AN EXPLORATION OF THE VIEWS OF HEALTHCARE PROVIDERS ON FAMILY WITNESSED RESUSCITATION IN AN EMERGENCY DEPARTMENT OF A PRIVATE HOSPITAL IN GAUTENG

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A research report is submitted to the Faculty of Health Sciences, University of the Witwatersrand, Johannesburg, in partial fulfilment of the requirements for the

degree of

Master of Science in Nursing

Johannesburg, 2018

DECLARATION

I, Mayush Narendra Ambelal, declare that this research report is my own work. It is being submitted for the degree of Master of Science (Nursing) to the University of the Witwatersrand, Johannesburg. It has not been submitted before any degree or examination at this or any other university.

Signature……

……dayof……2018

Ethics number: **M140875**

DEDICATION

This study is dedicated to all the healthcare providers, my colleagues and friends in the unit, keep up the amazing working that you, nobody can do better than what you do and that is saving lives on a daily basis.

ACKNOWLEGDEMENTS

I would firstly acknowledge the most important being that has made this possible; by blessing me with everything I have today, my saver, my Lord, my God.

I would like to thank the following people who were with me each step of this journey, who have helped by contributing to this report and who have encouraged me not to give up.

To my supervisor Andrea Hayward encouraged, supported and sacrificed a lot to help me produce this report, I am highly thankful.

To Professor J.E Maree thank you for what you have done for thus far.

To my mother and friends who have always granted me support and encouragement through this journey, I really appreciate it.

ABSTRACT

Background: There has been an international move towards allowing family member presence during the resuscitation of a relative for many years, but not in South Africa. This practice is discouraged in many hospitals locally. There is a lack of formal protocols on allowing family member presence during resuscitative efforts. Communication with the family is left to a doctor and often only occurs once the patient has demised.

Aim: The aim of this study was to explore the views of the healthcare providers on the practice of family member presence during the resuscitation of their relative in an emergency department in a private hospital setting in Gauteng. The results were intended to inform policy for future reference on the practice of family member presence during the resuscitation of their relative in an emergency department.

Design: This study was carried out at a level two private hospital with a busy emergency unit which receives complex trauma and medical cases. A qualitative, exploratory, descriptive and contextual design was used for this study. A total of twenty four (n=24) multidisciplinary healthcare providers at the selected study site were selected. The sample size was determined by saturation of information during data collection. Open ended questions in an interview were used and the data recorded using an audio recorder. Tesch's method was used to analyse the data collected. Measures of trustworthiness were applied to ensure rigor of the findings in this study.

Findings: This study revealed five themes with nine sub themes. The five themes included perceptions of emergency room staff, buy in towards family member presence, concerns from staff, family emotions as perceived by staff and balancing your act.

Conclusion: The findings of this study show that there is no consensus between the different healthcare providers on family witnessed resuscitation.

Key words: Family member presence, resuscitation, witnessed resuscitation, perceptions and healthcare providers.

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LIST OF ABBREVIATIONS

TTRN: Trauma trained registered nurse

S: Trauma surgeon

RN EXP: Experienced registered nurse

D: Doctor

R: Radiographer

E: Emergency care practitioner (paramedic)

AHA: American heart association

P1: Priority one

CPR: Cardiopulmonary resuscitation

ATLS: Advanced trauma life support

PALS: Paediatric advanced life support

ROSC: Return of spontaneous circulation

CHAPTER ONE

OVERVIEW OF THE STUDY

1.0 INTRODUCTION

Family witnessed resuscitation is a controversial issue amongst healthcare professionals nationally and internationally, despite international studies reporting positive lived experiences and opinions of healthcare professionals and family members (Badir and Sepit 2007). Resuscitation is a sequence of lifesaving interventions required to sustain life when the heart stops beating such as artificial ventilation, electric shock or chest compressions until spontaneous blood circulation is restored (AHA 2016). According to Howlett, Alexander and Tsuchiya (2010) there has been an international trend of allowing family member presence during the resuscitation of their relative but this has not occurred in South Africa. Madden and Condon (2007) argues that family presence during the resuscitation of a relative remains an emotional and controversial practice that often causes conflicts amongst healthcare providers.

Attitudes, beliefs and knowledge of healthcare providers have been shown to be the most significant reasons for excluding families from resuscitation (Chapman, Watkins, Bushby and Combs 2012). Based on the above observations family witnessed resuscitation in the current clinical environment takes place haphazardly.

1.1 BACKGROUND OF THE STUDY

In an emergency department where the researcher is currently employed family members are often asked to leave the resuscitation room and wait in the waiting area whilst the resuscitation is in process. In many instances family members have verbalized

their experience of isolation in a sense that often nobody provides them feedback and/or information post resuscitation until one of them enquires from a healthcare provider about the outcomes of the resuscitation. There are instances where family members do witness the resuscitation because it is a paediatric patient or when there is a communication barrier.

This hospital is a level two hospital. The emergency department is also classified according to the Department of Health as a level two trauma unit providing a 24 hour emergency services and consulting approximately 66 to 100 patients per day. The categories of patients accessing these services ranged from those who presented with coughs and colds, to complex medical and traumatic conditions such as septicaemia and traumatic amputations. On a daily basis the emergency department encounters at least three to four resuscitations, the majority of which were successful. In section 3.3 the context in which the study was conducted is further discussed. The healthcare team comprises of doctors, nurses, occasionally the paramedics and radiographers. Currently, to the best knowledge of the researcher there are no formal South African protocols, guidelines or policies regarding family witnessed resuscitation. Doughal, Anderson, Reavy and Shirazi (2011:153) refer to the literature findings stating “the absence of a family presence policy lead to misunderstandings and variations in practice among healthcare team members”. From a family perspective according to James, Cottle and Hodge (2011) having the above mentioned formal procedures and processes outlined promotes optimal care for family members by assessing their coping mechanisms and preparedness for witnessing a resuscitation such as informing them that a radiographer may come and take x-rays and that they will be expected to leave the room. In addition to that, it is important to ensure that the patient safety is not compromised during the resuscitation.

The doctors and nurses are present from the onset. When there are shortages of staff in the unit the paramedics are often requested to assist. The radiographer’s role was to

take x-rays thereby aiding the healthcare providers in making a clinical diagnosis. During the acquiring of the image family members and some of the healthcare providers not wearing a lead apron are asked to vacate the area due to radiation exposure. Procedures such as these create uncertainties for the family members regarding the seriousness of the condition of the patient and they expect the worst. Radiographers are often questioned by the family members outside the resuscitation bay on the outcomes of the resuscitation as well as the results of the radiographs that were taken. In many instances this information is not divulged to the family. When confronted by family members the radiographer often answers that the doctor will come and give the results of the x-rays once the x-rays have been analysed. In the absence of formal protocols and guidelines the person whose role it is to communicate and inform the family members is not clear (Dougal *et al.* 2011). Healthcare providers' personal preferences towards family witnessed resuscitation may highlight the reasons healthcare providers' choice to invite or not to invite the family's presence during the resuscitation is divided (Critchell and Marik 2007). An empirical gap was identified which triggered the researcher's interest to conduct a study on family witnessed resuscitation from a healthcare providers' perspective in the emergency department.

1.2 PROBLEM STATEMENT

Family member presence during the resuscitation of a relative is the current trend internationally but it is not known whether this practice is acceptable in the South African context from a healthcare providers' perspective. This study is an attempt to explore the views on the topic from the healthcare providers' perspective.

1.3 PURPOSE

The purpose of this study was to explore and describe the views of healthcare providers on the practice of family member presence during the resuscitation of their relative in an emergency department in a private hospital in Johannesburg.

1.4 RESEARCH QUESTION

What are the views of the multidisciplinary healthcare providers on family witnessed resuscitation in an emergency department in a private hospital in Johannesburg?

1.5 RESEARCH OBJECTIVES

The objectives for this study were to explore and describe:

Healthcare providers' views on family witnessed resuscitation in an emergency department in a private hospital in Johannesburg.

Factors that influenced the decision making processes regarding family witnessed resuscitation.

The feasibility of implementation of family witnessed resuscitation practice from the healthcare providers' perspective.

1.6 SIGNIFICANCE

This information will provide the hospital management, healthcare providers and nurse educators with a deeper understanding of factors that influence the decision regarding allowing of family witnessed resuscitation. It will also highlight areas where institutional

policy and educational interventions could strengthen the supportive role for families. From an organizational perspective this study will assist to develop formal guidelines and protocols regarding family witnessed resuscitations.

1.7 PARADIGMATIC PERSPECTIVES

Creswell (2009) stated that a paradigm is a worldview it is a set of beliefs that guides all thoughts, actions and human behaviors. In order to guide the direction and subsequent phases of the study all research must be placed in a paradigm. The paradigmatic perspectives in this study included the meta-theoretical, theoretical and methodological assumptions, which are discussed in the section below.

1.7.1 Meta- Theoretical Assumption

According to Schumacher and Mcmillan (1993) and Creswell and Poth (2018) qualitative research is based on an interpretivist naturalistic approach. A constructivist philosophy based on the assumption that reality is multiple, interactive, shared, social experience that is interpreted by individuals. The authors also believe that reality is a social construction that is derived by individuals or ascribes meanings to specific events, persons, processes and objects. They continue that people form constructions to make sense of their world and recognise these constructions as viewpoints, perceptions, and belief systems. In other words people's perceptions were what they considered real and thus what directs their actions, thoughts and feelings.

The Person

The nurse is the first person in the emergency care setting that a patient comes into contact with. If the patient is brought in with a private vehicle the family member would be the first person the nurse encounters. However, the nurse cannot exist in isolation. The nurse has to triage, formulate a nursing diagnosis, inserts intravenous lines, prepares for

invasive procedures and calls allied healthcare workers to assist with diagnostic tests and procedures. Once the emergency medicine physician has been notified he or she will examine the patient and request further investigations or diagnostic tests. The nurse will then call upon other allied healthcare workers to carry out these specialised investigations such as the radiographer who performs diagnostic imaging (CT scans, MRI and x-rays), the phlebotomists who draws blood and the trauma counsellor who is notified telephonically to counsel awaiting family members.

Environment

The trauma and emergency environment is a complex environment within a health institution which forms part of the health system. The emergency department consists of a diverse team of highly skilled healthcare providers. The core members of the healthcare team are medical providers such as professional nurses and doctors. Other members are often called upon to provide diagnostic services such as laboratory technicians and radiographers. In some instances medical field experts such as Radiologists are consulted to aid in the clinical diagnosis and care of the patient. Their roles and responsibilities are governed by the institutional structure, culture and climate in addition to the policies, protocols, rules and regulations. The type of services rendered in this environment ranges from simple to complex aided by sophisticated equipment and technological devices in diagnosing, treating and managing patient care.

The patient enters the healthcare system by either direct or indirect referral route with a problem, condition or situation that requires medical intervention. In most cases the first point of entry is emergency and trauma. At this point the patient is either alone or accompanied by his or her family. The patients are then triaged by the nursing professionals. Depending on the complexity of the patients' condition, the patient is then allocated to the appropriate unit. During this process the patient is referred for diagnostic tests and depending on the outcomes of the diagnostic tests the patients' treatment and

management plan is devised and the patient is then referred to the appropriate specialist. The family members' role with regards to decision making, the accompanying of the patient, advocacy of the patient, support and witness a resuscitation as with this study is determined by the rules, regulations and policies governing that particular unit. In the absence of the latter it is the discretion of the healthcare providers to decide on the involvement of the family members in the medical encounter of the patient.

Nursing

To deliver care in a manner that preserves and protects the autonomy, dignity, rights, values, beliefs and preferences of the health care user and family in the midst of dehumanizing environment such as high technology, buzzing alarms and complex decisions is extremely difficult. The nurse recognises the significance of the critically ill patient and family in ethical decision making within the multidisciplinary team ensuring that they take informed decisions. The nurse upholds and advocates for the critically ill patient's confidentiality within the legal and ethical framework because critically ill patients are not in control of their situation (South African Nursing Council 2014). For the purpose of this study it is the indirect implication of integrating family members to witness a situation as an expansion of critical care processes having some influence on the quality of care. The role of the nurse in the trauma and emergency department is to demonstrate sensitivity to cultural, technological diversity within the multidisciplinary team and critical healthcare continuum. It is also to orientate families to the critical care environment in collaboration with other health care teams (SANC 2014).

Trauma and emergency care encompasses a field of nursing where the focus is on the care of patients that are critically ill or unstable, in collaboration with members of the heath care team (SANC 2014). Thus, it is important to obtain formal and informal feedback regarding one's own practice from health care users, peers, professionals, colleagues and others. Actively engaging with the intra and inter-professional peers and

colleagues contributes to one's professional perspective to enhance professional practice or role performance. The nurse functions within a complex technological environment and displays a high level of knowledge, skill and competence in caring for the patient and family or a support system to discharge the patient to a safe place. Due to the complexity of the illness the nurse care is also within a multidisciplinary context which also encompasses provision of holistic care. Therefore, it is important for such nurses to have adaptive and transferable skills. The implications thereof, is accepting accountability for increased responsibility for one's own professional and clinical judgment, actions, health care outcomes and continued competence in accordance with the prescribed Scope of Practice, relevant Health and Nursing Acts and Regulations. The nurse is required to engage in self-evaluation of his/her own practice on a regular basis, as well as areas in which professional growth is needed. This study will share the outcomes of a multi-provider perspective on family witnessed resuscitation in order to collaboratively initiate the concept family witnessed resuscitation.

Health and Illness

Health systems include all organizations, institutions and resources "whose primary purpose is to promote, restore or maintain health" (Hyder, Merritt, Ali, Tran, Subramaniam and Akhtar 2000: 5). They can be viewed from several perspectives and include individuals or populations. Acute care is included in the health system. Components include care delivery platforms used to treat sudden, often unexpected, urgent or emergent episodes of injury and illness that can lead to death or disability without rapid intervention.

Therefore, in the context of emergency nursing care is only necessary for a short period of time. The patient is treated for a brief period for the traumatic or a medical emergency he or she presents with. This pattern of care is often necessary for only a short period of time, unlike chronic health care.

1.7.2 Theoretical Assumptions

Rothbaum, Rosen, Ujiie and Uchida (2002) focused on family dynamics, which consists of rules, communication patterns, boundaries and power relations. According to Tucker (2008) family members as well as the resuscitation team members do not exist in isolation and they are all inter-dependent. There are rules of operation in a family. Those rules also exist when the resuscitation team is activated. At times these rules are unspoken but guided by policy and members are well aware of them. When the resuscitation team is activated there is a team leader who guides the resuscitation proceeding in a manner similar to a family setting where the breadwinner (father or mother - leader) guides the household. According to Rothbaum *et al*. (2002) the family depends on the resuscitation team to save their family member.

Family members are complex subsystems within the family system which implies that the integration of family members as recipients of care must be included and not just the patient (Kerr 2000). Excluding treatment to some of the parties could result in stress through somatisation and negative affective and behavioural responses. It is assumed that the family member's intersystem balance between internal needs and external demands is disrupted. During resuscitation it is predominantly the external needs that are disrupted. Thus, adequate balanced care is important and can help the patients and families by refocusing relationships and goals that may fall by the wayside (Kerr 2000). In order to develop protocol and guidelines and to develop interventions within the trauma and emergency setting regarding family witnessed resuscitation it is important to establish multi-healthcare providers' base knowledge and skills on the critical care experience which incorporates family members. Due to the short period of time the pattern of care is in constant flux and therefore the approach would be to establish how healthcare providers could facilitate and cope with affective stress responses (Kerr 2000).

