
University of Natal

Witnessed resuscitation -
exploring the attitudes and practices
of the emergency staff working in the level
one emergency departments in the province
of KwaZulu-Natal.

Toni Jennifer Goodenough

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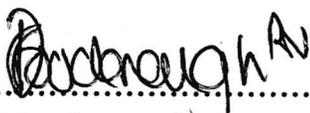
A Dissertation Submitted
to
The School of Nursing at the University of Natal, Durban.

Submitted in partial fulfilment of the requirements
for
a Masters Degree in Critical Care and Trauma Nursing.
(M Cur)

By Toni Jennifer Goodenough
Supervised by Petra Brysiewicz

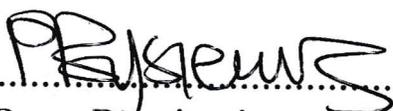
Declaration

I declare that this research project entitled “Witnessed resuscitation - exploring the attitudes and practices of the emergency staff working in the level one emergency departments in the province of KwaZulu-Natal,” is my own work. It is being submitted for the degree of: Masters in Critical Care and Trauma Nursing at the University of Natal, Durban, South Africa. It has never been submitted for any other purpose. All references used or quoted have been acknowledged by means of referencing.

Signature 
Toni Jennifer Goodenough

Date 20/2/2002

This study has been approved for submission by the supervisor of this study, Petra Brysiewicz.

Signature 
Petra Brysiewicz

Date 20/2/2002

Dedication

This study is dedicated to the people of

KwaZulu-Natal, with love.

Acknowledgements

My sincere thanks go to the following:

The emergency staff who willingly participated in this study, SHAUN, PENNY, LUCY, BONGI, BOB and SIMBA. Thank you for your interest, time and input.

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Abstract

Aim: The aim of this study was to explore the attitudes and practices of the emergency staff working in the level one emergency departments in the province of KwaZulu-Natal, with regard to witnessed resuscitation.

Methodology: A qualitative approach was used to explore the attitudes and practices of the staff. Two semi - structured interviews were conducted with each participant, an initial and a verifying interview, with each interview lasting between 15 - 30 minutes long. The researcher applied the principle of theoretical saturation and a total of six participants from two of the four level one emergency departments were included in this study. One provincial and one private emergency department were chosen. All of the interviews were taped and transcribed prior to manual analysis, in which categories and themes were identified from the data.

Findings: The emergency staff disliked the idea of witnessed resuscitation. They believed it to be a harmful experience for the witnesses, a threat to the resuscitation process, threatening for the emergency staff, and impossible to implement in their emergency departments that are already short of staff and space. Although these were their dominant feelings, there were subtle references made during the interviews that revealed that there were some aspects of witnessed resuscitation that they liked once they had considered the practice.

There were no written policies to dictate how the relatives were handled, but all the staff agreed that the relatives were asked to wait outside of the resuscitation area, they were kept informed and then brought in when the patient was stable or had died. A number of recommendations are suggested for education, practice and further research in an attempt to introduce witnessed resuscitation as an option in KwaZulu-Natal's emergency departments.

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Chapter 1

Introduction

In this chapter the background to this study as well as its significance and problem statement are presented. The purpose and objectives of this study are also outlined.

1.1 Background to the study

The topic of witnessed resuscitation is being actively debated. Witnessed resuscitation, according to Boyd (2000, p. 171) “is the process of active ‘medical’ resuscitation in the presence of family members”. There is much research available on the positive effects that witnessed resuscitation has on the family members, especially with regard to their improved ability to cope with the grieving process after the loss of their loved one (Rattrie, 2000). However, the area of emergency staff’s attitudes and practices with regard to witnessed resuscitation is an area that has not been as thoroughly researched. Available research has shown their attitudes to be mixed resulting in much debate over this practice (Rattrie, 2000). Furthermore, although limited research has been conducted internationally, through literature searches done by the researcher, it appears that no research into witnessed resuscitation has been conducted in KwaZulu-Natal or South Africa.

Resuscitation and death are traumatic events that emergency staff deal with every day, and it is ultimately the emergency staff that promote or prevent the practice of witnessed resuscitation. They are the people who comfort, counsel and guide the relatives, the ones who

answer the relatives' questions, and it is these professionals that the relatives ask for access to their loved ones. Thus, the attitudes and practices of the emergency staff play an important role in the actual practice of witnessed resuscitation. Stucky (1998, p. 6) states that in South Africa, "Death due to trauma injury - sustained in traffic or household accidents or through inter-personal violence - far outnumber deaths caused by AIDS." For each of the people that die, there are families left to cope with their death, and it is these people that the practice of witnessed resuscitation is aimed at helping.

1.2 Significance of the study

Through this study, a better understanding of the emergency staff and the practice of witnessed resuscitation in KwaZulu-Natal has been attempted. This was done with the aim of providing insight into the practice of witnessed resuscitation in KwaZulu-Natal. This study has also attempted to provide an indication of the demand for witnessed resuscitation as experienced by the emergency staff. Because there is limited research on the attitudes and practices of emergency staff with regard to witnessed resuscitation internationally, and apparently none in South Africa, this study will contribute to research done internationally and provide a basis for further study with regard to witnessed resuscitation in KwaZulu-Natal and South Africa. Finally, this study will hopefully aid in the re-evaluation of medical practices and contribute to information that will be necessary in the development of a successful programme that will adequately benefit the patient, family and staff.

1.3 Problem statement

“Evidence is becoming increasingly available to reinforce the premise that relatives not only want the choice to witness the resuscitation of a loved one, but actually benefit from witnessed resuscitation” (Rattrie, 2000, p.32). The emergency staff working in the KwaZulu-Natal emergency departments play an essential role in resuscitation and in dealing with the relatives of the person being resuscitated, however their attitudes and practices with regard to witnessed resuscitation remain largely unexplored.

1.4 Purpose of the study

This study was conducted with the purpose of exploring and describing the attitudes and practices of the emergency staff working in the level one emergency departments in KwaZulu-Natal, with regard to witnessed resuscitation.

1.5 Objectives of the study

The objectives of this study were to:

- Establish what the emergency staff understood by the term witnessed resuscitation.
- Establish the attitudes of the emergency staff to witnessed resuscitation.

- Establish the practices of the emergency staff members with regard to witnessed resuscitation.
- Establish the existing policies of the level one emergency departments for dealing with the relatives of a patient being resuscitated.

1.6 Definition of terms

- **Witnessed resuscitation**

The definition used in this study is by Boyd (2000, p. 171), who defines this term as “the process of active ‘medical’ resuscitation in the presence of family members”. It is the practice of allowing relatives into the resuscitation room while the emergency staff are attempting life saving measures on their loved one.

- **Attitudes**

Attitudes are closely related to behaviour - exploration of a person’s attitudes can provide a better understanding of their behaviour. The definition of attitudes that has been used by the researcher is by Greenberg & Baron (1997, p.170) where attitudes are defined as “relatively stable clusters of feelings, beliefs, and behavioural predispositions.”

- Practices

Practices are defined, as being “usual or customary action” (Hanks, 1989, p. 1013).

In this study the ‘customary actions’ of the emergency staff in dealing with relatives’ requests to be allowed into the resuscitation area have been explored.

- Emergency staff

The emergency staff in this study consisted of the professional health care providers, that is the doctors and nurses, who work in level one emergency departments and provide immediate, life saving medical attention to people in need thereof.

- Level one emergency department

This is an emergency department that is designed, equipped and staffed to provide advanced life support to severely injured people. It is operational 24 hours a day, seven days a week and is approved at a national level against specific criteria.

In the next chapter a discussion of literature related to the study shall be presented along with an explanation of the conceptual framework used in this study.

Chapter 2

Literature Review

This chapter provides an overview of available literature related to this study, followed by an explanation of the conceptual framework used by the researcher.

2.1 Trauma in South Africa

“Trauma - both physical and non-physical - is possibly the most ignored public health issue in South Africa” (Stucky, 1998, p.6). Stucky (1998) goes on to mention that death resulting from trauma injury sustained on the roads, in households or through interpersonal violence, far out number those deaths caused by Aids. The majority of the physical trauma affects the young, economically active men, and the most prevalent cause of this trauma is interpersonal violence (Stucky, 1998). Peden, cited in Stucky (1998, p.6), remarks on trauma in South Africa, saying, “It’s a whole fabric of poverty, social circumstances, alcohol, drugs and risk taking - all rolled into one.”

