing, by exploring depth, richness and complexity of a phenomenon (Burns & Grove 2007:12). De Vos, Strydom, Fouche et al. (2006) describe qualitative research as a paradigm that elicits participant accounts of meaning, experience or perceptions.

This research is of an exploratory, descriptive and contextual design.

Exploratory studies set out to explore a relatively unknown field, of which the purpose is to gain new insights into the phenomenon under study, clarify central constructs and concepts and determine priorities for further research (Uys & Basson 2000:38). In this study the researcher set out to explore and gain insight into a select group of critical care nurses perceptions and opinions of family witnessed resuscitation.

Descriptive research is used to gain more information about characteristics within a particular field, and to provide a picture of a situation as it naturally occurs (Burns & Grove 2007:18). In this study the researcher aims to describe the current clinical practice involved in family witnessed resuscitation, and critical care nurses perceptions and opinions thereof.

According to the Concise Oxford English Dictionary (2006) context can be described as the circumstances that form the setting for an event statement or idea. This study was conducted within a tertiary level academic hospital in Gauteng. Critical care nurses

employed at this institution practice within the Scope of Practice as set out by the South African Nursing Council (Nursing Act 50 of 1978).

5.1.3 Research Method

The population included critical care nurses employed in the intensive care units at the provincial hospital under study. According to De Vos, Strydom, Fouche et al. (2006), qualitative research is concerned with small samples, which are most often purposively selected. Purposive sampling may sometimes be referred to as judgmental or theoretical sampling and involves the conscious selection of certain subjects by the researcher (Burns & Grove 2007:344). In this study, critical care nurses were selected by purposive sampling using inclusion criteria. Data was collected using semi-structured one-on-one interviews with the participants. Interviewing is considered the primary method of data collection in qualitative research (De Vos, Strydom, Fouche et al. 2006:287). Data collection and analysis occurred concurrently, and the analysis process was guided by Tesch's method of qualitative data analysis (in Creswell, 2009:186).

5.2 MAIN FINDINGS

In this study, the participants were divided in their perceptions of the acceptability of family witnessed resuscitation within critical care. The nurses wavered with this regard and ten of the eleven nurses were relatively inexperienced with family witnessed resuscitation. Only one participant had one previous experience of family witnessed resuscitation within the institution where the study was conducted.

Four nurses interviewed in this study felt that family witnessed resuscitation is unacceptable, and two were unsure. However, as mentioned, these nurses' did waver with regards to this. Participants' expressed reservations regarding family witnessed resuscitation including the potential traumatic effects that it could have on the family. In addition to this, concerns that family members may interfere with resuscitation efforts came to light. Six participants also feared that their own shortcomings may be exposed to family members should they observe resuscitation attempts. Three nurses in this study believe that family members may misinterpret issues, and that the physical space at the bedside would be inadequate. Six participants pointed out that it is norm to ask family members to leave the resuscitation area, in part due to habit, and thus could be preventing family members been invited to the bedside. In addition to this, lack of policy guidelines may be acting as a barrier to allowing and facilitating nurses to invite family members to witness resuscitation.

In contrast, five nurses in this study had accepting views on family witnessed resuscitation. This, despite the lack of previous experience these nurses had with regards to witnessed resuscitation. And as mentioned, some of these nurses did waver with regards to this. Pre-preparation of the family emerged as a concern for the participants. Three nurses would extend an offer to family members to be at the bedside during resuscitation. Four participants interviewed in this study felt that family witnessed resuscitation may offer an opportunity for closure for the family should the resuscitation attempt be unsuccessful.

5.3 LIMITATIONS OF THE STUDY

The researcher has identified the following limitations in this study:

5.3.1 Small sample/study

This study had a small sample of participants of eleven interviews in total. Therefore the results of this study cannot be generalized beyond the context of this study. A larger sample could have yielded different results.

5.3.2 Demographics of the Sample

Two participants in this study spoke English as their home language. In addition to this, all of the participants interviewed were female. As interviews were conducted in English, a sample comprising of predominantly English speaking participants may have yielded different results. In addition to this, a sample comprising of male participants may also have yielded different results.

5.4 RECOMMENDATIONS FOR THE FUTURE

Clinical Nursing Practice

According to Caterinicchio (1995), nursing should be based on a needs based principle, and should be individualized to suit each patient and their family. The patient and families needs should be assessed on an individualized and family centered basis respectively.

Nursing Education

At a level of basic nursing education and post basic nursing education, an awareness of the international trends with regards to family witnessed resuscitation should be created. In addition to this, the skills needed for the implementation of family witnessed resuscitation should be introduced.

Management

Dialogue should be started with hospital management and relevant stakeholders with regards to policy. Policy direction should be based on the benefit and guidance for family witnessed resuscitation.

Future Nursing Research

A follow up study should be conducted focusing on the differences between the different intensive care units. For example cardio thoracic intensive care unit is primarily an elective post operative unit, whereas a trauma intensive care unit is largely an acute setting involving patients who are admitted suddenly, which leaves family members unprepared and in crisis.