1.7.3 Concepts

Family witnessed resuscitation: family members are present whilst the medical team is actively resuscitating their relative during a cardiac arrest (Oman and Duran 2010).

Family member: Collectivism enables South Africans to practice the social values of Ubuntu. Family did not mean biological bonds, but instead bonds of unity. Family involvement is highly important in an African community. In the African context family members are expected to show compassion and care according to the principles of Ubuntu, this is a sign of humanity. Participation by the family members in the care of a loved one is an opportunity to honour the principles of Ubuntu (De Beer and Brysiewics 2016).

Family presence: This practice allows a family member in the resuscitation room witnessing the resuscitation of a family member from a distance (De Beer and Moleki 2012).

Healthcare providers: healthcare professionals also referred to as healthcare providers are either involved in direct or indirect emergency care of the patient. These professionals such as trauma trained registered nurses and experienced registered nurses, medical doctors, emergency medicine physicians, trauma surgeons and paramedics are directly involved in emergency care management. Whereas professionals such as the radiographers focus mainly on providing indirect care such producing diagnostic images (Makanjee 2013; Oman and Duran 2010).

For the purpose of this study the concept healthcare providers is a collective term used for all the categories of healthcare professionals.

Views: The term view (point of views) is a synonym for opinions or perceptions (Le Goff 2012).

Private hospital: is a hospital owned by a profit company or non-profit organisation and privately funded through payment for medical services by patients themselves and by insurers (Young 2016).

1.7.4 Methodological Assumption

Research methodology refers to particular strategies or techniques a researcher uses to collect data necessary for developing a theoretical framework (Giacomini 2010). This research was explorative descriptive design and took place in a natural setting, used qualitative research methods that were interpretive in nature (Ponterotto 2005).

1.8 RESEARCH METHODS

This describes the type of research and introduces the method used. In this study a qualitative, exploratory, descriptive and contextual design was proposed to explore the perceptions of healthcare providers in an emergency department in a private hospital in Johannesburg. This research method was chosen to address a specific research question and to fill an empirical gap in the literature regarding the South African context.

Qualitative designs often involve merging together various data collection. Due to the exploratory nature of the research question, multiple provider views and opinions will be sourced and merged regarding opinions and views on family witnessed resuscitation (Polit and Beck 2012). Using this approach will enable a holistic understanding from the health providers' perspective by selecting a diverse group of health provider participants involved with resuscitations. This research is explorative and descriptive and takes place in a natural setting, using qualitative research methods (Ponterotto 2005).

Research method refers to particular strategies or techniques a researcher uses to collect data necessary for developing a theoretical framework or testing a theory (Giacomini 2010). Qualitative methods encompass a broad spectrum of empirical procedures

designed to describe and interpret the experiences of research participants in a context-specific setting (Pontoretto 2005 and Tracy 2010). To address the research objectives formulated to answer the research question the most suitable will be an exploratory descriptive research approach to describe how the concept of family witnessed resuscitation is viewed by various health providers.

For this study the researcher used semi-structured interviews in order to explore and describe the findings as well as contextualise multi-provider perspectives (doctors, nurses, paramedics and radiographers) on family witnessed resuscitation in the emergency and trauma setting in accordance to the formulated objectives. Tesch's (1990) method will be used to analyse the data collected. The method of Lincoln and Guba (1985), which includes credibility, dependability, conformability and transferability, will be utilised to ensure trustworthiness of the findings in this study.

1.8.1 Research design

This describes the type of research and introduces the method used. In this study a qualitative, exploratory, descriptive and contextual design was proposed to explore the perceptions of a multi-disciplinary team of healthcare workers in an emergency department in a private hospital in Johannesburg. This research method was chosen to address a specific research question and to fill an empirical gap in the literature regarding the South African context.

1.8.2 Population

The population for this study included all registered nurses, medical doctors, paramedics and radiographers working in the emergency department at a private hospital in Johannesburg. There was a total number of twenty four (n=24) healthcare providers working in the emergency department at the selected study site.

1.8.3 Sample and Sampling

Purposive sampling was used in the recruitment of participants as sources of data that provided and expanded upon the data needed to achieve the study's aims and objectives. The researcher recruited trauma surgeons and emergency doctors, paramedics, nurses as well as experienced radiographers. This sampling method enabled the researcher to recruit specific participants who were considered to be a rich source of information and was able to share their views from their experiences on the topic under investigation. A minimum of 15 healthcare providers were targeted and the actual sample size was determined by saturation of information during data collection (Polit and Beck 2012). Saturation of information was established once the interviews generated no new ideas (De Vos 2005).

For this study, the inclusion criteria of healthcare provider participants were as follows:

- Trauma nurses who held an additional clinical qualification and registration with the South African Nursing Council in trauma and emergency care
- Medical doctors currently registered with the South African Health Professions Council as a specialist
- Medical doctors registered with the South African Health Professions Council without specialist training and qualification who provide a service to the emergency department and have a special interest in the field of study
- Radiographers registered with the South African Health Professions Council who provided a service to the emergency department and have a special interest in the field of study
- Healthcare providers (nurses, paramedics, doctors and radiographers) working in this capacity for at least 5 years

- The researcher included paramedics as they also provide some services in the emergency department. Inclusion of paramedics in this study depended on the presence in the department since they are not employed by the hospital.

1.8.4 Data Collection

Potential participants were identified and invited to participate in the study. The participants were given an information sheet to read. Written consent was obtained from the participant. The researcher collected data using semi-structured one-on-one interviews according to Tesch's (1990) method. An open ended question was asked with additional probes if necessary. In addition, contact details of the participants were obtained for a follow-up interview for confirmation and clarification. Interviews were tape recorded and transcribed using codes. Field notes were compiled in all the interviews.

1.9 STRATEGIES TO ENHANCE TRUSTWORTHINESS

Trustworthiness refers to the degree of confidence qualitative researchers have in their data. The method of Lincoln and Guba (1985) which included credibility, dependability, conformability and transferability this was utilised to ensure trustworthiness of the findings in this study (Polit and Beck 2012).

1.9.1 Credibility

The researcher watched resuscitations with keen interest over his years of trauma and emergency nursing practice. This has assisted in formulating this research in the researchers mind as the views of health care providers were explored. The researcher had frequent member checks and peer review with regard to relevant literature searches, data collection and analysis. This research was relevant to emergency nursing, as it was not researched in this particular setting.

1.9.2 Transferability

Transferability refers to the generalizability or external validity of the study (Lincoln and Guba 1985). The researcher provided description of the specific research context and process.

1.9.3 Dependability

The researcher reviewed the literature on similar studies conducted in similar contexts. The researcher left a decision trail on the theoretical, methodological and analytic choices used throughout the study.

1.9.4 Confirmability

Confirmability captures the traditional concept of objectivity, and if the results of the study was confirmed by another (Lincoln and Guba 1985). The researcher provided an audit trail, by keeping track of all references used, audiocassettes made, transcripts of interviews with accompanying field notes and all rough copies of data analysis for peer review and member checking in order to validate how the results were obtained.

1.10 OUTLINE OF STUDY

This research report comprises of five chapters, which are:

- Chapter one: Overview of the study
- Chapter two: Literature review
- Chapter three: Methods
- Chapter four: Findings
- Chapter five: Discussion and recommendation

1.11 SUMMARY

In this chapter an overview of the background and rationale of this study were outlined. A brief overview of the way in which the South Africans healthcare providers' handled family witnessed resuscitations as well as the way in which family witnessed resuscitation was handled abroad was dealt with. The problem statement, main research question, objectives and aims were the basis for planning the structures of the chapters to follow. The literature review is discussed in more depth in Chapter two by introducing the reader on the content of the chapter.

CHAPTER TWO

LITERATURE REVIEW

2.1 INTRODUCTION

In the previous chapter a general overview of the study was provided. It included the background to the study, the problem statement, the research question, the purpose of the study, the research objectives, significance of the study and the paradigmatic perspectives. It also described the theoretical framework and the meta-theoretical assumptions, research methods and ethical considerations briefly.

In this chapter a summary of literature on this topic will be discussed. Previous research was examined. This literature contains the worldview and local view on family witnessed resuscitations despite lived experiences healthcare providers are still excluding family members from resuscitation areas due to various reasons. The family members would like to know what is happening to their loved one and often enough the resuscitation team members do not keep the family members in the waiting area updated on their progress.

Literature review provides the researcher with evidence on the research topic. It also helps the researcher understand what has already been done as well as what already exists and how this study can be done in order to contribute towards the body of existing knowledge. Additionally literature review can assist the researcher in interpreting the outcomes (Burns and Grove 2013).

2.2 GLOBAL PERSPECTIVE ON FAMILY WITNESSED RESUSCITATION

Family witnessed resuscitation remains a controversial issue amongst healthcare professionals globally, despite international studies reporting lived experiences and opinions of healthcare professionals and family members (Badir and Sepit 2007). Family presence often causes conflicts amongst healthcare providers (Madden and Condon 2007).

When there is resuscitation we often ask family members to excuse themselves from the resuscitation area. Family members express feelings of isolation and neglect. However we do make a few exceptions towards family witnessed resuscitation for example when there are communication barriers and when the patient is a minor. The biggest obstacle towards family witnessed resuscitation is the multidisciplinary teams' attitude, beliefs and knowledge towards family witnessed resuscitations (Chapman *et al.* 2012). Based on the above observations family witnessed resuscitation at the current clinical practice environment takes place haphazardly.

The American public believes that it is their right to be in the resuscitation room instead of making family member presence an option (Critchell and Marik 2007). Internationally hospitals have made provision for family witnessed resuscitation by making dedicated areas where family members can witness their loved one being resuscitated (James, Cottle and Hodge 2011). In comparison we have made no such provision. If we had to implement such a policy the resuscitation area will be overcrowded and there will be a lack of privacy between the resuscitation bays.

Patients are not the only receipts of care. Family members are also regarded as recipients of care (Coulter, Parsons and Askham 2008). There are rare instances where family members do witness the resuscitation because it is a paediatric patient or when there is a communication barrier (McLean, Gill and Shields 2016).

2.2.1 Healthcare providers in favour of family witnessed resuscitation

Attitudes towards family witnessed resuscitations are changing amongst healthcare providers (Fulbrook, Latour and Albarran 2005). There are various factors such as the introduction of family centred care in midwifery, paediatric practice and expansion of palliative in promoting the idea of family member presence in the dying hours of their loved one(Fulbrook *et al*. 2005). Family members became more involved in patient centred care (Fulbrook *et al*. 2005).

Healthcare providers agree that family presence assisted with the grieving process, provided family members with opportunity to see all the efforts that had been made to save their relative, family members to provide a medical history to staff and provide closure if the witnessed resuscitation was not successful (Chapman *et al.* 2012; Vaz, Alves and Ramos 2016). Family member presence gave the witnessing family member a realistic view on resuscitative attempts and the possibility of death (Walker 2006).

Therapeutic relationships are developed through family member presence with healthcare providers the patients' satisfaction and outcomes may improve and promotes mutual respect, honesty and dignity (Dougal *et al.* 2011). Family member presence creates positive experiences for both the patient and family (Dougal *et al.* 2011). Family members may benefit emotionally and spiritually by feeling supportive and present, especially at the time of death (Dougal *et al.* 2011).

Most nurses felt that family witnessed resuscitation created a stronger bond between the witnessing family member and the nursing team (Badir and Sepit 2007). In the event of an unsuccessful resuscitation attempt family witnessed resuscitation would have positive benefits during the grieving process (Fulbrook *et al.* 2005 and Vaz *et al.* 2016). Nurses also found it important that family members be able to share their last moments with their loved ones (Thompson 2008). Nurses believe that the family members are more likely to accept decisions taken to withdraw treatment if they were present at the time (Fulbrook

et al. 2005). The treatment provided during the resuscitation was more aggressive due to family member presence and the resuscitation teams' performance was unaffected by the family's presence (Gunes and Zyback 2009).

A Physicians' consideration of family witnessed resuscitation was strongly based on past experiences. Physicians with less than 5 years of experience were unlikely to allow family presence (Feagen and Fisher 2011). Once emergency physicians' confidence, competency and experience increases they become more accepting towards family member presence (Critchell and Marik 2007). A study conducted by Chapman *et al.* (2012) reports that once the resuscitation team members have experienced family member presence they tend to endorse the practice. The resuscitation team views family member presence as an opportunity to promote open communication between the team and family members (Chapman *et al.* 2012). Nurses tend to have a more positive approach towards family witnessed resuscitation than physicians (Oman and Duran 2010 and Howlett *et al.* 2010). The emergency physician's demeanour, the nurses' experience and a calm and non-distressing family member was considered important (O'Malley, Barata and Snow 2014).

Compton *et al.* (2011) describe how both nurses and doctors who held specialities personally wanted their family members present and thus had greater family witnessed resuscitation experience. The more senior and experienced nurses and doctors report greater self-confidence in managing family member presence when compared to their younger counterparts (Chapman *et al.* 2012). In many healthcare settings family witnessed resuscitation is practiced on an informal basis depending on the healthcare providers' self-confidence (Chapman, Watkins, Bushby and Combs 2014). This could demonstrate the emergency department's commitment to patient or family centred care (Chapman *et al*. 2014).

2.2.2 Healthcare teams against family witnessed resuscitation

The resuscitation teams raised multiple concerns of occurrences of incidents that might cause distraction and elevated stress levels amongst the team during resuscitation (Critchell and Marik 2007). Emergency physicians complained that allowing family members to witness resuscitations slowed them down and that family members lose control of themselves and distract the team from what needs to be done therefore delaying resuscitative efforts (Critchell and Marik 2007). There was one incident where a witnessing family member had to be resuscitated (Critchell and Marik 2007). In a separate incident a mother pulled the emergency physician off her child while the emergency physician was attempting resuscitation (Critchell and Marik 2007). Having family member presence may have negative outcomes on the resuscitative process. In some instances family members asked the resuscitation team to stop resuscitative efforts prematurely (Dougal *et al.* 2011; Hassankhani *et al.* 2017; Oman and Duran 2010).

Nurses, trauma surgeons and emergency medicine physicians are reluctant to invite family members in during resuscitative efforts because it is not common practice, inappropriate, not beneficial for the patient and only beneficial towards the witnessing family member and not towards the resuscitation team (Critchell and Marik 2007). Healthcare providers did not like being watched and experienced stress when they were unsuccessful and this was a result of poor communication during the resuscitation (Chapman *et al.* 2012). Staff would not invite family presence if the family member's behaviour was considered unacceptable, there was limited space in the resuscitation area, environmental safety, attitudes, beliefs, knowledge, when it is against the family wishes or when there is inadequate support for family members (Chapman *et al.* 2012). Some family members did not request to witness the resuscitation. This may be due to family members not knowing that this option exists. The nurses also thought that the resuscitation process would be prolonged during family witnessed resuscitations

(Critchell and Marik 2007; Oman and Duran 2010; Badir and Sepit 2007 and Fulbrook *et al.* 2005).