2.1.1 A description of trauma in KwaZulu-Natal

KwaZulu-Natal is approximately 91.481 square kilometres and has an estimated population of 7.7 million people. This figure is about a quarter of South Africa’s total population. KwaZulu-Natal is a province which has a population that continues to swell, health resources that continue to dwindle, a level of violence that persists with more powerful weapons being used, and heavy road traffic (Simon-Meyer, 1998). The four level one emergency departments

in KwaZulu-Natal are in the Durban area, and in Durban alone in 1995, 3816 non-natural deaths were reported. Of these 3533 were trauma related deaths (Steenkamp, 1997). In 1998 a survey of non-natural deaths in the Durban area between January and May revealed that 48.9% were due to homicide, 29.9% were traffic related, 7.6% were as a result of suicide, another 7.6% were due to other accidents and 6.0% of the deaths had undetermined causes (Peden, Meumann & Dada, 1998). Each of these deaths results in grieving families.

2.2 An overview of research on witnessed resuscitation

Witnessed resuscitation is when the patient's family, or significant others, are allowed into the resuscitation area to be with the patient while resuscitation is in progress. This has not been the established norm in the emergency departments internationally (Rattrie, 2000), however according to Boyd (2000), early reports of programmes created to promote witnessed resuscitation first appeared in the early 1980's. There is abundant research on the positive effects of witnessed resuscitation for the relatives - especially with regard to their improved grieving process. There is less research available on staff attitudes towards witnessed resuscitation (Rattrie 2000). Rattrie (2000) concludes that from the research done it has been found that staff attitudes are mixed, making witnessed resuscitation an issue of debate between the family of the patient being resuscitated and the emergency staff, this despite increasing evidence in support of witnessed resuscitation.

2.2.1 Experiences of family members denied witnessed resuscitation

A survey done of the family members, of the then recently deceased patients, in Michigan in 1982 (Hanson & Strawser, 1992), revealed that 72% of the respondents wished that they had

been present at the resuscitation of their family member. Gregory (1995), a senior charge nurse who was denied access to her daughter in the resuscitation area, records that she has a lasting memory of not being with her daughter, and that she regrets not just pushing her way into the resuscitation area to be with her. In an article by Doris (1994, p. 43), entitled "A Chance to Say Goodbye," the mother of a baby is quoted as saying "I want my voice to be the last that he hears, I want my touch to be the last he feels." The nurse with her stated that it was obvious it hadn't occurred to her that she wouldn't be with her son when he died. It is evident that there are people who strongly wish to be with their relatives during resuscitation.

Cole (2000), cites an incident where the wife of a man critically injured in a road accident arrived in the emergency department whilst resuscitation of her husband was in progress. She requested to see him but was told she would be called when he was "more stable". She finally got to see him an hour and a half later, once he had died. In another incident, a relative is quoted by Cole (2000, p. 3) as saying "I would have loved to have held his hand but I didn't dare ask."

2.2.2 Experiences of family members granted access to the resuscitation area

Research done on the effects of witnessed resuscitation on the 'witnesses' reveal that the experience is not harmful and in the majority of the cases is emotionally beneficial for the family members of the person being resuscitated. In a study done in Ohio in 1994 (Belanger & Reed, 1997), the effects of witnessed resuscitation over a year were studied. All relatives granted access into the resuscitation area and allowed to witness the resuscitation of their family member reported better coping with the grieving process. A study conducted in

Cambridge between November 1995 and February 1997, by Robinson, Mackenzie-Ross, Campbell Hewson, Egleston and Prevost (1998) revealed that all the relatives that attended the resuscitation of their loved ones were content with their choice. Furthermore, when they were assessed three months after the witnessed resuscitation, a trend toward lower degrees of intrusive imagery, post-traumatic avoidance behaviour and symptoms of grief was found in relatives that witnessed resuscitation. Another interesting finding was that three of the patients that survived said that they had felt supported by the presence of family. Eichhorn, Meyers, Thomas & Cathie (1996), trauma specialists with extra psychological training, showed in a small study that the feeling of anguish over not being with the loved one was paramount, and that through witnessed resuscitation the anguish of being separated and alone without knowing what was happening to the loved one was eliminated. People were found to be able to cope better with their loss through being able to say goodbye still holding an alive or warm hand and knowing that the sense of hearing is the last sense to cease. Williams (1993, p. 479), a registered nurse and clinical nurse specialist in crisis intervention, states, "Ultimately, I believe that the persons who must have authority to decide this issue are the ones most vested in the outcome - the family. They are also the ones who must learn to integrate the death into their lives." Connors (1996), a staff nurse, views witnessed resuscitation as successful for relatives as it provides an opportunity for the family to see that everything possible was done for their relative. This sentiment is reiterated by Eichhorn et al (1996), and Cole (2000) in their articles. However, there are concerns amongst the emergency staff that result in access by the family to the resuscitation area still being denied.

2.2.3 Concerns of the emergency staff

Cole (2000), gives an overview of staff concerns that prevent emergency staff from allowing

witnessed resuscitation. Firstly there is the concern about sensory disturbance for the relatives, visual, auditory and olfactory. These sensory disturbances occur as a result of the resuscitation of a patient, life saving measures can appear potentially harmful, blood, secretions and certain injuries such as burns can produce upsetting smells, and an unconscious patient or a patient in pain, can cry out. All of these experiences are perceived by emergency staff as potentially upsetting for the patient's family. This concern is also noted by Eichhorn et al (1996), who despite this regard witnessed resuscitation as being an integral part of the preserving the family unit from birth to death. Cole (2000) presents three points with related to this concern, namely that there is a need to respect the wishes of the relatives, that by allowing them to see that all is done, terrible imagery or anxiety may be alleviated, and that furthermore, television programmes mean that the public may not be as unfamiliar with the resuscitation process as believed.

Another concern is for patient confidentiality. Confidentiality cannot be maintained during witnessed resuscitation because the witnesses will also be witnessing the discussions regarding the patient and in this way may receive information regarding the patient without the patients' consent (Cole, 2000). This concern was addressed in a study by Robinson et al, (1998), in this study the three survivors of resuscitation expressed that they did not feel their confidentiality had been compromised.

Emergency staff reportedly also have a fear of litigation by the witnesses should a comment, action or procedure during the resuscitation, appear unacceptable to them (Cole, 2000). This concern over litigation is also recognised by Eichhorn et al (1996). However in a study by Robinson et al, (1998), it was found that none of the relatives that were allowed to witness the

resuscitation of their family member commented on technical procedures done during the resuscitation.

Finally, there are also concerns that a grief-stricken relative may disrupt the resuscitation, or that the resuscitation team will be reluctant to stop a failed effort when the relatives are in the resuscitation area urging the team to continue trying (Cole, 2000). A study done in Michigan, in the Foote Hospital (Hanson & Strawser, 1992), reported that no relatives interfered with the resuscitation during a trial of witnessed resuscitation, although it was reported that some relatives who became hysterical were led away from the resuscitation area. This study also reported that staff, through witnessed resuscitation, regarded the patient more holistically and that therefore witnessed resuscitation brought staff's emotions closer to the surface and made the resuscitation even more stressful for them.

2.2.4 Attitudes of the emergency staff towards witnessed resuscitation

Emergency staff's attitudes towards witnessed resuscitation, are mixed. Responses to questionnaires distributed by Mitchell & Lynch (1997), in which emergency staff were asked if they were in favour of the presence of selected relatives during a resuscitation, were predominantly negative. Osuagwu (1993) had the same result to the same question at an Advanced Cardiac Life Support course in 1993.

In contrast, is a study done by Chalk (1995), where questionnaires distributed randomly to medical and ambulance staff, showed the majority of the staff to be positive about witnessed resuscitation. Of this majority the largest proportion were nurses, with doctors tending to be more reluctant. Another study done by Back & Rooke (1994) showed that the majority of the

staff agreed with the statement that relatives should have the opportunity to be with a family member during resuscitation, provided appropriate professional support was available.