Research needs to be conducted on the public and patient's wishes for family witnessed resuscitation in South Africa.

5.5 CONCLUSION

In this chapter a summary of the study was outlined. Thereafter, a brief description of the research methodology was given. Main findings were then discussed. The limitations of the study namely small sample/study and sample demographics have been outlined. Thereafter, suggestions for future research, clinical, education and management have been outlined.

APPENDIX 1: Copies of permission granting letters

APPENDIX 2: Transcribed interview

Interview 4 :

Key:

C: Chanel

4: Interviewee four

INTRODUCTION:

4 is a registered nurse that has been working for > 10 years in this capacity.

C: Are you happy, I just need to get verbal consent on audiotape, that you are happy for me to audiotape this interview, and you have read through the ethical considerations, such as if you want to withdraw or anything like that…

4: Yes, I do, thank you.

C: Ok, so basically, all that I am looking for is your opinion, there is no right or wrong answer, I want to know what are your perceptions, what is your opinion. So, my question is, as a critical care nurse working particularly within this institution, how would you feel if you were busy resuscitating your patient, and the family members requested to be present?

4: Uh, well, it has happened before, and I have had the experience of having somebody (family) present, and I think that there is no problem. I have no problem to have the family members there, and I actually think that it is nice for them to see that you are actually doing something right to the very end.

C: Ok, so do you feel that it benefited the family members?

4: Yes, I did think that it did benefit the family members, because they could see that we were going right from CPR, to drugs. It was emotional for them, but I think that they actually got the just that the patient was extremely ill, and that the staff cared for the patient and really did whatever they could.

C: Where exactly did this happen?

4: Um, ok this happened two years ago, and it was in the high care unit of this hospital, and it was in March. It was accidental, um, it was a resuscitation where accidentally the family walked in, and we left it like that with the consent of the Prof, because it is a hot topic to have relatives there, and it was the first time that we actually had relatives present.

C: Ok, and you feel that it was beneficial to them?

4: Yes I do.

C: If given the opportunity would you do it again?

4: Yes, I think we would, um, and I think that we should actually try as much as we can to let the relatives in. People may react differently, nobody came and screamed and shouted at us, they were just quite emotional, and I think that we must always give the family the choice.

C: Would you like to share what happened in this resuscitation?

4: Ok, so they called us to resuscitate, and so we ran across to high care (affiliated with ICU), intubated the patient, got the nurse from the unit to bag, I got on and did CPR, and the doctor and I alternated with medication, and while we were doing the CPR, the family arrived. We just left them for them to see what we were doing, and then the professor spoke to them afterwards. They actually saw us difibbing, doing CPR, and we carried on for an hour and forty five minutes.

C: Was there somebody standing with them?

4: No, they came in and they watched, and then like two or three of them went to go and sit on the chairs. They didn't stay the whole time they went to sit on the visitors chairs, there wasn't, anyone to go and sit with them. It was just the husband that stayed and one of the relatives.

C: Do you think it was beneficial to them?

4: Yes, ill tell you why I think it was beneficial to them, is because they came back the next day, to get some documents signed for insurance, and when I spoke to the relatives, the mother and the aunty, I asked them, how did they feel that we were doing CPR and shocks. They actually said that they understood that we had to do it, it was something that they didn't really think would happen, but it was something that had to be done. And emotionally, you could see that they had actually now, that the daughter had died, and it gave then closure. It was purely from the discussion afterwards, and yes, I admit, it must have been very emotional for them, but when they came back, a few days later for all the paperwork to be filed in, the felt much at ease, and they knew, they were very grateful that we tried whatever we could do.

(Pause)

4: Even the Prof. was quite chuffed that we allowed them (to witness), because it is a hot topic, because you should allow relatives (to witness resus). Not everyone will want to be there, but should allow them, and we shouldn't feel bad because that is a part of life. And it is apart of our treatment, and they need to see what has actually happened, and it may bring closure. Also of times people feel that the hospital didn't do (enough), or that they have neglected them, now they can see that right to the end the patient was cared for and everything that could have en done was done right till the end.

C: And, are you aware of any policy in place with regards to this, in this particular institution?

4: No, I don't know of anything at all in place.

C: Ok, thank you very much

4:Thank you.

CONCLUSION:

I feel that this interview went well. I am finding that it is beginning to show that the more experience critical care nurses are more receptive to allow family members into a resuscitation, as compared to the newly qualified critical care nurses. This may be due to their professional maturity and confidence within their own ability. I find her insight to the necessity for family members been offered the choice enlightening.

She also pointed out that she has recently seen and been part of a witnessed resuscitation. This is the first participant that has actually formally been part of a formal witnessed resuscitation.

Also interesting is that without a policy, this is a very subjective decision that is made, so for example, with an experienced critical care nurse, family are more likely to be invited into the resuscitation, but this depends on the teams feelings at the time etc. There is a clear lack of consistency amongst HCW with regards to this, and hence a lack of consistency in the options that family members given.

APPENDIX 3: Copy of consent form

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