2.2.3 Paramedics

Paramedics are the first to respond to traumatic and medical emergency resuscitations however little is known about their experiences regarding family witnessed resuscitations (Walker 2013). Emergency care practitioners developed respect for witnessing family members and bystanders because they were assisted by them whilst they were performing CPR (cardiopulmonary resuscitation) (Walker 2013 and Hassankhani *et al.* 2017). In contrast nurses view bystanders and witnessing family members as passive observers. However nurses and paramedics share the same views on witnessing family members being key informants (Walker 2013). When paramedics are compared to nurses' professional dominance emerged and witnessing family members were overlooked by a sense of clinical urgency (Walker 2013).

Failure of continuity of care in family presence was noticed by the paramedics and frustration with rules and regulations were evident (Walker 2013). Family member presence in a pre-hospital setting was viewed as natural (Walker 2013). Assessments were conducted by the paramedics on scene in order to determine suitability for family presence, to maintain a safe environment and support those who are performing lifesaving interventions (Walker 2013). In comparison the suitability for family member presence in the resuscitation room was determined by agreement from the resuscitation team, severity of patient injury, nature and severity of CPR (cardiopulmonary resuscitation) attempt, invasiveness of intervention, conduct of family member, space, time and support person for the witnessing family member (Walker 2013).

2.2.4 Staffing

One of the problems experienced by the nurses during family member presence was not having enough staff to provide emotional support for the witnessing family member

(Gunes and Zyback 2009). In South Africa we experience this problem on a daily basis and it becomes more apparent once we have concurrent resuscitations. Once there are concurrent resuscitations the witnessing family members would be left unattended.

2.2.5 Policies

The participants in a study conducted by Chapman *et al*. (2012) view policy development on family witnessed resuscitation as important. In the absence of a policy confusion and misunderstanding amongst the resuscitation team members are created. Policy development is considered to contribute towards a more family – centred approach (Madden and Condon 2007 and Dougal *et al.* 2011).

Only five percent of United States hospitals have written policies on family witnessed resuscitation. Many other studies have shown similar patterns (Feagen and Fisher 2011). Nurses who experienced family witnessed resuscitation and had more than one bad experience state that it may be due to a lack of family witnessed resuscitation exposure and the lack of policies or guidelines (Gunes and Zyback 2009; Critchell and Marik 2007).

Only a small number of the nurses have reported having a unit protocol that covered family presence. Some nurses indicate that this protocol does not exist (Madden and Condon 2007). Many healthcare settings practice family witnessed resuscitation on an informal basis and without any formal guidelines and policy (Chapman *et al.* 2014). However, this did not deter nurses from taking families to the patients' bedside during resuscitative efforts (Madden and Condon 2007).

This may result in conflict amongst emergency team members (Madden and Condon 2007). Emergency nurses prefer a written policy on the option of allowing family witnessed resuscitations (Madden and Condon 2007).

Advanced nurse practitioners are best suited for policy and guideline development as well as implementation but frank discussions needs to take place amongst the multidisciplinary healthcare providers before such policies are developed (Howlett *et al.* 2010).

2.2.6 Risk of litigation

Increased risk for litigation

The lack of support for the witnessing family member increases the risk for litigation (Fulbrook *et al.* 2005; Critchell and Marik 2007). Due to the emotional intensity of the resuscitation there are legal and ethical risks that follow. The dignity of the patient is lost during resuscitative efforts for example when a urinary catheter is inserted. There are confidentiality issues such as privileged medical information not known by family divulged in an emergency situation (Critchell and Marik 2007 and Chapman *et al.* 2014). Healthcare providers fear that family members could see and hear information and misinterpret healthcare providers' behaviour during resuscitation efforts all of which may lead to litigation (Meyers, Eichhorn, Guzzetta, Clark, Klein, Taliaferro and Calvin 2000).

Decreased risk for litigation

There are no publications reporting litigation therefore family members are gaining our trust through observing the resuscitation teams' actions (Dougal *et al*. 2011; Critchell and Marik 2007). According to Critchell and Marik (2007) family members who have witnessed resuscitation of their relatives that have died all thought that the resuscitation team had done everything possible (Saif *et al.* 2017). Litigation is less likely to occur if family members through observation believe that the resuscitation team has not been negligent or dismissive (Critchell and Marik 2007).

Many healthcare professionals are against family witnessed resuscitation because they fear litigation but advocates of family witnessed resuscitations believe that the legal risk

decreases (Gunes and Zyback 2009). Nurses would be influenced by their cultural and religious beliefs. This will either enhance or impede their view on family witnessed resuscitation (Gunes and Zyback 2009).

2.2.7 Feelings

Increased stress levels experienced during family witnessed resuscitation are voiced by the doctors more than the nurses. Some healthcare providers experience an increase in health care providers' performance anxiety, stress, some express fear of repercussions, family members' misinterpretation of the resuscitative process, and interference by the witnessing family member, emotional distress and emotional trauma (Oman and Duran 2010 and Saif, *et al.* 2017). However, resuscitation team members who had pre-hospital experiences portray less stress (Mortelmans, Cas, Van Hellemond and De Cauwer 2009). Nurses and physicians expressed discomfort when dealing with the family's grief and this contributes towards psychological stress of the resuscitation team (Howlett *et al.* 2010). Both nurses and paramedics felt that witnessing family members created feelings of unease and discomfort especially at times when they knew resuscitation attempts were unsuccessful and death was imminent (Walker 2010). The resuscitation teams also feel nervous, uncomfortable and distracted and this decreases the teams' focus on the resuscitation (Hassankhani *et al.* 2017). The resuscitation team fears witnessing family members may observe poor practice or mistakes and this increases the resuscitation teams' anxiety levels (Critchell and Marik 2007; Chapman *et al*. 2014 and Walker 2013). Families benefit emotionally by being supported and present especially at the time of death. Opportunities to say goodbye can facilitate the grieving process (Dougal *et al.* 2011). Providing support to the already distressed family member places an additional burden on staff members.

2.2.8 Educational program on family witnessed resuscitation

Inter and intra-professional collaboration is needed to deliver holistic emergency resuscitative care. This could be achieved by formal education of the multidisciplinary healthcare providers with regards to family witnessed resuscitation, currents laws that are in practice, hospital policy, implementation of such policies and strategies to guide us during family witnessed resuscitation (Walker 2013 and Madden and Condon 2007). A study by Dougal *et al.* (2011) states that the whole resuscitation team was taken for training on family witnessed resuscitation. The team was given informal education via visual reminders on the bulletin boards in the staff tea room and leaflets describing family presence were placed in high traffic areas throughout the emergency department (Dougal *et al.* 2011). If there were no family facilitators present family witnessed resuscitation could not be conducted (Dougal *et al.* 2011). The family facilitators' role was to support the witnessing family member, prepare the family with regards to what they should expect, give reasons for doing the procedures performed and staying with the family member throughout as these can be highly emotional times (Dougal *et al.* 2011). Family facilitators were required to have excellent communication skills, knowledge to make an initial assessment of the family's wishes for family presence and evaluate if the witnessing family member is ready to enter the resuscitation room (Dougal *et al.* 2011). The family facilitator seeks consent from the resuscitation team before allowing family members to witness resuscitative efforts (Dougal *et al.* 2011). The witnessing family sits outside the resuscitation room and it is expected of them not to interfere with the resuscitative proceedings (Dougal *et al.* 2011). The family facilitator then informs family members on a regular basis of the patients' condition (Dougal *et al.* 2011).

After physicians went for training on family witnessed resuscitation they felt more favourable towards family presence (Feagen and Fisher 2011). Physicians' also favoured family witnessed resuscitation as a patient and family right (Feagen and Fisher 2011).

The findings were similar when compared to the nurses after education on family witnessed resuscitation (Feagen and Fisher 2011). However, nurses' support for family witnessed resuscitation and as a right was much higher before undergoing the educative proceedings when compared to the physicians (Feagen and Fisher 2011).

There is a demand for more hospital and medically oriented television programmes with the aim to inform people and make the public more knowledgeable in the event of resuscitation (Fulbrook *et al.* 2005).

2.2.9. Family members perspectives on family witnessed resuscitation

Families not only support family witnessed resuscitation but they believe that they have the right to be present during resuscitative efforts (Madden and Condon 2007). Family members who have lost their relatives in the emergency rooms believed that they should have been allowed to be with their loved one when they desired and didn't want them to die with strangers and would like to be given the opportunity to be present during resuscitative attempts (Critchell and Marik 2007). Badir and Sepit (2007) argue that family members struggle with the decision to witness the resuscitation when offered the opportunity. Those who have witnessed invasive procedures would prefer to be present should the situation arise again because their emotional and psychological needs were met (Badir and Sepit 2007). Family members believed that their presence was beneficial and this was achieved by providing comfort and support towards the dying person and in turn their adjustment to death was made easier (Dougal *et al.* 2011; Critchell and Marik 2007; Madden and Condon 2007). Family members desire to be with their relative in order to provide them with the support needed whether it is emotional or physical comfort (Barreto *et al.* 2016).

Family members who had the opportunity to witness the resuscitation had positive experiences because it enabled them to stay connected and they did not experience any adverse psychological effects, lose control of themselves or disrupt the resuscitative

process (Badir and Sepit 2007 and Barreto *et al.* 2016). However at the Foote Hospital in Jackson, USA healthcare providers report instances where witnessing family members experienced uncontrollable grief and had to remove themselves from the resuscitation site for periods of time whilst others needed to remove themselves permanently (Critchell and Marik 2007 and James, Cottle and Hodge 2011). Compton *et al*. (2011) shows similar findings (Critchell and Marik 2007) of witnessed pre-hospital resuscitation attempts are associated with an increase in symptoms of posttraumatic stress disorder. A study by Compton *et al.* (2011) shows that after witnessing the resuscitation of their loved one 60 days later the participants started showing signs and symptoms of posttraumatic stress disorder and lasting depression. Some witnessing family members found it non-therapeutic, regretful and traumatic enough to haunt the surviving family members for the rest of their lives (Walker 2006; Critchell and Marik 2007). Family members emphasised the importance of screening, family preparation and identification of a family liaison person dedicated to talking to family members throughout the resuscitative process (Oczkowski *et al.* 2015). However, relatives who have elected to observe the resuscitative efforts have denied that the experience was excessively traumatic for them (Madden and Condon 2007). Many family members would rather witness the resuscitation than imagine the possibilities in the waiting area (Madden and Condon 2007).

Family members would like to help their loved ones, be informed of their loved ones' condition, be comforted, supported by the health care personnel and feel that their loved one is receiving the best care possible (Madden and Condon 2007). In some cases family members aided emergency care practitioners on the scene and at the back of the ambulance (Walker 2006). Family members viewed themselves as active participants, rather than the passive observers (Walker 2006). These family members were more concerned about their family members opening their eyes and ability to breathe rather than observing the errors of the resuscitation team (Walker 2006).

2.2.10 Patients perspective on family witnessed resuscitation

Family members in South Africa are often asked to excuse themselves from the resuscitation area whilst we are resuscitating their loved one. Patients want their family members present while they are being resuscitated. When family members were present patients felt safer, comforted and felt that their family member acted as advocates by providing the resuscitation team with important information (Dougal *et al.* 2011). Patients felt that by having their family member present they felt secure and their satisfaction towards the health care provided increased (Dougal *et al.* 2011). A study by Vaz *et al.* (2016) indicated that when parents of children are present during invasive procedures there is a reduction in stress and pain. The presence of parents also decreases negative behaviour during pain causing procedures.

Patients who were resuscitated and survived did not consider themselves violated by the presence of their family member (Critchell and Marik 2007). People who preferred family attendance were young and those who did not want family presence gave reasons such as embarrassment, psychological distress, and fear of getting in the way of the resuscitation team and an invasion of privacy (Critchell and Marik 2007 and Dougal *et al.* 2011). Patients believed that their family member may prefer to remember them when they were well (Dougal *et al.* 2011). Madden and Condon (2007) argue that family members prefer being at their loved ones beside while their loved one is being resuscitated.

2.3 SOUTH AFRICAN PERSPECTIVE ON FAMILY WITNESSED RESUSCITATION

In an emergency department were the researcher is currently employed family members are often asked to leave the resuscitation room and wait in the waiting area whilst the resuscitation is in progress. Some doctors never considered family witnessed resuscitation. In many instances family members have verbalised their experience of

isolation in a sense that often nobody provides them feedback and/or information post resuscitation until one of them enquires from a healthcare worker at the section about the outcomes. However, nurses would allow family members into the resuscitation area once the patient is stabilised. Inexperience in family witnessed resuscitation is caused by nurses constantly asking family members to leave the resuscitation area. There has been an international trend of allowing family member presence during the resuscitation of their relative for many years in other countries but not in South Africa (Gordon *et al.* 2011; Le Goff 2012; Goodenough and Brysiewicz 2003).

The common practice of excluding family members during the resuscitation of their loved one does not relate to child resuscitation, as the parents are always present during resuscitative efforts (Madden and Condon 2007). In South Africa we employ the same principles. The question is, why do we allow family members of children to witness resuscitative efforts and not family members of adults?

2.3.1 Policies

Policies regarding family witnessed resuscitation are non-existent (Goodenough and Brysiewicz 2003). Motsepe (2015) argues that policies and protocols do exist in South Africa but a small number of nurses are aware. Nursing in South Africa has its focus on a holistic patient and family centred care and can advocate for a family witnessed resuscitation policy. The clinical nurse specialists are best suited to develop and implement such a policy due to their knowledge and expertise (Gordon, Lorilla and Lehman 2012). The multi health care providers will have to engage in frank discussions with regards to implementing the family witnessed resuscitation policy (Howlett *et al.* 2010).

Nurses in South Africa prefer a written policy or guideline against family member presence because they feel exposed to litigation (De Beer and Moleki 2012). If or once this policy or guideline was/is passed nurses would like to have the witnessing family

member chaperoned and prepared for what they are about to witness (Le Goff 2012 and Motsepe 2015).

2.3.2 Staffing

The biggest problem in South Africa is staffing at all levels (de Beer, Brysiewicz and Bhengu 2011). The participant in a study conducted by Motsepe (2015) brought the shortage of nursing staff to the researchers' attention and mentioned that a dedicated resuscitation team member is required. Currently there is insufficient amount of staff members available to support family member presence during resuscitation (Motsepe 2015). Internationally healthcare providers raised similar concerns with regards to staffing levels.

2.3.3 Litigation

Family witnessed resuscitation increases the risk for litigation (De Beer and Moleki 2012). No studies to date have reported litigation due to family witnessed resuscitation (Gordon *et al.* 2011). Locally we practice family witnessed resuscitations. When it comes to paediatric patients we do this by allowing one of the parents of the child to be present while the resuscitation team perform lifesaving procedures.

2.3.4 Feelings

Emergency team members felt that the witnessing family member would be in the way because they are emotionally attached (De Beer and Moleki 2012). Resuscitation members raised concerns such as: posttraumatic stress for the witnessing family member, decisions may upset family member, too traumatic, bonds between family members and staff won't strengthen, family witnessed resuscitation won't help with the grieving process, performance anxiety, insecurities whilst being watched, stressful process for both staff and witnessing family member (De Beer and Moleki 2012; Motsepe 2015; Goodenough and Brysiewicz 2003).