2.3 A description of the conceptual framework used in this study

In order to study attitudes it was important for the researcher to define attitudes and to recognise the different components that comprise attitudes. Greenberg & Baron (1997, p. 170) define attitudes as “relatively stable clusters of feelings, beliefs, and behavioural predispositions”. Three major components of attitudes are recognised, namely, the ‘evaluative component,’ the ‘cognitive component’ and the ‘behavioural component’ (Greenberg & Baron, 1997). The evaluative component of the emergency staff’s attitudes addresses their like or dislike of witnessed resuscitation, the cognitive component addresses their beliefs’ about witnessed resuscitation, and the behavioural component refers to the emergency staff’s tendencies to behave according to their feelings and beliefs about witnessed resuscitation. Although exploration of the behavioural component of a participant’s attitudes will reveal their predisposition to behave in a certain way, this component cannot necessarily be predictive of their behaviour. As an example, a department policy that dictates actions that are inconsistent with the emergency staff’s evaluative and cognitive components may cause their behaviour to be inconsistent with their attitudes. The emergency staff may strongly believe in witnessed resuscitation but be required in their employment contract to abide by unit policies that dictate that no relatives are to have access to the resuscitation room whilst a resuscitation is in progress. This framework, together with the literature reviewed, will form the conceptual framework for this study.

In the following chapter the research approach, setting, selection of participants and data collection processes shall be discussed. This is followed by details of the ethical considerations taken in this study and evidence of the trustworthiness of this research. Methods of analysis used in this study are also presented.

Chapter 3

Research Methodology

In this chapter the research approach, setting, selection of participants and data collection processes shall be discussed. This is followed by details of the ethical considerations taken in this study and evidence of the trustworthiness of this research. Methods of analysis used in this study are also presented.

3.1 Research approach

This research was conducted in the form of a qualitative survey. The rationale for choosing this approach is that the majority of the limited research done internationally on the attitudes of the emergency staff towards witnessed resuscitation, has been done through anonymous questionnaires. This quantitative approach may not provide an explored, holistic study of their attitudes and practices. Thus a qualitative approach has been chosen for this study, as this approach allowed for a thorough, individual exploration of the participants' attitudes and practices as well as a descriptive discussion of the findings of this study. This research was carried out in emergency departments through interviews with emergency staff in which their understandings and experiences were explored.

3.2 The setting

All four level one emergency departments in KwaZulu-Natal are found in the Durban

Metropolitan area, thus participants in this study were from two of these four departments. The researcher was employed in a full time capacity in one of the two private level one emergency departments, thus the other private level one emergency department was selected for use in this study. The provincial emergency department used in this study was randomly selected from the two provincial level one emergency departments in KwaZulu-Natal.

3.3 Selection of participants

The participants in this study were the doctors and registered nurses who comprised the emergency staff of the level one emergency departments in the province of KwaZulu - Natal. It is a combination of the attitudes of both the clinical staff - the nurses employed in the unit, and managerial staff - the doctors and nurses in charge of the departments, that determine what is practised in the emergency departments. Thus the researcher's sample comprised of key clinical and managerial informants, chosen through purposive sampling, from one of the two privately run level one emergency departments, and from one of the two provincial level one emergency departments in the province of KwaZulu - Natal. The participants needed to have been employed in the department for more than six months. This was specified in order to ensure that the participants had had sufficient exposure to the resuscitation process. Specialized emergency training was not required as a criterion. The principle of theoretical saturation was applied in this study

After gaining access to the hospitals used in this study and the respective department management, the researcher introduced herself and the research subject to the emergency staff in the respective departments. Each participant was informed about who the researcher was,

why the research was being done and how confidentiality was to be maintained. After the introduction, the staff either volunteered to participate in the research or accepted nomination by a colleague. The participants were found to be willing to participate in the study, and they were informed of their right to withdraw at any time. Each participant met the criteria of having been employed in the unit for more than six months, and none of the participants chose to withdraw from the study. A doctor, the nurse in charge of the department and a nurse working in the department were interviewed from each of the respective hospitals and theoretical saturation was achieved. At the start of each interview a pseudonym was chosen by each of the participants in order that their identity remained confidential.

3.4 Data collection process

Two semi-structured interviews were conducted per participant and all these interviews were carried out by the researcher. The first interviews were based on the questions found in Appendix 1. The second interviews were verifying interviews, in which the researcher reported back the findings of the first interview to the participant for confirmation of the interpretation of the data collected in the first interview.

All the interviews were conducted while the participants were on duty in their respective emergency departments. The researcher waited until the department was quiet and the staff were available to be interviewed. The interviews were then conducted in the emergency departments, either in the doctor's office, nurse in charge's office, an empty treatment room or an empty grieving room. 'Do not disturb' signs were placed on the doors and the staff in

the department knew that the interviews were taking place and where. The interviews were recorded with the permission of the participants.

Each participant was asked in the initial interview, about the existence of department policies that dealt with the relatives of a patient being resuscitated. This was done in the search for data in the form of documentation that could impact the practices of witnessed resuscitation in each of the respective emergency departments.

3.4.1 The initial interview

The initial interviews studied the participants' attitudes and practices and were semi-structured through a selection of questions as seen below. The interviewer explored the participants' answers, asking for further information when needed for depth or clarity and also observed for non-verbal clues. (Full interview guide in Appendix 1)

The six main questions used in the initial interview, were as follows:

- What do you understand by the term 'witnessed resuscitation'?
- What are your thoughts regarding witnessed resuscitation?
- Do relatives ask to be allowed to witness the resuscitation of their family member? If so,
 - a) how frequently?
 - b) what is your answer and why?
- Have you been involved in a witnessed resuscitation, if so what do you think about the experience?

- Does your department have any policies to deal with the relatives of a person being resuscitated? If so, what is the policy, who designed it, and is it practised?
- If a member of your family was being resuscitated, would you want to be present and witness his/her resuscitation, and why?
- How do you think you would feel if a member of your family was allowed to be in the resuscitation area while you were being resuscitated?

3.4.2 The verifying interview

This interview verified the findings of the first interview. The researcher summarized and repeated the findings of the initial interview to the participant for confirmation. Any areas that were found to be unclear were clarified and areas that required further exploration were explored further. The participants were also asked to add any thoughts regarding witnessed resuscitation that they may have had in the time between the interviews. The interviews were recorded with the permission of the participants.

3.4.3 Department policies

Records, in the form of department policies for dealing with the relatives of a patient being resuscitated, were also considered as data for this study. Each participant was asked in their initial interview about department policies or protocols available.

3.5 Ethical considerations

Permission and ethical clearance to conduct this research was obtained from the University of Natal and from the board of managers of the private hospital as well as from the medical superintendent of the provincial hospital, before the research was undertaken. Please see Appendix 2 and 3 for a copy of these letters granting the researcher permission to conduct this study.

Before starting the interviews, the participants were each informed of the research being undertaken, and that participation in this study was voluntary. The participants were advised of their right to withdraw from the study at any point and this decision was respected. The interviews were taped, with the knowledge and verbal consent of the participants, for transcription purposes. Once the interviews had been transcribed, these tapes were destroyed - only the transcriber and the researcher had access to the recorded interviews before they were destroyed. The identity of the emergency departments and emergency staff involved in this study have been kept confidential and have not been mentioned or alluded to in this study. Each participant was asked to choose a pseudonym at the beginning of the initial interview, and this has been used throughout the study, therefore data is not able to be traced back to the source.

3.6 Trustworthiness

Numerous methods have been used in this study in providing credibility of the findings.

In order to address the risk of "sampling bias," (Brink, 1993) both managerial and clinical

informants have been selected in this research, and all the participants selected showed evidence of sufficient experience, knowledge and the ability to recall and present their attitudes and behaviours prior to the interview. All the participants had been employed in the respective emergency departments for more than six months and thus had experience in patient resuscitation.

Four recognised and commonly used criteria for establishing the trustworthiness of qualitative data are credibility, transferability, dependability and confirmability (Polit & Hungler, 1993). In applying these concepts to the study the following steps were taken. The verifying interviews used in this study provided one of the main techniques used. In these interviews the research participants reviewed, validated and verified the researcher's interpretations and conclusions of their initial interviews. Any data that was unclear or required further exploration, was clarified. A detailed database and thick descriptions were also used in the study in order to enable others to determine whether the findings of the study are applicable to another context. Through the recording and transcribing of the interviews, of which an example is available in the study (Appendix 4), a means for independent analysis of the researcher's interpretations, by a more experienced researcher, was provided. The use of semi-structured interviews, that were conducted according to the guide found in Appendix 1, also provided a standard for the interviews that can be repeated.

'Bracketing, found in Appendix 5, has been provided in this study in order to eliminate "researcher effects" (Brink, 1993) throughout the research. Bracketing is the process whereby the researcher examines her/himself in order to identify and make known his/her values and assumptions about the research topic (Brink, 1993). This is done in order to recognise the risk

for researcher effects on the participants of the study and therefore control the risk. Thus, through this exercise, the researcher has examined and provided her underlying values, experiences and assumptions about the attitudes and practises of emergency staff towards witnessed resuscitation, in the level one emergency departments in KwaZulu-Natal.

3.7 Analysis of findings

The recorded data was transcribed into written text by the researcher and a person trained in transcribing. The data was then manually analysed using qualitative context analysis to derive patterns and themes from the recorded data, a method recognised and discussed by Brink (1996). The researcher became immersed in the data and identified themes in the interviews, categorising these themes under the appropriate categories identified in the conceptual framework used in this study. These findings were reported in the narrative form and a detailed database and thick descriptions were used. In the transcribing of the interviews a format compatible with the qualitative computer analysis program NVIVO was used so that if the data from this research became too extensive for manual context analysis, this program could be used in the analysis of the data. This is a practice recognised by Brink (1996) as being useful in the analysis of qualitative data.

The following chapter discusses the setting, the participants and the interviews. The findings of the interviews are then presented.

Chapter 4

Presentation and Discussion of findings

In this chapter the setting, the participants and the process of gaining access to the participants, is described. A profile of the participants is then provided followed by a discussion of the interviews and an analysis of the findings.

4.1 Introduction

A total of six emergency staff members were interviewed. The researcher followed the principle of theoretical saturation, thus data were collected until no new material was being provided. Of the six participants in this study, three were from a private emergency department and three were from a provincial emergency department. Each participant was interviewed twice, the second interview being a confirming interview used to confirm the findings of the initial interview. As was proposed, emergency staff from both the managerial and the clinical fields were interviewed.

Although each participant was asked about the existence of a ward policy regarding witnessed resuscitation, all the participants reported there to be no formal documented policy, but rather a general understanding in each department about what was done, thus there were no records that were analysed as part of the data in this study.

4.2 The setting

The interviews took place in the emergency department of the respective hospitals involved in this study, as this was the most convenient time and place for the participants to meet the researcher. The interviews were conducted whilst the participants were on duty and the department was quiet. Each interview was held in a quiet room, either an office, empty treatment room or empty grieving room, and a “do not disturb” sign was placed on the door.

Before starting the interviews, the participants were each informed of the research being undertaken, and that participation in this study was voluntary. The participants were advised of their right to withdraw from the study at any point and that this decision would be respected. The interviews were taped, with the knowledge and consent of the participants, for transcription purposes. The researcher also made notes after the interviews, on her thoughts regarding the interview and the non - verbal cues that were noted from the participant during the interview.

4.3 The participants

4.3.1 Private emergency department

After having received permission from the hospital, and after gaining telephonic permission from the nurse in charge of the department, the data gathering process began. The researcher asked to be introduced to the staff by the matron in charge of the emergency department. This was felt to be necessary in establishing the staff’s trust. The department was quiet and the staff

welcoming. An explanation of the research, why it was being conducted and how, as well as what it would involve, was given to all the staff. It was explained that each participant needed to have worked in the department for at least six months and that an interview with the staff member in charge of the department was desired if possible. The nurse in charge agreed. It was also explained that an interview with one of the trauma doctors was needed, one of the two doctors was nominated by the staff and subsequently agreed to participate. The third participant was nominated by her colleagues - she too subsequently agreed to participate. The researcher then interviewed these three participants. These interviews were between 15 - 30 minutes long.

A week later the researcher returned to the same emergency department and did confirmation interviews with the same three participants. The department was busier than before but the participants were reassured that there was no urgency for the interviews. The interviews were done as each participant became available. These interviews again ranged from 15 - 30 minutes long.

4.3.2 Provincial emergency department

Permission was then received from the provincial hospital, and after gaining telephonic permission from the nurse in charge of the department, the data gathering process began. The nurse in charge, upon being given an explanation of the research, why it was being conducted and how, as well as what it would involve, agreed to participate. It was explained that each participant needed to have worked in the department for at least six months. The nurse in charge then asked for a certain nurse to come to the office. The department had patients but was not very busy. When the nurse arrived the nurse in charge explained what the researcher

was doing and asked if the nurse concerned would participate. The researcher emphasised that the nurse was under no obligation to participate, however, she reported being interested in the study and agreed to participate.

The nurse in charge then suggested that the doctor that was most senior in the department be interviewed. It was then discovered that this doctor was unavailable, through speaking to the other doctors in the department the researcher understood that the senior doctor was fulfilling a largely administrative role and was thus seldom in the department. The researcher then approached one of the other doctors in the department, but found this doctor to be reluctant to participate. However, a doctor who was working in the same room immediately volunteered to participate in the study. These interviews were each between 15 - 30 minutes long. All the participants were found to be welcoming and interested in the research.

A week later the researcher returned to the same emergency department and did confirmation interviews with the same three participants. The two nurses were interviewed in the morning and the doctor was interviewed that evening as he was doing night shift. These interviews again varied between 15 - 30 minutes long.

Of all the participants, four were trained specifically in emergency care and two had no post basic training. All of the participants had been employed in their respective departments for more than six months. A profile of the participants in this study can be found in Table 4.1.

Table 4.1 Profile of the participants

Pseudonym	Position in Unit	Years in the Unit	Description of participants
SHAUN	Medical Officer	8 years.	He had not participated in a witnessed resuscitation prior to this study. He had done Advanced Cardiac, Trauma and Paediatric Life Support and a diploma in Emergency Medicine and Care. He was married with children at the time of the study.
PENNY	Registered Nurse	2 years and 9 months.	She had never participated in a witnessed resuscitation. She had worked in the same emergency department since she qualified. She had no children and was not married at the time of this study, however both of her parents and her sister lived in Durban.
LUCY	Registered Nurse in charge of the unit.	9 months.	She had participated in a witnessed resuscitation when working on an ambulance, the resuscitation occurred in the patients home. She did her diploma in trauma nursing in 1998. She was married at the time of this study.
BOB	Registered Nurse in charge of the unit.	8 years.	He had not participated in a witnessed resuscitation. He had been in charge of the emergency department for two years. His brother died in a motor vehicle collision.
BONGI	Registered Nurse	2 and a half years.	She had not participated in a witnessed resuscitation. She had no post basic training. She had had a baby boy nine months previously.
SIMBA	Medical Officer	2 years.	He had participated in a witnessed resuscitation in the emergency department in a situation where the relatives had refused to leave the resuscitation area. He had done Advanced Cardiac, Trauma and Paediatric Life Support and was currently studying a diploma in Emergency Medicine and Care.

4.4 The interviews

All of the participants were interviewed whilst they were on duty at a time that both suited them and the department. The interviews were not interrupted as there were fortunately no emergencies that occurred during the interviews, and the staff in the department knew that the interviews were taking place and where they were taking place. A “do not disturb” sign was placed on the door. It is possible that the participants may have felt less relaxed in the interviews because of the possibility that they could be called out to attend to an emergency at any time. However, no reference was made to such concerns, and no non - verbal clues were noted that indicated that this was a concern for any of the participants.

LUCY was initially scared by the idea of the interview being recorded, but the other staff soon convinced her that she had nothing to be concerned about, and during the interview she relaxed and spoke freely. None of the other participants appeared to be concerned about the recording of their interviews. Strangely, two of the participants, when initially asked to choose a pseudonym for themselves, said they didn't mind using their own names. They were both encouraged in the second interview to choose a pseudonym in order that they not be linked with the contents of their interviews.

Another unexpected occurrence during the interviews involved the definition of witnessed resuscitation. Prior to doing the interviews, the researcher clarified what the research was about and discussed the research process. However, all three participants from the private institution then gave incorrect definitions of witnessed resuscitation at the start of their interview. SHAUN defined witnessed resuscitation as “...*how we perceive the resuscitation*”

to have gone...”, and both PENNY and LUCY described witnessed resuscitation to be the situation where the arrest of the patient is witnessed by an emergency staff member who then immediately implements life saving measures. Because of this experience, extra care was taken in the interview to explain what was being researched and extra time was spent ensuring that the participants from the provincial emergency department understood the research subject before their interviews were carried out.

4.5 Discussion of findings

This study was conducted with the aim of exploring and describing the attitudes and practices of the emergency staff working in the level one emergency departments in KwaZulu-Natal, with regard to witnessed resuscitation.

The twelve interviews from the six participants in this study formed the data of this discussion, and the contents of the interviews have been discussed in categories under the components defined in the conceptual framework used in this research. In this framework, attitudes are seen to consist of three major components, namely the evaluative component, the cognitive component and the behavioural component. This discussion is followed by a discussion of the practices of the emergency staff, with regard to witnessed resuscitation. There were no written policies that dealt with the relatives of the patient being resuscitated in either of the departments, thus no documentation was available for analysis.