If family witnessed resuscitation was offered nurses feel that the multidisciplinary team should take the decision on whether the family member should be present or not (Motsepe 2015).

2.3.5 Healthcare providers for family witnessed resuscitation

Small amount of nurses offered family member presence and report that family members do not request to be present. Nurses believe that family member presence prevents misconceptions regarding the resuscitative process (Motsepe 2015).

Once doctors gain experience they tend to open up to the idea of family witnessed resuscitation. However doctors who attended the ATLS (advanced trauma life support) and PALS (paediatric advanced life support) course would endorse family witnessed resuscitation (Gordon *et al.* 2011). One doctor reported a positive experience when exercising family witnessed resuscitation (Goodenough and Brysiewicz 2003).

By witnessing their loved one being resuscitated family members report that they were able to observe that everything possible was being done instead of being told that. By having family member presence it provides the witnessing family member with closure (De Beer and Moleki 2012).

2.3.6 Healthcare providers against family witnessed resuscitation

Emergency staff report incidences when family members requested to be present during the resuscitation process and some were reluctant to leave when asked to (Goodenough and Brysiewicz 2003). During the resuscitation one of the witnessing family member interfered with the process when they realised that resuscitative efforts were being terminated. Emergency staff members didn't like the idea of family witnessed resuscitation (Goodenough and Brysiewicz 2003). A study by Le Goff (2012) reveals that nurses who refuse family member presence during resuscitative efforts are insecure and lack confidence in their abilities.

Emergency staff members are concerned with the nature of the proceedings during the resuscitation such as invasive procedures, decrease in work space, no benefit for the witnessing family member, confidentiality of patient is lost, tension between staff members, not beneficial, inadequate staffing levels, social media publications regarding the witnessed resuscitation, complaints, exposure of inadequacy, physical interference, unsuccessful resuscitation attempts blamed on resuscitation team members, misconception regarding the resuscitative process, prolonged resuscitative efforts, resuscitation process being less effect and witnessing family members getting in the way (De Beer and Moleki 2012; Le Goff 2012; Motsepe 2015; Goodenough and Brysiewicz 2003).

Some nurses experienced family member presence but only a few had positive experiences. Nurses prefer if family witnessed resuscitation was not made an option. Nurses report that the reluctance of doctors remains high (Motsepe 2015).

Local doctors share the same concerns with regards to family witnessed resuscitation for example: cohesiveness of the resuscitation team hinders performance of the resuscitation team, performance anxiety when a witnessing family member has a medical background and being critically assessed by the witnessing family member (Goodenough and Brysiewicz 2003).

2.3.7 Education

Lack of knowledge among staff members on family witnessed resuscitation makes this option remain unexplored and new (Goodenough and Brysiewicz 2003). Policy development as well as an educational programme during under graduate and postgraduate training is required (Motsepe 2015; Goodenough and Brysiewicz 2003 and Gordon *et al*. 2011). The public are becoming more aware of resuscitations due to television shows which serves as an educative medium (Le Goff 2012).

2.4 SYNTHESIS OF LITERATURE

In this literature review, there was an overview of numerous studies on family witnessed resuscitations. The results of several studies show that globally family witnessed resuscitation remains a controversial issue. Internationally this creates conflicts amongst healthcare providers. Although internationally provision has been made for witnessing family member however locally we have made no such provision.

Both locally and internationally policies on family member presence exist however locally nurses prefer a policy against family member presence.

Internationally the multidisciplinary team experiences performance anxiety, fear of repercussions, interference from the witnessing family member, fear that poor practice may be observed, feel burdened due to the support required, emotional distress and trauma. Locally the multidisciplinary team raised multiple concerns such as: posttraumatic stress for the witnessing family member, decisions may upset family member, too traumatic, bonds between family members and staff won't strengthen, and family witnessed resuscitation won't help with the grieving process, performance anxiety, insecurities whilst being watched, stressful process for both staff and witnessing family member.

Internationally an educational programme was developed on family member presence and medically oriented television programmes exist to make the public more knowledgeable but locally no educational programme regarding family member presence exists.

Locally no studies have been done on the extent of family members wanting to be present during resuscitative efforts. However, internationally family members believe it's their right to be present during resuscitative efforts. Internationally studies show that some witnessing family members would witness their loved one being resuscitated should the need arise again. Some family members aided paramedics during

resuscitative efforts. Witnessing family members were concerned about loved one's ability to open their eyes and breathe.

Internationally post resuscitation patients participated in a study, described wanting their family members present because they felt safer, comforted and they felt advocated for. Post resuscitated patients who didn't want family members present gave the following reasons: psychological distress, fear of getting in the way and invasion of privacy and want to be remembered when they were well.

2.5 SUMMARY

Chapter two provided the literature review of both international and local views and understanding on family member presence during resuscitative efforts. Chapter three represents the research methods used to conduct this study.

CHAPTER THREE

RESEARCH DESIGN AND METHODS

3.1 INTRODUCTION

The previous chapter discussed the literature. This chapter presents the research methods and includes research design, the research context, population, sample, the inclusion criteria, data collection, a description of the instrument used in the data collection including measures of trustworthiness of the instrument and the ethical procedures followed.

3.2 RESEARCH DESIGN

A qualitative, exploratory, descriptive and contextual design was proposed for this study to explore the perceptions of healthcare providers on family presence during the resuscitation of a relative in an emergency department in a private hospital in Johannesburg. This research method was chosen to address a specific research question and to fill an empirical gap in the literature about the South African context.

3.2.1 Qualitative research

According to Grove, Burns and Gray (2013:57), “qualitative research is a scholarly approach to describe life experiences from the perspective of the persons involved.” The qualitative research design gives a better understanding towards the subjective human experience in order to increase our knowledge and guide nursing practice (Grove *et al*. 2013). This research design increases our understanding of a phenomenon of interest (Grove *et al*. 2013). According to Grove *et al.* (2013:57), “qualitative research is conducted within a naturalistic holistic framework, which allows one to explore depth,

richness, and complexity inherent in the lives of human beings." This process allows us to understand the healthcare provider's views, guide emerging theories and builds knowledge as nurses (Grove *et al*. 2013).

3.2.2 Exploratory – qualitative research

According to Grove *et al.* (2013:66) "an exploratory research entails investigating or describing a situation or phenomena" in order to establish their perceptions or understandings. For example, exploration of healthcare provider's perceptions and understandings on family member presence during resuscitation attempt.

3.2.3 Descriptive - qualitative research

"A descriptive qualitative study is conducted to address an issue or a problem in need of a solution" (Grove *et al.* 2013:76). For example, family witnessed resuscitation is a global phenomenon but not in South Africa. Interviews were conducted by the researcher in order to gain the perspective as to why we have not implemented this practice in a South African context.

3.2.4 Contextual Design

According to Grove *et al.* (2013: 66), "contextual research is defined as findings valid within the time space and value context in which the study is being done." This study is focused on the exploration of the views of healthcare providers on family witnessed resuscitation in an emergency department.

3.3 RESEARCH CONTEXT

The study was done in the emergency department of a private hospital, where the researcher is currently employed, which is located just off a busy motorway interchange, which is an extremely busy region in Gauteng. This private hospital has a 24 hour level

two emergency department. The emergency and trauma section is a 17 bedded unit, four beds of which are resuscitation beds. The other 13 beds consist of a surgical procedural room, a sexual assault room, a plaster of paris room and an eight bedded out patients section. In this section of the hospital from 2000 to 3000 patients per month are treated. This is on average between 66 to 100 patients per day. More than 25% of these cases are acute or critical in nature and this often results in three to four resuscitations per day sometimes simultaneously.

3.4 POPULATION

The population for this study included experienced and trauma trained registered nurses, trauma surgeons, emergency medicine physicians, doctors, radiographers and paramedics working in the emergency department at a private hospital in Gauteng.

3.5 SAMPLE AND SAMPLING

According to Grove *et al.* (2013:357), "purposive sampling is the recruitment of participants as sources of data that can provide and expand upon the data needed to achieve the study aims and objectives." Trauma surgeons and emergency doctors, experienced and trauma trained nurses, radiographers and paramedics. This sampling method enabled the researcher to recruit specific persons who were potentially information-rich participants who were able to share their views from their experiences on the topic under investigation. A number of healthcare providers were targeted and the actual sample size was determined by saturation of information during data collection (Polit and Beck 2012). Saturation of information was established on account of the number of interviews that generate no new ideas (De Vos 2005). A total of 24 (n = 24) participants were identified and interviewed.

For this study, the inclusion criteria of healthcare provider participants will be as follows:

Nurses who hold an additional clinical qualification and registration with the South African Nursing Council in the category of trauma and emergency nursing,

- Experienced nurses who is currently registered with the South African Health Nursing Council who is currently employed in the emergency department and have a special interest in the field of study,
- Medical doctors who have current registration with the South African Health Professional Council as a trauma and emergency specialist,
- Medical doctors registered with the South African Health Professions Council without specialist training and qualification who provides a service to the emergency department and have a special interest in the field of study,
- Radiographers registered with the South African Health Professions Council who provide a service to the emergency department and have a special interest in the field of study,
- Healthcare providers (nurses, paramedics, doctors and radiographers) who have been qualified for at least 5 years and
- Paramedics were included as they also provide some services in the emergency department.

3.6 DATA COLLECTION

According to Grove *et al.* (2013:268), “data collection is basically selecting participants and gathering data from them.” In this study data was collected with the aid of a voice recorder and scribing of field notes. Before collecting data from participants a pilot test was conducted in order to clarify any confusion and develop strategies when challenges arise whilst collecting data.

According to Grove *et al.* (2013), there four tasks required when collecting data:

- Participants were selected
- Data were collected in a consistent manner
- The study design was adhered too
- The solving of problems that threaten to disrupt the study" was conducted

The participants were selected by using purposive sampling in order to expand upon the data required to conduct this study. Data was collected by interviewing the participants with a voice recorder and by writing field notes during the interview. A qualitative, exploratory, descriptive and contextual design was chosen to address a specific research question and to fill an empirical gap in the literature about the South African context. The final step was adhered to by conducting a pilot test with the research supervisors whereby a scenario was created with possible problems, interruptions or irregularities with the questions asked that may arise during data collection.

The figure below is a diagrammatic representation of the four tasks used to collect data.

Figure 3.1: A diagrammatic overview of four tasks required when collecting data (Grove *et al.* 2013)

3.6.1 Instrument

Data was collected by using a semi-structured one-on-one interview design with the participants.

3.6.2 Procedure

The research protocol was submitted for peer review to the Department of Nursing Education and the feasibility of the study was assessed. The research protocol and procedures was submitted to the University's Postgraduate Committee for permission to conduct the study. Clearance from the post graduate committee and committee for Human Research Ethics Committee (Medical) of the University of the Witwatersrand was obtained (**M140875**). Clearance and permission was granted to conduct this study at the private healthcare provider (Appendix H). Potential participants were identified and participated in this study. Written consent to participate in this study was explained and signed by the participants (Appendix D). All participants received written information and consent forms relating to the study (Appendices D, E and F) and could withdraw at any time without any adverse consequences. The participants were made aware of audio taping devices and the purposes thereof. Written consent for the use of the tape recording device was obtained (Appendix F). In addition, verbal consent (captured on audiotape) was obtained. The interview then commenced and semi-structured one-to-one interviews with the participants was used to collect data. One open ended question was asked with additional probes if necessary. The interview was conducted with the participant and field notes were taken. In addition, contact details of the participants were obtained should a follow-up interview be needed for clarification. The first interview was conducted as the pilot interview together with the research supervisors to allow clarification of questions and interviewing techniques. Interviews were tape recorded and transcribed using pseudo-names and field notes were made on all the interviews. The participants' names were replaced with pseudonyms in the form of researcher generated

codes by doing so confidentiality will be attained but not anonymity of the participants. Hard copies were kept under lock and key, and only the researcher and supervisors had access to the hard copies. When the study and data collected is electronic it is stored on a password protected computer and laptop.

3.7 DATA ANALYSIS

After recording and accurate transcribing of the interviews together with the field notes of observed behaviour, the data analysis was completed. The Tesch's(1990) method of qualitative data analysis (in Creswell, 2009) was followed.

- Read through all transcripts and field notes thoroughly to get an overview. Highlight important ideas.
- Read through each interview and question the objective and underlying meaning.
- Distinguish between main, unique and other themes.
- Code themes and highlight themes throughout the text.
- Describe and categorise themes and identify relationships between them.
- Assemble data from text into identified categories.
- Analyse the data.
- If necessary, data can be recoded and reanalysed.

The figure below is a diagrammatic representation of the steps used or followed to analyse the data, distinguish other and unique themes as well as categorise and identify the relationship between them.

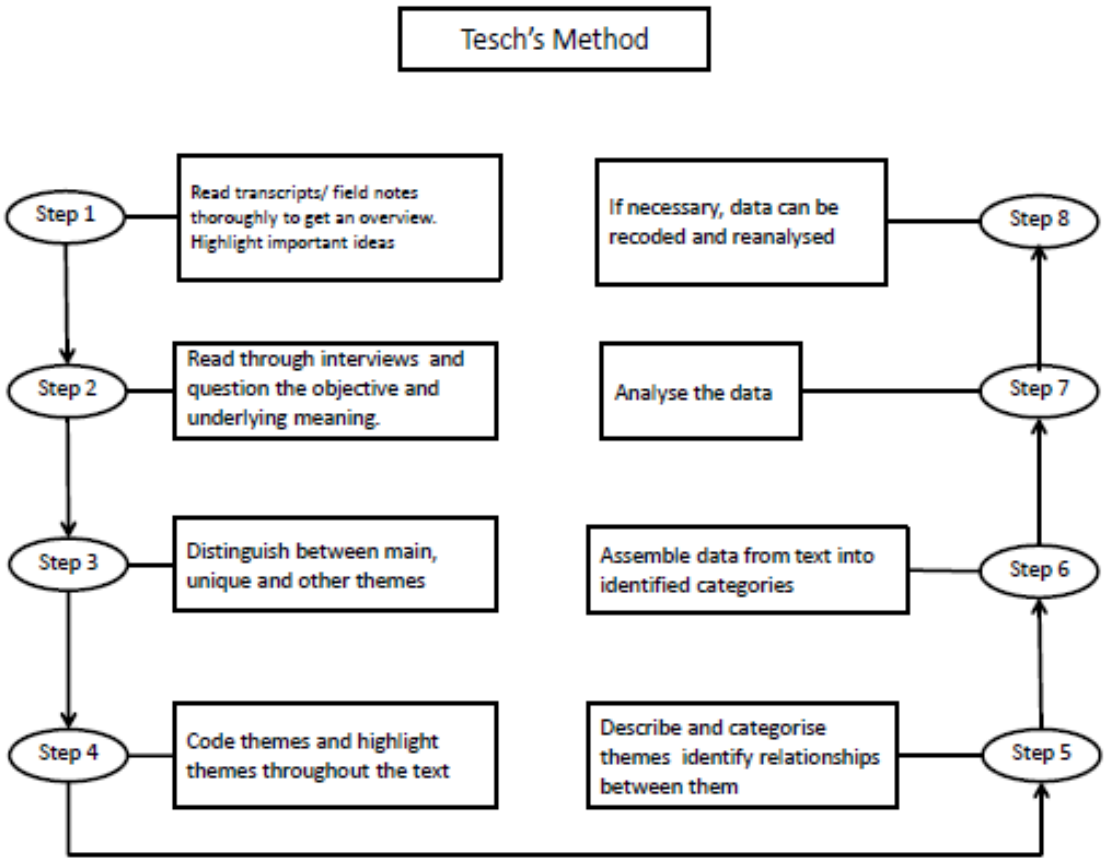

Figure 3.2: A diagrammatic overview of Tesch's method of data collection (1990) (in Creswell 2009)

Reading and re-reading of each line of the transcriptions was done and the coding process was started, often referred to as open coding (De Vos 2005). This immersion is referred to as dwelling with the data (Grove *et al.* 2013). In the next level of analysis themes and sub–themes (Strauss and Corbin 1990 cited in Patton 2002; De Vos 2005 and Patton 2002) were identified with a view to generating theoretical concepts by going back to the literature review (Patton 2002).

3.8. PILOT TEST

According to Grove *et al.* (2013), a pilot test was conducted in order to identify problems the researcher might encounter while data was being collected. A pilot test helped the researcher develop strategies when problems arose during data collection. The first interview was conducted as the pilot interview together with the research supervisors to allow the researcher to clarify questions and interviewing techniques. Interviews were tape recorded, and transcribed using pseudo-names and field notes were made on all the interviews.

Special attention was paid towards how long it would take the researcher to interview the participant, obtain informed consent and collect the required data. On average the interviewing process would take 20 minutes per participant. The participant were asked to identify any questions asked that may have been confusing or unclear. Based on the outcomes of the pilot test, the researcher modified the data collecting methods and interview question in order to ensure the feasibility, validity, and reliability of the study (see Appendix G for the final interview questions).

3.9 STRATEGIES TO ENHANCE TRUSTWORTHINESS

Trustworthiness refers to the degree of confidence qualitative researchers have in their data. The method of Lincoln and Guba (1985), which includes credibility, dependability, conformability and transferability, will be utilised to ensure trustworthiness of the findings in this study (Polit and Beck 2012).

The validity and reliability of the instrument was determined once the researcher recruited and interviewed the participant. Once this was accomplished the participant helped me to identify problems with regards to the questions asked during interview or aspects during the interviewing process that confused the participant or aspects that was

unclear. Hard copies were kept under lock and key, and only the researcher and supervisors had access to the hard copies. When the study and data collected is electronic it is stored on a password protected computer and laptop.

3.9.1 Credibility

The researcher watched resuscitations with keen interest over the years of trauma and emergency nursing practice. This has assisted in formulating this research in the researchers mind as the views of health care providers were explored. The researcher had frequent member checks and peer review with regard to relevant literature searches, data collection and analysis. This research is relevant to emergency nursing, as it has not been researched in this particular research context.

3.9.2 Transferability

“Transferability refers to the generalisability or external validity of study” (Lincoln and Guba (1985: 290). The researcher provided a description of the specific research context and process. This research was carried out in the private sector which may differ from the public sector and therefor might only be transferable in the private sector.

3.9.3 Dependability

The researcher reviewed the literature on similar studies conducted in similar contexts. The researcher left a decision trail about the theoretical, methodological and analytic choices used throughout the study.

3.9.4 Confirmability

“Confirmability captures the traditional concept of objectivity, and if the results of the study can be confirmed by another” (Lincoln and Guba, 1985:290). The researcher provided an audit trail, by keeping track of all references used: audiocassettes made, transcripts of interviews with accompanying field notes and all rough copies of data

analysis for peer review and member checking in order to validate how the results will be obtained.

3.10 ETHICAL CONSIDERATIONS

Ethical issues in nursing research are standards of ethical conduct intended to safeguard the study subjects and integrity of the research process (Polit and Beck 2012). The following ethical requirements were taken into consideration during and prior to the study.

Protocols were submitted for peer review to the Department of Nursing Education to assess the feasibility of the study. Research protocols and procedures were submitted to the University's Postgraduate Committee for permission to conduct the study. Clearance to conduct research to the Human Research Ethics Committee (Medical) of the University of the Witwatersrand was granted (**M140875**). Permission was granted from the private healthcare provider, where the researcher is currently employed, to conduct the study (refer Appendix H). Written consent to participate in the study was explained and signed. All participants received written information and consent forms relating the study, and may withdraw at any time without adverse consequences (refer Appendix D and Appendix E). Replacing participant's names with pseudonyms in the form of researcher generated codes ensured confidentiality will be attained but not anonymity of the participants. Participants were made aware of audio taping devices, and the purposes thereof. Written consent was obtained for the use of the tape recording device. In addition, verbal consent (captured on audiotape) was obtained (refer Appendix F). Hard copies were kept under lock and key, and only the researcher and supervisors had access to the hard copies. When the study and data collected is electronic it is stored on a password protected computer and laptop.

3.11 SUMMARY

This chapter described the research methodology. The research design was selected to appropriately meet the study's purpose and objectives. An in-depth description of the instrument for data collection was provided. A pilot test was conducted at the main study site using the interview schedule. The interview schedule successfully met the study's objectives. The following chapter presents data analysis and research findings.

CHAPTER FOUR

FINDINGS

4.1 INTRODUCTION

This chapter represents the findings of this study. Themes and sub-themes that emerged whilst analysing data are represented and discussed in this chapter. The discussion in this chapter was supported with literature so that the findings are meaningful.

For this study, a total number of 24 healthcare providers were interviewed and their characteristics are as follows:

- Five registered nurses were interviewed. All the nurses interviewed were female participants. There was one registered nurse who had 20 years of trauma and emergency experience however the other participants interviewed obtained a post basic diploma in trauma and emergency care. The clinical nurse specialists had five to fifteen years of nursing experience,
- five medical doctors were interviewed. Two of the five interviewed were males. There was one doctor who obtained a post basic qualification (emergency medicine physician) who has 10 years of experience. The other medical doctors interviewed are without specialist training and qualification who provides a service to the emergency department and have varied experience of 10 to 15 years,
- seven radiographers were interviewed. All the radiographers interviewed were female. None of the radiographers interviewed have specialist training and qualification but provide a service to the emergency department. The radiographers who were interviewed varied in their work experience from five to thirty years,
- three trauma surgeons were interviewed. All the trauma surgeons interviewed were males and have varied experience of 10 to 20 years and

- five paramedics were interviewed. Three of the five paramedics interviewed were females. None of the paramedics interviewed have specialist training and qualification but provide a service to the emergency department. The radiographers interviewed varied in experience from five to thirty years of working experience.

4.2 SUMMARY OF THEMES

Discussions between the researcher and supervisor resulted in the extraction of the themes and sub-themes. Themes and sub-themes generated are tabulated and identified below

Table 4.1: Emerging themes and sub-themes

Themes	**Sub-themes**
Perceptions of healthcare providers	• Lack of experience • Lack of space
Buy in towards family member presence	• Chronic illness • Resuscitation - I give it my all
Concerns from healthcare providers	• Responsibility towards patient • Responsibility towards family • Malpractice potential
Family emotions as perceived by healthcare providers	• Fear • Closure
Balancing your act	

Codes were given to the participants and indicated the qualification and number allocated. Trauma trained nurses (TTRN) and experienced registered nurses (RN), radiographers (R) with more than five years of experience, emergency care practitioners (paramedics = E), trauma surgeons (S) as well as doctors with five years or more emergency medicine experience (D).

The emerging themes and sub-themes generated by the researcher and the supervisor will be discussed in the following sections.

4.3 THEMES AND SUB-THEMES

Themes and sub-themes are a recurring regularity emerging from an analysis of qualitative data (Polit and Beck 2012). During this study five themes and nine sub-themes were produced from perceptions of emergency room staff on family witnessed resuscitation to balancing your act and sub themes from lack of experience to closure.

4.3.1 Theme 1: Perceptions of healthcare providers

It's in the way in which the resuscitation team understands or interpret having a family member present whilst performing life-saving interventions.

Lack of experience

Lack of experience during CPR may be one of the many reasons as to why we are not practicing family witnessed resuscitation. Not all healthcare providers present at resuscitation share the same qualifications and experience globally. Family witnessed resuscitation remains a controversial issue amongst the multidisciplinary healthcare providers and this may be due to attitude, beliefs and knowledge despite studies reporting lived experiences (Badir and Sepit 2007). In this study family witnessed resuscitation is viewed similarly.

When participants were asked to share their opinions on family witnessed resuscitation, there were different concerns about the experience of the team members.

T3: "Some staff members are not even experienced."

D3: "I won't feel comfortable."

R4: "I don't want the family to be there and to see what I am doing…. that's what."

Once a patient triaged as a priority one (P1) is placed in the resuscitation area the attending resuscitation team members need to assess and treat the patient according to the protocols set out in the unit. The attending healthcare providers are required to know how to initiate inotropic support, assist the emergency medicine physician whilst inserting an A-line (arterial line for invasive blood pressure monitoring), intercostal drain or central line and with intubation. Healthcare providers are also required to know how to operate emergency equipment such as defibrillators and electrocardiograms. Experience or lack thereof plays an important role and may influence the patient outcome.

Lack of space

Healthcare providers also raised a concern about lack of space. Generally the size of the resuscitation area does not cater for large numbers of people and by having family members present work space is significantly decreased. This is evidenced by the following statements:

R7: "With the adults it's a little bit all over the place."

S3: "It creates I mean already a bit clustered environment decreasing the space."

R3: "We don't always have the space."

E3: "Very small resus [area]."

The resuscitation area needs to be free of clutter because team members could get hurt by tripping and falling over equipment. When there are more than six people in the resuscitation area access to the patient and equipment is limited (American Heart Association 2016). Manoeuvrability around the resuscitation bed is rather limited as well. The resuscitation area is not big enough to accommodate a witnessing family member.

Summary of theme one

Theme one consisted out of two sub-themes namely lack of experience and lack of space. Participants lack exposure of having family members present during resuscitative efforts. Participants also state that all healthcare providers do not share the same qualifications or experience globally. Participants cannot accommodate large amounts of people in the resuscitation area because space and access to the patient is limited.

4.3.2 Theme 2: Buy in towards family member presence

In this study some healthcare providers preferred family member presence and saw the importance and advantages thereof. Some of the team members would like the witnessing family member to observe the amount of effort that goes into a resuscitation attempt.

Resuscitation- I give it my all

Accompanying family members are often asked to wait in the waiting area whilst the resuscitation team perform life-saving interventions. A couple of minutes later family members enquire about their loved one's condition. Nurses and paramedics who worked in the emergency department believed that the family should be present because they would be able to observe the effort put into the resuscitation attempt. The team felt that if the witnessing family member observes the amount of effort that goes into a resuscitation attempt then only will they realise that the resuscitation team members have done their best to revive their relative.

T1: "It's very important so that they can see that you do your best."

T2: "I think it's good for them to see exactly what happened and the circumstances in which it happened."

E4: "I think it's a good thing that you get the family involved it's their family member anyway."

Family member presence during resuscitative efforts gave the witnessing family member a realistic view on resuscitative attempts and even the possibility of death (Walker 2006). In a study conducted by Hassankhani *et al.* (2017) participants wanted family members present so that efforts by the resuscitation team could be observed and in turn improve their overall satisfaction regardless of the resuscitation outcomes.

Chronic illness

The view about family witnessed resuscitation changes and is accepted by the resuscitation team if the patient is chronically ill. All the participants see the benefits in family member presence when the patients are chronically ill and do not respond to any other form of medical treatment.

S2: "I can see benefits."

R2: "I really feel completely comfortable with that. I think it's important that they see."

D1: "An old chronically sick person who the family stays with while they die… [a] *completely different thing. I think that that's important."*

They do not however agree that there is a benefit in the family witnessing trauma resuscitation. This was shown by the following responses:

S2: "I think in the acute trauma setting I think it's [thinking] I would not enjoy having family members present and the reason why is that [pauses] .....What happens if one has a look at the patient and one decides straight away that it is a no go situation?"

The participant goes on to say

S1: [The] *family is going to want us to do whatever we can and we have issues convincing nursing staff sometimes that we have to stop at this point."*

R2: "I think it's good for them to see exactly what happened and the circumstances in which it happened."

R1: "Before you take them in tell [them] *how the patient is, tell them what you are doing."*

D4: "I would I would try and be as empathetic as possible."

According to Gunes and Zyback (2009) therapeutic relationships with healthcare providers are developed through family member presence. The patients' satisfaction and outcomes may improve and promotion of mutual respect, honesty and dignity can take place.

The views of both the trauma surgeon and trauma trained and experienced registered nurse differs. Trauma trained nurses and paramedics would prefer to have family members present in any setting or situation but trauma surgeons and every other healthcare provider only wants family member presence if the patient is chronically ill. Trauma surgeons see no benefit from family members witnessing a resuscitation attempt in an acute trauma setting whereas some nurses do see the benefit. Nurses would like to explain to the witnessing family member in what condition their relative is in before allowing them to witness. These nurses do not say whether they would prefer to have the witnessing family member present in an acute trauma or medical setting.

The healthcare providers see benefit for both the witnessing family member and the resuscitation team. According to Critchell and Marik (2007), by family members witnessing their loved one being resuscitated they are able to see that everything was done in order to revive their loved one. Witnessing family members also provide the resuscitation team with important medical history (Chapman *et al.* 2012). In this study

some healthcare practitioners view family member presence as a positive experience for both the witnessing family member and resuscitation team members. One of the healthcare providers viewed family member presence as a right of the patient.

Summary of theme two

Two sub-themes emerged namely: gave it my all and chronic illness. Respondents want family members to witness and appreciate the amount of effort that goes into a resuscitation attempt however the views of the trauma surgeon and trauma train nurse differ.

4.3.3 Theme 3: Concerns from healthcare providers

In this study resuscitation team members are concerned about witnessing family members interrupting the closed loop communication during a resuscitation attempt. By doing so the resuscitation outcomes are poor (AHA 2016).

Responsibility towards the patient

The healthcare providers in this study have multiple concerns with regards to introducing a witnessing family member into the resuscitation room. In this study the healthcare providers work by using a closed loop communication approach (AHA 2016). There were concerns regarding a witnessing family member interfering with the team members and leader conducting the resuscitation. This might result in the team loosing track of the algorithm. There were strong feelings about this evidenced by the following statements

S1: "Asking questions all the time."

S3: "Disrupting the processes."

R6: "Ruining the work flow."

E4: "You get the family member that gets involved to the point where they become obstructive."

D3: "It's a distraction, I can't follow, I can't give proper instructions to the to the team members."

Literature tells how emergency physicians complained that allowing a family member to witness resuscitation slowed them down and felt that the family member loses control of themselves and distracts the team from what needs to be done therefore delaying resuscitative efforts (Critchell and Marik 2007 and Hassankhani, *et al.* 2017). There was an incident where a witnessing family member had to be resuscitated (Critchell and Marik 2007). In a separate incident a mother pulled the emergency physician off her child while the emergency physician was attempting resuscitation (Critchell and Marik 2007).

Once there is interference from the witnessing family member the resuscitation team members and leader lose focus on the task at hand because the team functions on a sequence or algorithm that requires frequent administration of drugs and defibrillation (AHA 2016).

The healthcare providers have raised many concerns regarding family member presence. Family members may not understand the procedure of resuscitation and perceive the resuscitative effort in an incorrect manner. Healthcare providers believed that the witnessing family member may disrupt the process and this could lead to poor resuscitative outcomes.