The categories and sub-categories used in the presentation and discussion of the data gathered in this research, are presented in Table 4.2.

Table 4.2 Categories and sub-categories derived from the data

Attitudes or practices	Categories	Sub-categories
Attitudes	*Evaluative component of attitudes - the emergency staff's likes or dislikes of witnessed resuscitation. *Cognitive component of attitudes - the emergency staff's beliefs about witnessed resuscitation. *Behavioural component of attitudes - the emergency staff's predisposition to behave in a certain way.	* 'Not a good idea' * 'Maybe not so bad' * 'Hurting the body' * Limited resources * 'Getting in the way' * Unsatisfied relatives * 'Maybe it could work' * Preventing witnessed resuscitation
Practices	*Practices of the emergency staff - the actual practices of the emergency staff.	* 'What is practised' * Relatives requests to be present * Staff experiences of witnessed resuscitation * 'More than a change of heart?'

4.5.1 Evaluative component of staff attitudes

This component deals with the participants like or dislike of witnessed resuscitation. The participants' responses have been discussed in the sub-categories below.

4.5.1.1 'Not a good idea'

All of the participants, on being asked their thoughts about witnessed resuscitation, expressed that they didn't like the idea of having the family present in the resuscitation room. Some

participants were more strongly against having the relatives in the resuscitation room than others, for example SIMBA said *"I totally disagree with allowing family members into the resuscitation room..."* whereas PENNY said *"I don't think it's nice..."*. Although their feelings were expressed in varying degrees, they all expressed that they didn't like the idea of having relatives in the resuscitation room. This finding is similar to those of Mitchell & Lynch (1997), who distributed questionnaires to emergency staff in which they were asked if they were in favour of the presence of selected relatives during a resuscitation. Their responses were predominantly negative. Osuagwu (1993) had the same result to this question at an Advanced Cardiac Life Support course in 1993.

On further exploration, all of the participants reported that they themselves would not like to witness the resuscitation of one of their family members - although SHAUN, LUCY, BOB and SIMBA, did clarify that if they felt that their expertise was needed, they would become involved in the resuscitation from a medical point of view. Medical involvement was a concern for the participants who expressed that they would feel drawn to become actively involved in the medical resuscitation because of their training, and in doing so would not be acting in the patient's best interests as their judgement would be emotionally affected. LUCY expressed this concern in the following words, *"...with every patient you just log on, do your work and that's it. It's not Mr so and so. It is a patient, a person with an aortic aneurysm, it's a person with bilateral femoral fractures, it is not a patient with a name and that."* She went on to say, *"...you are going to be in the way because you are emotionally involved."* BONGI summarised the participants' feelings as follows, *"I'd prefer to hear of the results of it, what happened, but I wouldn't like to be there."* These feelings of their relative being known to them and therefore making the resuscitation more difficult, are feelings that were

also expressed in a survey done in Michigan in 1985 (Hanson & Strawser, 1992). In this survey the staff reportedly found that just having the patient's family present, brought staff emotions closer to the surface and made the resuscitation even more stressful for them. These feelings would be intensified should the patient be a relative of theirs.

All of the participants reported that, should they themselves require resuscitation, they would prefer that their family members were not present in the resuscitation room. A quote from LUCY expressed most of the opinions of the participants, her response was as follows, '*Gasps* No, out, no it's going to be a big shock...' This feeling is acknowledged by Eichhorn et al (1996), where they state that family members are usually prevented from being in the resuscitation area as it is believed by the staff that they will not be able to cope with the crisis. Interestingly in a study done by trauma specialists with extra psychological training, it was discovered that the feeling of anguish over not being with the loved one was paramount, and that through witnessed resuscitation the anguish of being separated and alone without knowing what was happening to the loved one was eliminated (Eichhorn et al, 1996).

It was initially evident to the researcher that the participants did not like the idea of having the patient's relatives present in the resuscitation area, that they would prefer not to be present at the resuscitation of one of their loved ones and that they would prefer for their family members not to be present should they themselves require resuscitation one day. The reasons given for the participants' dislike of the idea of witnessed resuscitation arise from their beliefs about witnessed resuscitation. These reasons have been explored fully in the discussion of the cognitive component of the emergency staffs' attitudes.

4.5.1.2 'Maybe not so bad'

As has been mentioned earlier in this study, on starting the interview process in the private emergency department, it became evident that witnessed resuscitation was a new and threatening topic. All three participants confirmed that they had understood the research topic, but then gave definitions that revealed that they had not understood the topic at the beginning of the initial interview. This was corrected through a repeat explanation and check that they in fact did understand the topic. The participants in this study, as apposed to actively debating the topic of witnessed resuscitation - as was found in international studies (Rattrie, 2000), were discovered to have little knowledge about witnessed resuscitation or the ongoing debate over the implementation of this practice.

However, by the end of the interviews, the researcher found the participants to be more interested and receptive to the concept of witnessed resuscitation than when the topic was initially introduced to them. Eichhorn et al (1996, p. 69), report a similar finding, and state, "Almost imperceptibly during a period of months attitudes have changed...health care colleagues are talking about questions or concerns they have regarding specific details of implementing our family presence program. Although our journey is not over, the mind set is changing." They perceived a change in people's attitudes, and felt that the possibility of practising witnessed resuscitation did not seem as remote as before.

This change was evident in BOB, who in his verifying interview reported a changed opinion about being present at the resuscitation of a member of his family. He still reported that for the lay person such an experience would be harmful, but reported that even if he was not there in a medical capacity he felt that he would probably want to be there to talk to his relative.

BOB concluded by saying, “...*I don't know, is there any research done to show that when a person is comatosed, listening to a relative talking to them has made a difference to the eventual outcome?*” Towards the end of his initial interview, SHAUN, after saying that he didn't think his wife would want to be present at his resuscitation, said that if his wife insisted on being there he would not have any objection to having her there. This is an indication that SHAUN was considering a practice that he had not really considered before.

In his interview, SIMBA also raised a new point saying, “*It would be nice to have known that they would have been there, but I wouldn't want them to see what was happening to me...*” Although his overriding thought is that he wouldn't want his family members to be present should he require resuscitation, it is interesting that he mentions that he would like to have known that they were there with him. It appears that through merely considering and exploring the attitudes and practises of the emergency staff with regard to witnessed resuscitation, their attitudes are less defined and more accepting of the idea of having relatives present at the resuscitation of their loved ones. Dolan (1998) as cited in Rattrie (2000), is quoted as saying that in order for holistic medicine to be effectively practised, the family must be included at times of life and death. Dolan (1998) as cited in Rattrie (2000), goes on to say that she is convinced that in a few years time witnessed resuscitation will seem natural to emergency staff. Over the course of this study there was a change in the participants' dislike of the idea of witnessed resuscitation, the evaluative component of the staffs' attitudes became more accepting of the idea.

4.5.2 Cognitive component of staff attitudes

This component of the staff's attitudes has to do with their beliefs regarding witnessed

resuscitation. The staff had numerous reasons for why they felt that witnessed resuscitation was 'not a good idea'.

4.5.2.1 'Hurting the body'

All of the participants felt that the experience of witnessed resuscitation would expose the relatives to detrimental sensory disturbances. SHAUN stated, "*I don't think it's good for the family to have that image in their mind of their loved ones essentially being hurt...*" BONGI, said, "*...I wouldn't like to see my relative being resuscitated having seen what we do to the patients.*"

The participants mentioned life saving measures that are often used in the resuscitation of a patient, that would be disturbing to family members should they see them. PENNY made the following statement, "*I don't think I would like to watch my family members being resus'ed. It's kind of...I mean people pressing on your chest, ribs breaking and things like that.*" Other measures specifically mentioned were, the insertion of chest drains, defibrillating, putting in pipes and sticking in needles, and intubation. All of these are invasive procedures that are, as LUCY mentioned, "*abnormal in their eyes,*" and therefore difficult for the relatives to witness.

The participants' concerns about sensory disturbances are concerns that are mentioned by Cole (2000). This author highlights visual, olfactory and auditory disturbances that occur in a resuscitation as part of the argument against the practice of witnessed resuscitation, but also goes on to mention that through seeing what has been done, terrible imagery and anxiety can be dispelled. This consideration is supported in a study conducted in Cambridge between November 1995 and February 1997, by Robinson et al (1998). The study revealed that all the

relatives that attended the resuscitation of their loved ones were content with their choice. Furthermore, when they were assessed three months after the witnessed resuscitation, a trend toward lower degrees of intrusive imagery, post-traumatic avoidance behaviour and symptoms of grief were found.

Intrusive imagery, the lasting effect of extreme sensory disturbance, was mentioned by half of the participants as a reason why they didn't think that the practice of witnessed resuscitation was a good one. BOB expressed his concern as follows, "*I could have nightmares as such, that this is all the turmoil and all the pain and all the trauma that the patient had to endure and despite all that they still died*". LUCY, when asked how she would feel should her family be allowed into the resuscitation area, expressed that she strongly felt that they should not be allowed in, one of her reasons being, as she stated "*.. and that is what they're always going to remember...*" SIMBA also addresses this point saying, "*... I wouldn't want them to see what was happening to me - that in itself would be a cause of post trauma - it can cause flashbacks.*" It is seen, from the above quotations that emergency staff are concerned about the risk of stress disorders and intrusive imagery for the witnesses in a witnessed resuscitation.

4.5.2.2 Limited resources

All of the participants made reference in their interviews to their concerns about the available resources in their departments to cope with the relatives in witnessed resuscitation, should this be practised. The main 'resource' that was noted to be insufficient was emergency staff. Most of the participants mentioned that a resuscitation used all their available staff not leaving anyone free to care for the relatives until the resuscitation was over or had quietened down due to a procedure such as x-rays. PENNY mentioned that she felt uncomfortable just leaving the

relatives in the grieving room unattended, but said that, despite staff efforts, this was often what happened during a resuscitation.

Another resource that was noted as lacking was space. The resuscitation areas are reportedly small making it highly likely that family members would hinder the resuscitation process. Furthermore, the provincial hospital has one resuscitation area in which up to four resus's can be taking place at a time - as mentioned by BOB, "*...we don't have an ideal set up to allow for patients relatives to be there.*"

This identification of the support structures necessary in order to practice successful witnessed resuscitation are in keeping with the conclusion by Cole (2000). This article mentions that structures, such as staff availability, support personnel, training costs and relative follow up, need to be addressed and the cost of developing them considered before witnessed resuscitation can be implemented as a practice, this need for a programme or structure is also recognised by Eichhorn et al (1996). Achieving this will be increasingly difficult in a province which has a population that continues to swell and health resources that continue to dwindle (Stucky, 1998).

4.5.2.3 'Getting in the way'

All of the participants expressed their concern for the possible interruption of the resuscitation process should witnessed resuscitation be practised. They all felt that the family members would get in the way of the staff and hinder access to the patient. A shared opinion was quoted by BONGI, "*We have to get to the patient and we have to do something for the patient, so they will be in the way.*" The concern that a grief-stricken relative may disrupt the resuscitation,

was identified by Cole (2000) as being a shared concern amongst emergency staff.

SIMBA also contributed an interesting observation with regard to having family members in the resuscitation area. He said *"...they tend to get in the way - and the mourning - and it changes the mood of the room. It also impacts on the people trying to do the resuscitation."*

This finding was also noted in a survey done in Michigan in 1985 (Hanson & Strawser, 1992), where the staff responded that witnessed resuscitation brought their emotions closer to the surface and made the resuscitation even more stressful for the staff. Having the patient's loved ones in the room made the situation increasingly stressful for the emergency staff as it became more difficult to remain emotionally detached from the tragedy.

Humour and laughter have also been identified as tools used in coping with stressful situations (Maeve, 1998). This method of coping would not be appropriate in a witnessed resuscitation where the relatives of the patient being resuscitated would witness this behaviour and certainly not understand it. Thus this is another way that the 'mood of the room' and the amount of stress placed on the emergency staff may be affected.

SIMBA expressed other ways that the family may impact the resuscitation, *"You could get someone who falls and faints and lacerates their head and you would have to stop that bleeding."* He also mentioned that *"...while you are resuscitating you can't have somebody tapping you and asking you what is the problem or what has happened - that sort of thing."*

SIMBA also said that in his experience *"...the moment the family heard that we were stopping, they want you to continue.."*

LUCY describes a different impact on the resuscitation and resuscitation team of emergency staff in the following words *"We are putting in pipes, we are sticking in needles and we are*

doing all those horrible things and all these people want to do is take a little wet cloth and wipe off his face, but as soon as everything is stable and under control, get the people involved. ” Throughout LUCY’s interviews it was evident that she believed family presence to be disruptive to the resuscitative process. This was summarized in her verifying interview where she stated, *“Ja, and you don’t want them to get in the way - that’s harshly saying it.”*

In contrast to the experiences and fears of the participants in this study, a study that was done in Michigan, in the Foote Hospital (Hanson & Strawser, 1992), reported that no relatives interfered with the resuscitation during a trial of witnessed resuscitation. However it was reported that some relatives who became hysterical in this study were lead away from the resuscitation area. This is an important aspect of witnessed resuscitation, without an adequate programme to support the family members of a witnessed resuscitation, the resuscitation is in danger of being affected (Cole, 2000). Eichhorn et al (1996) in relaying their witness resuscitation programme, state, “A family member is never left alone at the bedside during a resuscitation or the performance of a procedure...families need to understand that they will be escorted out of the room if they act overwhelmed, disturb the resuscitation efforts, or distract the resuscitation team.” (Eichhorn et al, 1996, p. 66)

Interestingly both SIMBA and LUCY mention how peoples’ cultural differences may impact on witnessed resuscitation. SIMBA expressed that *“Families come in droves - and they don’t come in one or two, they come in ten, twelve, twenty! And there’s certain cultures and religious beliefs that actually (hesitates) in South Africa we are very diverse with a whole lot of cultural systems where some of them want to come in at twenty...”* LUCY also mentions this difficulty in dealing with the families of different cultures, she said *“...they come and*

stand here by the resus bed and you can hardly get to the patient and you feel like you want to say 'when you need me please call me I will be in the front.' It is annoying and you need to say firmly and properly, 'go and wait for us over there.' You take them where-ever and they are quite co-operative. Especially in the Indian culture we see this so often. Because they want to be involved, they want to be here and everyone wants to be here. Everyone is there."

From these quotes it is seen that these two participants have observed differences amongst peoples cultures that impact on the resources and the resuscitation in different ways.

This is an important aspect of witnessed resuscitation. Different cultures and different people have different ways of coping with death and grief. Should it be decided that witnessed resuscitation is to be practised in a specific department, the training of support structures will need to address the needs of different people and cultures in order to ensure that the resuscitation process itself is not rendered less effective through an inappropriate or ineffective programme.

4.5.2.4 Unsatisfied relatives

Most of the participants mentioned their concern that the family members present in a witnessed resuscitation may not understand what has been done and may misinterpret the interventions of the emergency staff. A staff member who clearly stated this concern is BONGI, *"Watching what is happening, you just take it in your own way if you don't know exactly what is going on and then, you know, that causes a misunderstanding and at the end of the day maybe the relative would not be satisfied with what happened..."* SIMBA also identified this concern, saying, *"We can't predict the outcome of a resuscitation, some people come back from an asystole and then somebody might have a normal sinus rhythm and die -*

not because of any malpractice but just because of the magnitude of the injuries.” He expands saying that the family members expect a patient to live despite the magnitude of their injuries.

This fear of the relatives being unsatisfied with the resuscitative efforts of the emergency staff and this leading to possible litigation against the doctor or the hospital, is a concern recognised by Cole (2000) and Eichhorn et al (1996). However in a study by Robinson et al, (1998), it was found that none of the relatives that were allowed to witness the resuscitation of their family member commented on technical procedures done during the resuscitation. As was particularly mentioned by PENNY and BONGI, in order to prevent misunderstandings and litigation from occurring due to witnessed resuscitation, it is important that the relatives have an informant that explains and justifies the resuscitation process.

4.5.2.5 ‘ Maybe it could work’

At the end of her initial interview, BONGI was noted to have said, *“Well I think that it is a very interesting topic, as I have said, I strongly believe that the public will have to be educated and it will have to take a lot, because you know even when the patients are well and the relatives are with them - the way they behave ,you know, they want something to be done for the patient there and then, they do not understand that the patient next to them also needs the same attention that their relative wants as well, so they really have to be educated for them to be allowed into the resuscitation room. And we also need a bigger resuscitation room.”*

BONGI’S words show that by the end of her initial interview she was considering what would be needed in the implementation of a witnessed resuscitation programme, and this in turn shows a change in the cognitive component of her attitudes towards witnessed resuscitation.