The healthcare provider's responsibility is to maintain the patient's airway, breathing, circulation and administration of medication in order to recover spontaneous circulation if possible. The healthcare providers are aware of this and said

D4: "I would make sure that I am able to sustain the patients' life."

D1: "You do what you have to for the benefit of the patient."

If this is not successful then the resuscitation effort is terminated. At times trauma doctors have to terminate resuscitation particularly when the patient fails to respond due to the

extent of injuries. Witnessing family members may not understand the rationale behind the withdrawal of treatment

S1: "You take decisions that may not be understandable [understood by] *to the family."*

R4: "The difficult thing to do is to call a resus [resuscitation] *off."*

Healthcare providers may need to take a decision that a witnessing family member may misconceive or misinterpret.

Responsibility towards the family

In this study healthcare providers preferred family members to wait in a dedicated area for updates, treatment given and plans for further management of the patient's present condition. If the resuscitation was unsuccessful family members can be placed in a cubicle, refreshments are then served and the trauma counsellor is then called out. Once the counsellor arrives the family members are addressed by the healthcare providers.

The participants in this study had many different views.

D2: "I think a good time to bring the family in would be once it's a bit more controlled."

D3: "Until further notice, we inform them what we found and what needs to be done."

D1: "Ethically we are obliged to allow them to be present if they would like to be."

James *et al.* (2011) and Critchell and Marik (2007), describe how there were times when the witnessing family member had to remove themselves from the resuscitation site for periods of time whilst others needed to remove themselves permanently if the circumstances surrounding the resuscitation environment became unbearable.

The nature of the resuscitation can be brutal depending on the type of intervention required to sustain life. The multidisciplinary team members would prefer family members outside the resuscitation area and in the waiting area. Once the patient has been

stabilised the family member may come in to see their relative. However if family members insist on being present during the resuscitation the healthcare providers should not remove the witnessing family member. A witnessing family member shouldn't be left unattended during the resuscitation. A staff member is required to explain the proceedings.

Malpractice potential

Due to the nature of the resuscitation there are legal and ethical risks that follow. The dignity of the patient is lost during resuscitative efforts for example when we expose the chest. Healthcare providers fear that family members could see, hear information and learn healthcare providers' behaviour during resuscitation efforts which may lead to litigation (Meyers *et al.* 2000).

During the resuscitation process things don't always go according to plan. There may be an element of panic especially if the team leader is not very experienced. Healthcare providers are not equally qualified. There may be a perception amongst the team that a lack of confidence and thus uncertainty may lead to the possibility of a malpractice suit. Healthcare providers fear that the witnessing family member would be able to recognise incompetence and this would lead to litigation. However there are no reports of lawsuits suggesting such (Dougal *et al*. 2011; Critchell and Marik 2007). Many healthcare professionals are against family witnessed resuscitation because they fear litigation but advocates of family witnessed resuscitations believe that the legal risk decreases (Gunes and Zyback 2009). Litigation is less likely to occur if family members believe that the resuscitation team has not been negligent or dismissive (Gunes and Zayback 2009; Critchell and Marik 2007). The participants in this study were not convinced as shown in these statements.

D2: "With us paying medico legal fees etc we are hearing about cases, colleagues being sued all the time."

R7: "So I think people standing on the side lines watching can pick up all the mistakes and I think there will be a lot of come backs on that."

E3: "Parents always have to be there for the paediatric [laughs] anything from a medico legal point of view from an emotional point of view."

One participant felt differently

E4*: "If you are worried about law suit then your team is incompetent."*

Both nurses and paramedics felt that witnessing family members created feelings of unease and discomfort especially at times when they knew resuscitation attempts were unsuccessful and death was imminent. Healthcare providers also feel nervous, uncomfortable and distracted and this decreases the teams' focus on the resuscitation. Healthcare providers fears witnessing family members may observe poor practice or mistakes and this increases the resuscitation teams' anxiety levels (Howlett, *et al*. 2010; Chapman *et al.* 2014; Madden and Condon 2007).

Healthcare providers prefer family members to stay in the waiting area while the patient is being resuscitated and wait for updates. Once the patient has been stabilised family members are allowed into the resuscitation room. Healthcare providers are concerned about witnessing family members looking for mistakes during the resuscitation which may lead to legal repercussions. Healthcare providers fear that witnessing family members may misinterpret the resuscitation process and by doing so it exposes the team to litigation. Litigation tarnishes the hospital's reputation.

Summary of theme three

Three sub-themes emerged namely: responsibility towards patient, responsibility towards family and malpractice. Participants don't want family members present due to interference and loss of algorithm. Participants would prefer to have family members in the waiting area. Healthcare providers fear litigation due to malpractice.

4.3.4 Theme 4: Family emotions as perceived by healthcare providers

Emotions are heightened or amplified when a family member or relative is admitted to the emergency department for any traumatic or medical condition that is life threatening. Family members often react in this manner due to concern.

R3: "I don't like to see the emotion on the family's faces. I don't. It upsets me and I mean I am there to do my work not there to get involved in the emotional side of it. There are people who can do that."

D1: "It's too stressful for the family."

R7: "The shock of it all to the family. I think it's greater than them knowing that the team is actually busy with the person without them actually seeing it."

By allowing family member presence healthcare providers experience an increase in anxiety, increased amount of stress, complaints from relatives, emotional trauma, health care providers' performance anxiety, misinterpretation of the resuscitative process, interference by the witnessing family member and emotional distress (Oman and Duran 2010 and Saif *et al*. 2017).

Healthcare providers do not want family member presence due to the nature of the resuscitation. Participants prefer not to deal with the witnessing family member's emotion and don't want to be observed performing their tasks. Healthcare providers feel that the environment is too stressful for both the team and the witnessing family member and doesn't want witnessing family members to observe mistakes or miscommunication amongst team members.

Fear

Fear is experienced by both healthcare providers and witnessing family members. The fear experienced by family member is that of losing their loved one. Fear experienced by

the emergency team is of the witnessing family member losing control of them. Healthcare provider's fear that if family members were given the opportunity to witness their loved one being resuscitated emotionally they would not be able to cope due to the nature of the intervention [resuscitation] and are likely to be left with traumatic memories.

Healthcare providers fear the most that the resuscitative efforts may be futile and the patient parishes. Team members also fear family members picking up their mistakes during resuscitative efforts.

TS1: "Is a stressful period of time for people and psychologically they may have issues later on."

TTRN1: "They can be aggressive; they can be emotional and they can subtract [distract] you to do your work as you will usually do it."

RN EXP: "Not only assault they become very vindictive."

Healthcare providers raised concerns such as posttraumatic stress for the witnessing family member decisions may upset the witnessing family member, the resuscitative proceeding being too traumatic, bonds between family members and staff won't strengthen, family witnessed resuscitation won't help with the grieving process, performance anxiety, insecurities whilst being watched, stressful process for both staff and witnessing family member (De Beer and Moleki 2012; Motsepe 2015; Goodenough and Brysiewicz 2003).

Healthcare providers fear that witnessing family members may be left with traumatic memories and some family members may become aggressive and emotional, which is distracting.

Closure

"Closing a closed condition" (Hawkins, 1979:112). Some nurses felt that by excluding family members from the resuscitation site made it psychologically difficult for the family to come to terms with the loss of the patient if the resuscitation was unsuccessful. In the event of an unsuccessful resuscitation attempt family witnessed resuscitation would have positive benefits during the grieving process (Fulbrook *et al.* 2005 and Vaz *et al.* 2016).

D1: "Personally I don't think it helps at all in somebody's psychological closure of a loved one."

R2: "Instead of wondering why and what they did and they didn't do, this you know might bring closure."

R2: "I feel they should be given the opportunity. Ja [Yes] because I do think that for a lot of people it would give them closure."

E5: "They go through those stages of denial, anger, bargaining, depression, and accepting It seems to me in my experience and they get through that quicker."

Family member presence decreases anxiety and fear and in turn leads to higher level of satisfaction with the care provided. Families benefits emotionally by being supportive and present especially at the time of death. Opportunities to say bye facilitates the grieving process (Dougal *et al.* 2011). Those who have witnessed invasive procedures would prefer to be present should the situation arise again because their emotional and psychological needs were met (Badir and Sepit 2007). Family members believed that their presence was beneficial and this was achieved by providing comfort and support towards the dying person and in turn their adjustment to death was made easier (Dougal *et al.* 2011; Critchell and Marik 2007; Madden and Condon 2007).

In the event of an unsuccessful resuscitation attempt witnessing family members' acceptance to death will be easier. Family witness resuscitation aids the grieving process. This provides higher levels of satisfaction towards the healthcare provided.

Summary of theme four

Two sub-themes emerged namely: fear and closure. By having family members present healthcare providers would feel anxious and stressed. Respondents fear that family members may become aggressive, emotional and left with traumatic memories due to the nature of the resuscitation. Family member presence facilitates the grieving process.

4.3.5 Theme 5: Balancing your act

In the emergency department balance whilst resuscitating a patient is achieved in some units by excluding family members from the resuscitation room. Any member of the resuscitation team that is required to accompany the witnessing family member is also needed to assist during the resuscitation therefor there is no one accompanying the witnessing family member. Healthcare providers prefer to settle or stabilise the patient and then call in the accompanying family member.

TTRN4: "I will have to assign [them] *to somebody and put them in the corner watching from that corner."*

D4: "I feel that particular responsibility should be delegated to somebody responsible who understands what is actually happening on scene. To reassure the family on the side to tell them that everything is going to be okay, to tell them everything possible is being done for the patient at the time right and just to allay those anxieties."

R6: "They should just sit in the waiting area until maybe the patient is stable; the patient is okay or well enough when everybody has done their job."

Healthcare providers would not invite a family member if their behaviour was considered unacceptable, limited space in the resuscitation area, environmental safety, attitudes, beliefs, knowledge, when it is against the family's wishes or when there is inadequate support for family members (Chapman *et al.* 2012 and Saif *et al.* 2017).

Healthcare providers prefer family members in dedicated waiting area, often enough the healthcare providers have no dedicated person accompanying the witnessing family member therefor leaving them unattended. The participants prefer to stabilise the patient first and once the patient is stabilised it is then when the team invites the family members in. The participants found it difficult to attend to both the witnessing family member and the patient.

Summary of theme four

Participants prefer to stabilise the patient before inviting the family members into the resuscitation area.

4.4 SUMMARY

Some team members see the benefit of having witnessing family during resuscitation. Others only see benefit when the patient is chronically ill. Some healthcare providers found witnessing a resuscitation attempt beneficial because it allows the witnessing family members to observe the amount of effort it takes to save their loved one. One of the participants found it beneficial to call the family member when the resuscitation was over and the patient was settled. Some participants ask witnessing family members to assist during resuscitative efforts.

Healthcare providers raised a multitude of concerns such as misinterpretation of the resuscitation proceedings, nature of intervention, overcrowding and hysterical family member. These are a few reasons as to why family members are not invited to witness.

Some decisions made during the resuscitation process are not always understood by the witnessing family member. Calling off or ending a resuscitation attempt prematurely or due to no haemodynamic responses from the resuscitative efforts may not be always understood by the witnessing family member. Patient confidentiality was also a concern amongst the team members.

There are concerns such as radiation safety and witnessing family members collapsing and having to attend to both concurrently.

Certain lifesaving interventions are required instantly and not all specialists are in the vicinity at the time so the doctors perform these tasks without them and this cannot be explained to witnessing family members. The doctor feels pressured and by having a family member present opens the multidisciplinary team for litigation. Witnessing family members increase stress levels in the resuscitation room and healthcare providers want guidelines against family member presence. Team members are afraid of witnessing family members picking up mistakes. Witnessing family members may not understand the resuscitation process and potentially misinterpret proceedings which may lead to litigation.

Witnessing resuscitation is viewed by the resuscitation team as traumatic psychologically. In order to avoid a traumatic experience the resuscitation team does not recommend family member presence. Healthcare providers fear that family members may lose control of themselves and emotionally traumatised due to an unsuccessful resuscitation attempt.

Witnessing a resuscitation attempt can bring closure and facilitate the grieving process. Some of the team members would have the witnessing family member chaperoned, some team members would stop and explain to the witnessing family member and other healthcare providers would like family members to wait outside until the patient is stabilised and then be addressed.

CHAPTER 5

DISCUSSIONS, CONCLUSION, LIMITATIONS AND RECOMMENDATIONS

5.1 INTRODUCTION

This chapter aims to discuss the finding of this study. It also discusses the findings, limitations of the study and recommendations for future nursing research. The conclusion is drawn from the findings.

5.2 OBJECTIVES OF THE STUDY

The objectives for this study were to explore and describe:

- Healthcare providers' views on family witnessed resuscitation in an emergency department in a private hospital in Johannesburg.
- Factors that influenced the decision making processes regarding family witnessed resuscitation.
- The feasibility of implementation of family witnessed resuscitation practice from the healthcare providers' perspective.

5.3 DISCUSSION OF THE FINDINGS

In the previous section themes and sub-themes were extracted and this was supported with literature. Five main themes and nine sub-themes were identified.

This study explored the views of the multidisciplinary healthcare providers who manage resuscitations in the emergency department of private sector hospitals in Gauteng in respect of the presence of relatives during resuscitation. The participants included registered nurses both experienced and trauma trained, emergency medicine physicians,

doctors, trauma surgeons, radiographers and paramedics. There was a difference in opinion depending on the patient's condition and environmental set up.

This was a qualitative study and Tesch's (1990) method was used to analyse the data collected. Themes were identified and extracted. These were supported with excerpts from the narratives obtained during data collection. The researcher has identified the concepts and provided an in-depth description. The concepts are supported by relevant literature.

Family members are brought into the emergency department because they can provide health care workers with information on the patient's past medical history. Family members also need closure and for their emotional and psychological needs to be met if the resuscitation attempt was unsuccessful. Family members can also assist the resuscitation team in making decisions and providing consent on behalf of the patient.

When relatives accompany their loved one in the back of an ambulance or rushing them in with a private vehicle to the emergency department the accompanying family members are asked to leave the resuscitation area and wait for an update. When patients are being resuscitated accompanying family members enquire about their loved one. When there is a paediatric patient being resuscitated both parents are present. This difference in approach is what sparked the researcher's interest in family member presence during resuscitative efforts.

5.3.1 Perception of healthcare providers

Participants were concerned about the lack of experience in the resuscitation area. Not all resuscitation team members share the same qualification and knowledge. Many researchers, (Gunes and Zyback 2009; Chapman *et al*. 2012; Motsepe 2015; Goodenough and Brysiewics 2003 and Gorden *et al*. 2011) show similar findings with regards to the lack of experience and knowledge. When working in the resuscitation area advanced skills are required such as preparation for intubation and insertion of invasive

lines in order to save the patient's life (SANC 2014). The participants felt that by having a witnessing family member present they would feel uncomfortable. Gunes and Zyback (2009) have similar findings regarding how the resuscitation team members felt being observed by a witnessing family member.

The team members felt pressured and didn't like crowded environments. The team members in another study were concerned with incidents that might result in the witnesses causing a distraction (Critchell and Marik 2007). This could cause elevated stress levels amongst the team during resuscitation (Critchell and Marik 2007). One of the concerns raised by the participants in the researcher's study was space and the ability to manoeuvre equipment as well as access to the patient. The resuscitation area in the hospital where the study was conducted was not large enough to accommodate another person.

The participants in Walker's (2013) study would only allow a witnessing family member in the resuscitation area by agreement from the resuscitation team and if the severity and nature of patient injury was not excessively traumatic. Chapman *et al.* (2012) shows similar findings with the participants in this study of environmental safety issues.

Summary of theme one

Participants raised multiple concerns such as the inequality in the level of knowledge and skills as well as overcrowding of the resuscitation area. Participants would feel uncomfortable if members were to be present.

5.3.2 Buy in towards family member presence

Some participants wanted the witnessing family member to see the importance of a resuscitation attempt and the others wanted the witnessing family member to observe the amount of effort that goes into a resuscitation attempt. Compton *et al.* (2011); Dougal *et al*. (2011); Badir and Sepit (2007); Oman and Duran (2010) show similar findings to this

study. Some participants feel that it's important that we involve the witnessing family member during resuscitative efforts. In contrast nurses view bystanders and witnessing family members as passive observers while paramedics view family members as active participants during resuscitative efforts (Walker 2013). However Critchell and Marik (2007) did not agree with the participants in Walker's study and some of the participants in this study. Nurses, trauma surgeons and emergency physicians are reluctant to accommodate a witnessing family member during resuscitative efforts because it is not common practice in America, inappropriate, not beneficial for the patient or the resuscitation team and only beneficial for the witnessing family member and (Critchell and Marik 2007).

The participants in this study see the benefits of have a witnessing family member present only when the patient is chronically ill. In the event of an unsuccessful resuscitation attempt family member presence would have positive benefits during the grieving process (Fulbrook *et al.* 2005 and Dougal *et al.* 2011). In an acute trauma or medical emergency setting the participants prefer family members in the waiting area and see no benefits of having family member presence. Critchell and Marik (2007) show similar findings and stated that the emergency medicine physicians complained that allowing family members to witness resuscitations slowed them down and that family members lose control of what's happening and distract the team from what needs to be done therefore delaying resuscitative efforts. The findings in Gunes and Zyback's (2009) study differ. The treatment provided during the resuscitation was more aggressive due to family member presence and the resuscitation teams' performance was unaffected by their presence.

Summary of theme two

Some participants wanted family members present in order to witness the amount of effort that goes into a resuscitation attempt. Other participants would allow family

member presence only if the family member is chronically ill not in an acute trauma or medical emergency situation.

5.3.3 Concerns from healthcare providers

The participants are concerned that allowing family member presence during resuscitative efforts may disrupt the close loop communication therefore resulting in poor patient outcome. Team members are concerned about possible interruptions by the witnessing family member. The study by Critchell and Marik (2007) on family member presence show similar findings when compared to the participants in this study. Emergency physicians complained that by having witnessing family members present the resuscitation team's reaction slowed down (Critchell and Marik 2007). This happens when the witnessing family member loses control of him or herself and distracts the resuscitation team from what needs to be done. The participants are required to follow an algorithm during resuscitation. This entails maintenance of the patient's airway, breathing, circulation and administration of drugs in order to obtain return of spontaneous circulation (ROSC). On the other hand the trauma surgeons responded by saying the witnessing family member will not understand if the respondent prematurely terminates the resuscitation attempt due to poor patient outcome. However Gunes and Zyback (2009) show different findings during resuscitative efforts whilst having family members present. In their study the treatment provided during the resuscitation was more aggressive due to family member presence and the resuscitation teams' performance was unaffected by the family's presence.

In this study the participants felt that it was in the family's best interest to wait in the dedicated waiting area for feedback. This was due to the nature of the resuscitation or interventions required to sustain the patient's life. They felt that once the patient has been stabilised family members may come in to see their loved one. However this practise may differ in other emergency settings.

Two of the participants fear litigation because the witnessing family members may observe mistakes during resuscitative efforts. Resuscitations don't always go according to plan and the witnessing family member may misinterpret the proceedings. However, one participant mentioned that during paediatric resuscitations both parents may be present. Another participant mentioned that the resuscitation team shouldn't be worried about malpractice and incompetence. Dougal *et al.* (2011); Gunes and Zayback (2009); Critchell and Marik (2007) all showed that family member presence decreases the chance of a law suit. If family members believe that the resuscitation team was dismissive or negligent chances of a law suit increases.

Summary of theme three

Participants raised multiple concerns such as disruption of the closed loop communication, possible interruptions, misinterpretation and premature termination of the resuscitation attempt. Two participants feared litigation. Participants preferred family members to wait in the waiting area and once the patient is stabilised family members may see their loved one.

5.3.4 Family emotions as perceived by healthcare providers

The participants don't like dealing with the family member's emotions. The participants in this study don't want family members witnessing a resuscitation attempt. The healthcare providers fear witnessing family members may be left with traumatic memories. A study by Badir and Sepit (2007) shows different findings with regards to family member presence during invasive procedures. Family members who have witnessed invasive procedures would prefer to be present should the situation arise again because their emotional and psychological needs were met. However studies by Critchell and Marik (2007) and James *et al.* (2011) show similar findings to this study. At the Foote Hospital in Jackson, USA healthcare providers report instances where witnessing family members experienced uncontrollable grief and had to remove themselves from the resuscitation

site for periods of time whilst others needed to remove themselves permanently. Resuscitation team members prefer it if family members are aware that we are trying to save their loved one instead of witnessing the resuscitation process. Participants fear that the witnessing family member may become aggressive and obstruct resuscitative efforts. The study by Critchell and Marik (2007) shows similar findings. In an incident a mother pulled the emergency physician off her child while the emergency physician was attempting resuscitation.

The healthcare providers raised concerns with regards to family witnessed resuscitation. The participants fear that the witnessing family members may lose control of themselves and resuscitative efforts may be futile and the patient dies. The study by Oman and Duran (2010) shows similar findings. Some healthcare providers experience an increase in performance anxiety and stress. Other team members express their fear of the repercussions of allowing family member presence, family members' misinterpretation of the resuscitative process and interference by the witnessing family member. Some healthcare providers fear that family members may experience emotional distress and trauma from witnessing a resuscitation attempt. The study conducted by Badir and Sepit (2007) show different findings. Family members who had the opportunity to witness the resuscitation had positive experiences because it enabled them to stay connected and they did not experience any adverse psychological effects, lose control of themselves or disrupt the resuscitative process. Gunes and Zyback (2009) show a different finding with regards to family member presence. The treatment provided during the resuscitation was more aggressive due to family member presence and the resuscitation teams' performance was unaffected by the family's presence.

Some participants felt that if family members are excluded it would make it difficult for them to come to terms if the resuscitation attempt was unsuccessful. By having family member presence in an unsuccessful resuscitation attempt the grieving process is facilitated and adjustment to death is made easier. Both Dougal *et al* (2011); Gunes and

Zyback (2009) show similar findings with regards to the emotional benefits of witnessing a loved one being resuscitated. Healthcare providers and family members believed that family witnessed resuscitation helps both the family member and the patient emotionally and spiritually, especially at the time of death and this in turn can assist with the grieving process.

Summary of theme four

Participants fear that witnessing family members may be left with traumatic memories or become aggressive, obstructive and lose control of themselves. However it might make it difficult for family members to come to terms if the resuscitation attempt was unsuccessful.

5.3.5 Balancing your act

The participants prefer family members in the waiting area while the multidisciplinary team stabilises their loved one. The resuscitation team members would find it hard to attend to both the on-going resuscitation and the witnessing family member. Often resuscitation team members who are assigned to chaperone the witnessing family are also required to assist the team during the resuscitation. Some participants would delegate someone to chaperone the witnessing family member but in reality we work with limited amount of staff and chaperoning is not always possible. Gunes and Zyback (2009) confirm that one of the problems experienced by the nurses during family member presence was not having enough staff to provide emotional support for the witnessing family member.

Summary of theme five

Owing to inadequate staffing at all levels the team member who is assigned to the witnessing family member is often required to assist during the resuscitation. There is thus no staff member available to support and assist the witnessing family member.

5.4 LIMITATIONS OF THIS STUDY

The following limitations were recognised by the researcher.

- This study is limited to one private emergency department. Bigger emergency departments may have different opinions on family member presence.
- The researcher only interviewed one group of healthcare providers.
- The researcher only used healthcare providers from one emergency department and government emergency departments or units were not included.

5.5 RECOMMENDATIONS

5.5.1 Recommendations for nursing practice

An educational programme needs to be developed and included in the basic nursing degree and implemented so that professional nurses are aware of the international trends with regards to family witnessed resuscitations. Policies and/or guidelines on family witnessed resuscitation require development and implementation. The advanced practitioner nurse is the best suited to equip other healthcare providers with the tools on how to handle family member presence. The resuscitation team members needs to encourage the witnessing family member to part take during decision making.

5.5.2 Recommendations for nursing management

The researcher recognises that there are additions and changes that are required where in order to accommodate a witnessing family member. In terms of the lack of space, bigger resuscitation areas need to be built in order to accommodate the resuscitation team members as well as the witnessing family member. Persons specifically trained in counselling but who may be volunteers needs to be arranged in order to accommodate witnessing family members. Alternatively healthcare providers require additional training

on counselling or need to attend counselling courses on family member presence. Policy development is required and should be directed towards the benefit and guidance for the practice of family witnessed resuscitations.

5.5.3 Recommendations for nursing research

- Both government and private emergency departments should be targeted in order to explore the various views of healthcare providers regarding family member presence.
- Various views of family members who have witnessed resuscitations should be explored.
- A research study can also be conducted on the opinions of patients' and their family members' wishes in the event of family witnessed resuscitation in South Africa.

5.5.4 What does this study add?

This study was chosen to address a specific research question and to fill an empirical gap in the literature about the South African context with regards to family witnessed resuscitations.

5.6 CONCLUSION

This study explores the views of the healthcare providers who manage resuscitations in one emergency department in a private sector hospital in Gauteng in respect of the presence of relatives during resuscitation. In this chapter a summary of this study was outlined. Thereafter a brief summary of the main research findings was given. The healthcare providers gave their reasons for not supporting family witnessed resuscitation. This included lack of experience, lack of space, malpractice potential, obstructive, ruining the work flow, disruptive, interrupting the close loop communication, misinterpretation of the resuscitation process, too stressful for the witnessing family member, traumatic

memories, aggressive and assault the healthcare providers. These fears and concerns voiced by the participants in this study are similar to those found in the literature both locally and internationally. Some participants do see benefits in having family members present. The participants gave the following reasons. The amount of effort that goes into resuscitation attempt, when the patients are chronically ill and do not respond to any other form of medical treatment and closure are amongst the reasons. In this study participants prefer family members in the waiting area and once the patient has been stabilised then only will the family member see their loved one. On the other hand trauma surgeons only see the benefits of having family member presence when the patient is chronically ill but not in an acute trauma setting. However family member presence is practiced haphazardly when it comes to paediatric patients or when there's a language barrier. The recommendations of the study namely: recommendations for nursing practice, recommendations for nursing management, recommendations for nursing research and what this study adds. The limitation of the study was also outlined In order to fulfill the requirements of the study three objectives were set.

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APPENDIX A

UNIVERSITY OF THE
WITWATERSRAND,
JOHANNESBURG

Private Bag 3 Wits, 2050
Fax: 027117172119
Tel: 02711 7172076

Reference: Mrs Sandra Benn
E-mail: sandra.benn@wits.ac.za

28 May 2018
Person No: 728951
PAG

Mr MN Ambelal
PO Box 1477
Brits
0250
South Africa

Dear Mr Ambelal

Master of Science in Nursing: Approval of Title

We have pleasure in advising that your proposal entitled *An exploration of the views of healthcare providers on family witnessed resuscitation in an emergency department of a private hospital in Gauteng* has been approved. Please note that any amendments to this title have to be endorsed by the Faculty's higher degrees committee and formally approved.

Yours sincerely

Mrs Sandra Benn
Faculty Registrar
Faculty of Health Sciences

APPENDIX B

RESEARCH OPERATIONS COMMITTEE FINAL APPROVAL OF RESEARCH

Approval number: UNIV-2015-0012

Mr Mayush Ambelal

E mail: mayush.ambelal@gmail.com

Dear Mr Ambelal

RE: AN EXPLORATION OF THE VIEW OF HEALTHCARE PROVIDERS ON FAMILY WITNESSED RESUSCITATION IN AN EMERGENCY DEPARTMENT OF A PRIVATE HOSPITAL IN GAUTENG

The above-mentioned research was reviewed by the Research Operations Committee's delegated members and it is with pleasure that we inform you that your application to conduct this research at Private Hospital, has been approved, subject to the following:

i) Research may now commence with this FINAL APPROVAL from the Committee.

ii) All information regarding the Company will be treated as legally privileged and confidential.

iii) The Company's name will not be mentioned without written consent from the Committee.

iv) All legal requirements with regards to participants' rights and confidentiality will be complied with.

v) The Company must be furnished with a STATUS REPORT on the progress of the study at least annually on 30th September irrespective of the date of approval from the Committee as well as a FINAL REPORT with reference to intention to publish and probable journals for publication, on completion of the study.

vi) A copy of the research report will be provided to the Committee once it is finally approved by the relevant primary party or tertiary institution, or once complete or if discontinued for any reason whatsoever prior to the expected completion date..

vii) The Company has the right to implement any recommendations from the research.

viii) The Company reserves the right to withdraw the approval for research at any time during the process, should the research prove to be detrimental to the subjects/ Company or should the researcher not comply with the conditions of approval.

ix) APPROVAL IS VALID FOR A PERIOD OF 36 MONTHS FROM DATE OF THIS LETTER OR COMPLETION OR DISCONTINUATION OF THE STUDY, WHICHEVER IS THE FIRST.

We wish you success in your research.

Yours faithfully

16/3/2015

Prof Dion [illegible]
Full member: Research Operations Committee & Medical Practitioner evaluating research applications as per Management and Governance Policy

Shannon Nell
Chairperson: Research Operations Committee
Network Healthcare Holdings Limited
Date: 17/3/2015.

This letter has been anonymised to ensure confidentiality in the research report. The original letter is available with author of research

APPENDIX C

R14/49 Mr Mayush Ambelal

HUMAN RESEARCH ETHICS COMMITTEE (MEDICAL)

CLEARANCE CERTIFICATE NO. M140875

NAME: (Principal Investigator)	Mr Mayush Ambelal
DEPARTMENT:	Nursing Education
PROJECT TITLE:	An Exploration of the Views of Healthcare Providers on Family Witnessed Rescuscitation in an Emergency Department of a Private Hospital in Gauteng
DATE CONSIDERED:	29/08/2014
DECISION:	Approved unconditionally
CONDITIONS:	
SUPERVISOR:	Andrea Hayward
APPROVED BY:	Professor P Cleaton-Jones, Chairperson, HREC (Medical)
DATE OF APPROVAL:	15/04/2015

This clearance certificate is valid for 5 years from date of approval. Extension may be applied for.

DECLARATION OF INVESTIGATORS

To be completed in duplicate and ONE COPY returned to the Secretary in Room 10004, 10th floor, Senate House, University.