PENNY, added in the closing of her verifying interview, that she felt that if this was going to be practised there would need to be a member of staff allocated to care for and explain everything to the family members. She is quoted as saying, “...*if they want to be there, there must be someone with them who can explain what’s happening, because otherwise it just looks really awful.*” This thought also shows her consideration of what it would take to make witnessed resuscitation an option.

4.5.3 Behavioural component of staff attitudes

The behavioural component describes a person’s predisposition to behave in a certain way in accordance with the evaluative and cognitive components of their attitudes.

4.5.3.1 Preventing witnessed resuscitation

It is evident from the evaluative and cognitive components of the attitudes of the participants of this study, that the participants have a predisposition towards preventing the relatives of a patient from entering the resuscitation room. In considering the evaluative component of the staff’s attitudes, their general feeling towards witnessed resuscitation was dislike and reserve, and in exploring the cognitive component of their attitudes it was found that the staff presented numerous reasons for their dislike of the practice. Thus it appears that the staff have a predisposition to prevent witnessed resuscitation in their emergency departments.

4.5.4 The practices of the emergency staff

Each participant was asked about the existence of department policies to deal with the relatives of a patient being resuscitated. All of the participants said that no written protocol existed, but that a general understanding amongst the staff, provided consistency in the management of the

relatives of a patient being resuscitated. This consistency was evident in their accounts of what was practised.

4.5.4.1 'What is practised'

All of the participants in this study said that the family of the patient being resuscitated were routinely asked to wait outside of the resuscitation area and that the members of staff kept them informed as often as they could. Once the patient had been successfully resuscitated or had died, the family were then allowed to be with the patient and all their questions would be answered by the resuscitation team.

In his confirming interview SIMBA summarized the general feelings expressed by all of the participants *"...we acknowledge that there is a need for the family to know, everyone would want to know what is happening, but we do it at a time and situation that will not interfere with the resuscitation. This is the most appropriate way, it's a compromise, the family understands - 'let them do what they can and we will wait until they are finished to get our information'."*

It is clear that the general understanding between the staff of the different emergency departments about what is done with the relatives of a person being resuscitated, is consistent, and that the practices in both the private and provincial hospitals are the same. The practices of these staff confirm the findings of Eichhorn et al (1996, p.59), they state "in most hospitals, family members are prohibited from being present during resuscitation...".

4.5.4.2 Relative requests to be present

Here the staff were found to have three different perceptions. PENNY had the experience that relatives didn't ask to stay in the resuscitation room. BONGI said that in her experience the relatives of a patient being resuscitated often did ask to remain with the patient, she stated, "*Most of them ask.*" SIMBA, LUCY, SHAUN and BOB, said that relatives didn't tend to ask to be allowed to stay - but each of them mentioned examples where the relatives tended to stay in the resuscitation room until asked to leave.

PENNY summarised the general feeling with regard to requests for witnessed resuscitation, "*I think that the relatives want to help so they are co-operative when we ask them to wait in the waiting room.*" PENNY went on to say that it may be because of the firm way in which the relatives were asked to wait in the waiting room, that influenced the relatives causing them to co-operate and not to ask to stay with their family member. This perception is one that is mentioned by Cole (2000, p. 3), where the relative of a person who was resuscitated is quoted as saying, "I would have loved to have held his hand but I didn't dare ask."

4.5.4.3 Staff experiences of witnessed resuscitation

SIMBA, who was the only participant to have been involved in a witnessed resuscitation in the emergency department prior to this study, said "*...They had refused to move when they were asked to wait in the waiting room, and we couldn't keep focussed on the family when the patient is (hesitated) so we concentrated on the patient and continued with the resuscitation as far as we could but the patient was actually already dead....*" The family in this instance became hysterical and broke down when they heard that the resuscitation had been unsuccessful and that the effort was to be terminated. They reportedly wanted the medical

team to keep resuscitating the patient. Such a situation is recognised by Cole (2000) as being a concern for emergency staff. In the study done in Michigan, in the Foote Hospital (Hanson & Strawser, 1992), it was reported that no relatives interfered with the resuscitation during a trial of witnessed resuscitation. However, as noted before, this study involved controlled and organised witnessed resuscitation which was not carried out in the witnessed resuscitation experienced by SIMBA. In the witnessed resuscitation experienced by SIMBA, the relatives stayed in the resuscitation room despite staff requests that they leave, there wasn't a member of staff available to stay with the witnesses, and the emergency staff did not have a programme to deal with a witnessed resuscitation.

LUCY, BONGI, PENNY, BOB and SHAUN had never been involved in witnessed resuscitation in the department in which they were currently employed. They had started a resuscitation in the presence of family members when the patient needed to be resuscitated in the car or ambulance, but they had then quickly moved into the department and away from the relatives. SHAUN also mentioned that on some occasions relatives had stood at the door to the resuscitation area and watched for a few minutes before leaving. The staff generally felt that they would prefer for the relatives not to have witnessed what they would have on these occasions, but said that at least the relatives could see that the staff were doing all they could for their loved one.

LUCY made an interesting reference to a resuscitation that she had had to perform in a patient's home when working with an ambulance service. This resuscitation, which had been unsuccessful, was witnessed by the patient's family. LUCY had reportedly felt she couldn't ask them to leave the room in their own home, and so the relatives had witnessed the

resuscitative efforts of the ambulance crew. LUCY said that in this case, she was glad that the family could see that all was done in an effort to save their son. When asked why this differed from her thoughts about witnessed resuscitation in the emergency department, she said that the lay person didn't know that an ambulance crew could do more than drive ambulances, so that on the road this experience was important, but that in hospital people knew that everything would be done to help their relative and so they didn't need to witness the traumatic event of the resuscitation.

4.5.4.4 'More than a change of heart?'

In SHAUN'S initial interview when asked about witnessed resuscitation he said, *"I must say, I generally discourage it, (hesitates), I don't think it's good for the family to have that image in their mind of their loved ones essentially being hurt, chest drains being put in, defibrilating and that sort of thing."*

However, on completion of SHAUN'S verifying interview, once the tape recorder was off, SHAUN relayed an experience he had had during the week between his initial and his verifying interview. He said that he had received an injured policeman with chest trauma who had required resuscitative interventions such as chest drains and fluid replacement and had then been taken to theatre for definitive surgical interventions. The policeman had been accompanied into the department by two of his work colleagues. SHAUN found that they were reluctant to leave their colleague's side and so let these two men stay with the patient in the resuscitation area during his resuscitation efforts. SHAUN was smiling as he relayed the incident in which one of the policeman had been explaining to the other everything that SHAUN was doing and why - the policeman had basic ambulance assistant training. SHAUN

said that the two policemen stayed with their colleague right to the theatre doors, where a member of the theatre staff who was reportedly surprised to see them, quickly told them that they couldn't come any further. SHAUN said that the whole incident had seemed natural, that the resuscitation hadn't been compromised and that the two policemen appeared to really appreciate being able to stay with their colleague as far as was possible.

It is evident through SHAUN'S actions that having considered the practice of witnessed resuscitation, he was more receptive to the idea and more aware of the possibility of allowing such a practice in selected circumstances.

A summary of the findings in this discussion, as well as the limitations, recommendations and conclusions of this study are presented in the following chapter.

Chapter 5

Summary of findings, Recommendations and Conclusion.

In this chapter the findings of this study are summarized, recommendations from the study are presented, its limitations discussed and the study concluded.

5.1 Summary of findings

This study was conducted with the aim of exploring and describing the attitudes and practices of the emergency staff working in the level one emergency departments in KwaZulu-Natal, with regard to witnessed resuscitation. The data consisted of twelve interviews conducted with six emergency staff members, each participant had an initial and a verifying interview.

5.1.1 Emergency staff attitudes

The conceptual framework used in this study and in the discussion of the findings divided attitudes into three components, namely the evaluative, the cognitive and the behavioural components. Thus the major findings of this study shall also be presented within these three components.

5.1.1.1 The evaluative component of staff attitudes

This component of the staff's attitudes addressed their likes or dislikes of the practice of witnessed resuscitation. It was evident in this study that witnessed resuscitation was a new and unexplored topic amongst the emergency staff in the level one emergency departments in

KwaZulu-Natal. The initial and overriding feeling of all of the staff in this study, was a dislike of the idea and the practice of witnessed resuscitation. They didn't think it was a good idea for the relatives of a person being resuscitated to be present at the resuscitation, they expressed that they would prefer not to be present at the resuscitation of one of their family members and they confirmed that they would rather that their families did not witness their resuscitation should they require resuscitation someday.