I/we fully understand the conditions under which I am/we are authorized to carry out the above-mentioned research and I/we undertake to ensure compliance with these conditions. Should any departure be contemplated, from the research protocol as approved, I/we undertake to resubmit the application to the Committee. I agree to submit a yearly progress report.

Principal Investigator Signature

Date 30/09/2014

PLEASE QUOTE THE PROTOCOL NUMBER IN ALL ENQUIRIES

APPENDIX D

PARTICIPANT INFORMATION LETTER

Good day. My name is Mayush Ambelal. I am conducting research for the purpose of obtaining a Master's degree in Trauma and Emergency Nursing at the University of the Witwatersrand. My study is entitled "An exploration of the views of healthcare providers on family witnessed resuscitation in an emergency department of a private hospital in Gauteng".

In this study my focus is the healthcare providers' views of family presence during the resuscitation of their relative in an emergency department in Gauteng. The main aim of this study is to explore the views of the trauma and emergency teams regarding the presence of family members during the resuscitation of their relative.

May I invite you to participate in this study? Should you agree your participation will entail being interviewed by me at a time and place that is convenient to you? The interview will last for approximately 1 hour. The interview will be recorded, with your permission, in order to obtain maximum accuracy of the research. Your participation is voluntary and you may decline should you not wish to participate with no consequences. You may refuse to answer any question and you may choose to withdraw from the study at any point. An example of the type of question would be: "What do you think about the presence of a family member during the resuscitation of their relatives"?

Complete confidentiality will be attained but not anonymity throughout the study. I intend to audio record the interview. All the digital audio recordings and transcripts used in this study will only be accessed by me and my research supervisors. The interview material will be kept in the nursing department at all times and all electronic transcripts will be password protected. Once I have written up the research, the transcripts, recorded material and interviews will be retained in the nursing department at the University of the Witwatersrand for a period of 6 years if no publication ensues, or for 2 years following

publication in an accredited academic or professional journal. The results of this study will be reported in a research report. Results of the study will be made available if you so wish.

While you may not benefit directly from participation in this study, it is hoped that it will help to clarify understanding of family witnessed resuscitation in our institution. The appropriate people and research committees of the University of the Witwatersrand and your health care institution will be asked to approve this study. Should you require further information regarding this study, you may contact Mrs Anisa Keshava, Secretary of the University of the Witwatersrand Human Research Ethics Committee (HERC) at (011) 717 2229.

Should you wish to contact me, or if you require any additional information, please do not hesitate to contact me on cell number 081 567 7542 or email address mayush.ambelal@wits.ac.za. Thank you for taking the time to read this information letter.

Yours sincerely,

Mayush Ambelal

(MSc Nursing student)

APPENDIX E

AN EXPLORATION OF THE VIEWS OF HEALTHCARE PROVIDERS ON FAMILY WITNESSED RESUSCITATION IN AN EMERGENCY DEPARTMENT OF A PRIVATE HOSPITAL IN GAUTENG

PARTICIPANT CONSENT FORM

I _____ (name), fully understand the contents of the information letter. I have been offered the opportunity to ask questions and these have been answered to my satisfaction. I understand that I may withdraw from this research process at any stage without penalty. I have been assured that my confidentiality will be maintained but not anonymity.

I hereby consent to be included in this study.

_____ _____

Date Signature

_____

Witness

APPENDIX F

AN EXPLORATION OF THE VIEWS OF HEALTHCARE PROVIDERS ON FAMILY WITNESSED RESUSCITATION IN AN EMERGENCY DEPARTMENT OF A PRIVATE HOSPITAL IN GAUTENG

CONSENT FORM FOR AUDIO TAPING A CONVERSATIONAL INTERVIEW

I _____ (name) have been given the information about this study. I have read the proposed method of data collection and understand that this will include a tape recording of the conversations. I will be able to make alterations during the process, should I not agree with the interpretation.

I consent to the researcher recording the interview and understand that my name will not appear in any documentation.

_____ _____

Date Signature

_____

Witness

APPENDIX G

INTERVIEW GUIDE

PARTICIPANT NO……..

I appreciate your willingness to participate in this study which is titled: **An exploration of the views of healthcare providers on family witnessed resuscitation in an emergency department of a private hospital in Gauteng.** Very little is published about family witnessed resuscitation in the South African context specifically from a healthcare providers' view. This will be an interactive discussion so feel free to share your experiences.

Primary question

What is your view on allowing the family to be present during resuscitation of a patient?

PROBES

- What is your understanding on family witnessed resuscitation?
- Based your experience and expertise in trauma and emergency what are your views?
- How do you feel having family member present, could you elaborate?
- How did you manage? Perhaps you have read or experienced something?
- Is there anything more you would like to add about family member presence?
- Tell me what you would anticipate difficult to do if a family member witnessed you resuscitate?

Thank you very much for your time. The proceeds of this discussion will be brought to you for validation after transcription of this interview and formulation of the exhaustive description of your views of healthcare providers' on family witnessed resuscitation.

APPENDIX H

Mayush Ambelal

Department of Nursing Education

Faculty of Health Sciences

University of the Witwatersrand

7 York Road

Parktown 2193

The Chief Executive Officer

Dear Mr Peter Louw

RE: PERMISSION TO CONDUCT RESEARCH AT THE PRIVATE HOSPITAL

At present, I am a registered student at the University of the Witwatersrand in the Department of Nursing Education. I hereby ask for permission to undertake research at this private Hospital. The title of my research is: *"An Exploration of the Views of Healthcare Providers on Family Witnessed Resuscitation in an Emergency Department of a Private Hospital in Gauteng".*

This study pertains to the exploration of the views of healthcare providers on family witnessed resuscitation in an emergency department and the research proposal is attached for your perusal. The reason for conducting this study is to explore the views of

healthcare providers regarding family member presence during the resuscitation of their relative. Since this private hospital has a level two (2) accredited trauma unit and a referral hospital for critically ill patients from the whole of Africa, this research will benefit both the hospital and the community at large and the results will add value to the management of similar situations in future.

The aim of this study is to explore the views of the healthcare providers on the practice of family presence during the resuscitation of their relative in an emergency department in a private hospital setting in Gauteng.

I assure you that the institution's name and personnel involved in the study will not be divulged in the research report. Informed consent will be obtained from all participants and a copy of the report will be available to you if so requested. I hope to conduct my research at the emergency department once my proposed study has been approved by the Committee of Human Research Ethics Committee of the University of the Witwatersrand.

Yours sincerely

Mayush Ambelal

MSc (Nursing) Student

Mayush.ambelal@wits.ac.za

Mobile: 081 567 7542

Work: 011 806 1652/3

APPENDIX I

KEY WORD/STATEMENTS BY NURSES

POSITIVE

TTRN1: "I am absolutely for it the family can be present as long as they behave and it make them accept it much easier than not be present and wonder"

TTRN1: "i am 100% for that."

TTRN1: "it's very important so that they can see that you do your best."

TTRN1: "So if it was not successful neh the grieving process after that make them to accept that easier than people that don't know what was going on."

TTRN1: "From the emergency perspective neh outside from the roads until to the trauma bays I don't mind."

TTRN1: "it's not a problem"

RN EXP: "I think its ok to allow the parent"

RN EXP: "you should have the parent one side being also look after by another nursing staff outside you know the resus place"

TTRN2: "I think it's really good to have family members present I think it's good for them to see what's happened. I think it clarifies you know questions that they may have and if the person dies it gives them clarity and closure. I think it should be [thinking] obviously they must have the opportunity to choose whether they want to or they don't"

TTRN2: "I think a lot of times it would be beneficial."

TTRN2: "I really feel completely comfortable with that I think it's important that they see"

TTRN2: “I think it’s good for them to see exactly what happened and the circumstances in which it happened.”

TTRN2: “I think it can be a positive experience for everyone.”

TTRN3: “it makes it easy to resuscitate a kid or to treat a kid while there are patients [parents] in there sometimes they can help with trying to calm the patient down”

TTRN3: “if there is only that kid in resus we give them a chair to just sit there and one of the staff members will take care of the parents while we are busy with the kid [chaperone]. So it’s really with kids we really don’t chase them away we just find a way to deal with them.”

TTRN4: “probably I will send somebody to be with them [chaperone] because it obviously if they are there they need somebody”

TTRN4: “the only thing I will have to assign to [pause] somebody and put them in the corner watching from that corner then somebody will be going through the whole resus.”

TTRN4: “I think for them to see the resuscitation maybe will bring/give them a closure.” {green colour as well}

TTRN4: “chronically sick people that have been sick for a very long time have been suffering and they are brought to hospital for resuscitation if the family members there I think they will bring closure”

NEGATIVE

TTRN1: “They can be aggressive, they can be emotional and they can subtract [distract] you to do your work as you will usually do it.”

TTRN1: “if the parents is angry and they are being aggression or something and they will withheld (hold you back) you from doing your best for the patient then its better and take them out but if they behave and standing on the bedside neh there on the foot end neh and they watch what you are doing to their relative that will not be a problem.”

TTRN1: “capture after that resus is not successful to get closure for that family is very difficult so to get that closure”

TTRN2: “if they start to argue with you”

RN EXP: “I as for one disagree on the family members being present”

RN EXP: “they either become very like nervous and a emotionally we have to like you busy with the resus then you have to attend to the family member who sometimes can faint there; fall down and become hallucinative and on the other hand you find that some of them [family member] will become very interfering in the resus as well like when we are doing certain procedures [insertion of central and arterial lines] they will object to say no they don’t want certain things to be done for the person or they will come and obstruct the resus you don’t know how they their their what you call this emotions can, be they action can be.”

RN EXP: “disrupt the resus”

RN EXP: “in the case where the parent is not understanding like what is happening; what we are doing for the child; we are resusing the child I think the parent should wait one side because then you will find sometimes they can become emotional; they will try and holt the resus”

RN EXP: “going to administer something [medication given as a push during the resuscitation] that will kill the child and they will become very emotional in that aspect and they will start interfering with your resus and it disrupts everything because then you

are busy trying to revive the child and you find the parent telling you what to do and then."

RN EXP: "I think we should just keep the parent one side"

RN EXP: "going to disrupt a lot of things"

RN EXP: "you have got nobody else to go there now and look after the parent" [in colour blue as well]

RN EXP: "parent getting emotional all worked up"

RN EXP: "I think that the parent should be outside" [? Disruption]

RN EXP: "not only assault they become very vindictive"

RN EXP: "they don't understand"

RN EXP: "it's a real threat to the nursing staff"

RN EXP: "disruptive as well."

RN EXP: "you feel you being implicated like you are at threat and you can't perform at your best"

RN EXP: "it's also disturbing to the staff very disturbing"

RN EXP: "the nurse answerable to the parent and the nurse will be liable"

RN EXP: "you become now killer and like culprit"

RN EXP: "I feel it's a threatening thing"

RN EXP: "it's going to make the situation worst and by us doing that we going to have more problems"

RN EXP: "you are more worried concerned about the parent"

RN EXP: “emotionally it’s very traumatic”

RN EXP: “I don’t think it’s a good thing”

RN EXP: “it’s a bad implication the hospital; it’s going to be a bad implication on nursing staff and the department”

TTRN2: “she didn’t have anybody explaining to her what was going on.”

TTRN2: “it is difficult when they get involved”

TTRN2: “it’s very difficult when you trying to do something and they are interfering and their… sometimes it can be obstructive”

TTRN3: “most of the time they cannot handle the situation”

TTRN3: “others are too emotional”

TTRN3: “you find that even the staff cannot function like well because they are like under pressure”

TTRN3: “you make a mistake you would be like making some comments that are not good”

TTRN3: “its disadvantageous to the healthcare professionals”

TTRN3: “I would not advice people to be in the resuscitation area with the patient while we are busy resuscitating.”

TTRN3: “It’s a traumatic experience you will find that you will find that you are dealing with patient then you must also deal with the parent”

TTRN3: “It’s a really traumatic experience for them also because it will be hectic for them [family members] to just sit there and watch while we are busy pumping the chest [chest compressions] of their kid.”

TTRN3: “I don’t like to be busy with my work while the family is in there because I don’t feel comfortable and I don’t feel at ease it makes me work under pressure because they [family members] will be watching my every move sometimes we end up making mistakes because people are watching. You will be doing the right thing but because they don’t understand what you are doing it will be like you are inflicting more pain to their relative or family member”

TTRN3: “It takes your focus off because now you are like watching the patient and also watching them (family members) because they will be there screaming some others are asking questions and then you must still answer those questions you will lose focus to what you are doing to your patient which is important.”

TTRN3: “parents are too emotional”

TTRN3: “Well it’s difficult when there are other patients in resus so we must also consider privacy of other patients so when I allow a…. because in resus there is no privacy.”

TTRN3: “it wouldn’t be fair to other patients because they will also want their relatives to be in there.”

TTRN3: “I will really not like to us to work under such condition”

TTRN3: “it’s disadvantageous to us and not only to us as staff members but to a patient also because if you lose focus of what you are doing because of the relatives of family you end up not doing the right thing to the patient of which it is not fair on the patient.”

TTRN3: “families or the relatives think you are inflicting pain”

TTRN3: “it gets difficult because now you need to stop what you are doing and explain to the relative”

TTRN3: “it’s disadvantageous to the patient.”

TTRN4: “for me I am not happy and I am not free”

TTRN4: “for us it’s like if we are not succeeding with that resus and they are going to sit and start pinpointing you didn’t do this you should have done that.”

TTRN4: “It’s traumatic for me its traumatic especially if the person is not going to make it. So it’s going to be traumatic for them [witnessing family member] it’s going to have that view of us running around resuscitating for the rest of their lives.”

TTRN4: “personally I feel intimidated [pause] because now this person is going to be looking at the mistakes not really seeing how hard we tried to resuscitate the person”

TTRN4: “if we didn’t win how’s the family going to feel we failed them (pauses) and then they are left with traumatic stress.”

TTRN4: “it’s just traumatic to tell them what has happened so what if what more if they were there and knowing we are losing the person.”

TTRN4: “Yes it will be traumatic to the nurse”

NEUTRAL

TTRN1: “take them out for a little while explain the procedure because if you don’t explain the procedure they don’t know what to expect inside.”

TTRN1: “before you take them in tell how the patient is look like; tell them what you are doing; were to stand everything and then they give the full co-operation. If it’s a child they will stand at the foot and end.”

TTRN1: “I think in South Africa it’s not a norm”

RN EXP: “I don’t think it’s going to look rationalised that you keep a parent who is unstable (emotionally) in there in the resus place.”

RN EXP: “can be going against the person’s privacy so confidentiality is important”

RN EXP: “So I think to protect ourselves we should have the parent outside”

TTRN2: “people are scared of it because they weren’t open opens to you know litigation”

TTRN2: “it should be controlled so I think they should stand to one side and out the way I don’t think they should be allowed to actually touch the person because then they will get in the way”

TTRN2: “it’s very important to have somebody with them either a nurse or a counsellor explaining to them exactly what’s happening and you know step by step”

TTRN3: “we cannot perform without consent so that’s why that’s the reason why we allow parent to be inside”

TTRN3: “once the patient is settled you can call them in”

TTRN3: “Some staff members are not even experienced so it would be very hard for them to perform their duty while the parents or relatives are in the room”

TTRN4: “For me myself I have never experienced that”

TTRN4: “The difficult thing to do is to call it a resus off”