Although these were the dominant feelings expressed, one of the staff also showed a tendency to like the idea of having the opportunity to talk to his family member during their resuscitation, another participant mentioned that although he wouldn't want his family to see him being resuscitated, it would be nice to know that they were there. One of the other participants mentioned that if his wife insisted on being with him during his resuscitation, he would not have any objections to this. Thus feelings of liking aspects of witnessed resuscitation were evident amongst the emergency staff.

5.1.1.2 The cognitive component of staff attitudes

This component addressed the participants beliefs about witnessed resuscitation. The participants had numerous and valid reasons for their overriding dislike of the practice of witnessed resuscitation. They were concerned about the sensory disturbances that would be experienced by the witnesses of the resuscitation, they were concerned that the witnesses would suffer from post-traumatic trauma in the form of flash-backs and in terms of what they remembered of their loved one. They were concerned about the limited space in the resuscitation area and the limited staff available to support the witnesses in a witnessed resuscitation. They were also concerned that the resuscitative process would be rendered less

effective because of the family presence and that the resuscitation would be more stressful for the emergency staff. There was also a shared concern that the relatives, who would be unsure of what a resuscitation involved and why, would not understand what was done and would therefore be unsatisfied with staff efforts.

However the staff did often conclude by discussing the resources that would be necessary in order to have witnessed resuscitation in their department. This revealed that the staff did not believe the practice of witnessed resuscitation to be totally unacceptable.

5.1.1.3 The behavioural component of staff attitudes

This component describes the staff's predisposition to behave in a certain way towards witnessed resuscitation in their emergency department. The emergency staff's dominant feelings were those of dislike, and their beliefs provided reason for their dislike of the practice, thus they are perceived to have a predisposition not to allow witnessed resuscitation to take place in their department.

5.1.2 Emergency staff practices

Attitudes provide insight into the emergency staff's predisposition to behave in a certain way, but what is practised is not necessarily consistent with the predisposition to behave in a certain way. Thus, the actual practices of the emergency staff were also explored. It was found that neither of the emergency departments used in this study had written department policies dictating staff behaviour with regard to the handling of the relatives of a patient being resuscitated. However the staff from both of the departments said that there was a general understanding amongst the staff that provided consistency in their dealing with the relatives

of a patient being resuscitated.

From the accounts by the staff it was evident that there was consistency in their practices and that the relatives were always asked to wait outside of the resuscitation area and they were kept informed about the resuscitation by members of the resuscitation team as often as possible. Once the patient was stable the relatives would then be allowed into the room and any of their questions would be answered by the resuscitation team.

There were mixed experiences by the staff with regard to relative requests to be present at the resuscitation of their loved one. It was evident that relatives often stayed with their family member until they were asked to leave, and some of the participants had experienced requests from the relatives to be present at the resuscitation of their family member. Certain incidences where the family were reluctant or refused to leave their relative's side were also reported.

Only one participant had been part of a witnessed resuscitation in the department in which he was employed. The relatives of the patient had been asked to leave the resuscitation area but had refused and had therefore been present at the resuscitation of their family member. The family in this incident reportedly interfered with the resuscitation process and became hysterical when they realised that the emergency staff were terminating their efforts on confirmation that the patient was already dead.

Another participant reported that she had been involved in a witnessed resuscitation when working with an ambulance service. She felt that in this case it was an important experience for the family members as they could then see that all had been done in an effort to save their

son. The resuscitation was done in the lounge of this family's home and the family did not disrupt the work of the ambulance crew.

Finally, one of the participants, the doctor from the private emergency department, reported that in the week between his initial and his verifying interview he had participated in a witnessed resuscitation. His resuscitative efforts had been witnessed by two of the patient's colleagues, one of which had medical training. The witnessed resuscitation reportedly went well and the witnesses appeared to have appreciated being allowed to stay. The participant felt that the experience had been beneficial to the witnesses and to the patient and reported no interference with the resuscitation process.

Thus, although witnessed resuscitation is not currently practised in the level one emergency departments of KwaZulu-Natal, it appears that, with further research and education, emergency staff may become more receptive of this practice and provide the option of a witnessed resuscitation to those people in KwaZulu-Natal that want to remain with their loved one during his/her resuscitation. However, it is important to note that should such a programme be successfully implemented, resources in the form of trained emergency staff and of space in the respective departments would need to be adequately addressed.

5.2 Limitations of the study

The fact that the interviews in this study were carried out whilst the participants were on duty can be argued to have affected the participants in that they would have been aware that should

they have been required in the department they would be called. It could also be argued that the recording of the interviews could have caused the participants to be less spontaneous in their responses than had they not been recorded. This was evident in that the participant who had practised witnessed resuscitation between his initial and verifying interview, only mentioned this important experience once the interview was complete and the recorder switched off. Also the presence of the researcher could have influenced the participants' responses, in that the participants may have aimed to provide answers that they thought were what the researcher wanted to hear.

Another limitation in this study is that the participants frequently used medical terminology and department 'slang' frequently. This has means that, for those readers who are not familiar with the emergency setting, understanding and interpreting the findings in this study could prove to be difficult. A further limitation is that this study has a small sample size, and therefore the findings cannot be generalised beyond the context of this study.

5.3 Recommendations for the future

5.3.1 Recommendations for education

During this study it was discovered that there is a need for the emergency staff of KwaZulu-Natal to be informed about witnessed resuscitation, its advantages, disadvantages, implementation and affects. It is recommended that the concept of witnessed resuscitation be introduced in the undergraduate and post graduate training of nurses.

It was also found in this study that in order for witnessed resuscitation to be successfully implemented in KwaZulu-Natal, the emergency staff will need to have training in different ways of coping with stressful situations so that the experience doesn't make the resuscitation

process even more uncomfortable for them and their stressful jobs unbearable.

5.3.2 Recommendations for practice

It was evident from the accounts of the participants, that limited resources would make the implementation of such a programme very difficult if not impossible. Two resources particularly mentioned were the need for more staff, that could support and inform the relatives, and the need for more space, to allow for the relatives to be present but not in the way of the resuscitation.

It was also discovered that there were no written policies in either of the departments involved in this study that addressed the issue of dealing with the relatives of a patient being resuscitated. Thus, there is a need for methods of dealing with relatives to be studied and a policy drafted that provides substantiated and informed reasoning for the actions expected from the emergency staff.

5.3.3 Recommendations for further research

There is a need for further research with regard to witnessed resuscitation in KwaZulu-Natal. There is a need for the wishes of the public to be explored, particularly in relation to the many different cultures and religious beliefs that co-exist in this province. There is a need for witnessed resuscitation trials to be conducted and through this the effects that it has on the people could be studied, as well as the particular effects on the emergency staff and the resuscitative process. There is a need for research to be done that establishes the resources that would be needed in the implementation of a witnessed resuscitation programme and there needs to be research done on how the people of KwaZulu-Natal feel about having their family members present at their resuscitation should the situation arise. This study is one of the first

on witnessed resuscitation in South Africa as well as in KwaZulu-Natal and there is much that still needs to be explored and established.

5.4 Conclusion

In this study the attitudes and practices of the emergency staff working in two level one emergency departments in KwaZulu-Natal, were explored and it was evident that witnessed resuscitation was a relatively new concept for the staff. The emergency staff tended to dislike the idea of witnessed resuscitation and due to their feelings and beliefs had a predisposition to prevent witnessed resuscitation in their respective departments. However, although their dominant feelings were feelings of dislike, there were subtle references made during the interviews that revealed that there were some aspects of witnessed resuscitation that they liked, once they had considered the practice.

There were no policies in either of the emergency departments used in this study, that dealt with or dictated how to deal with the relatives of a patient being resuscitated. Consistency in dealing with the relatives in such a situation was achieved through a general understanding amongst the staff in the respective departments. This shared understanding ensured that the relatives of the patient being resuscitated were asked to leave the resuscitation area.

Through this study, it appears that although witnessed resuscitation is not currently practised in the level one emergency departments of KwaZulu-Natal, with further research and education, emergency staff may become more receptive of this practice and eventually provide the option of a witnessed resuscitation to the people in KwaZulu-Natal.

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Appendix 1

Research Instrument: Full interview guide.

Qualification:

Number of years employed in current emergency department:

Position held:

- 1) What do you understand by the term 'witnessed resuscitation'?

- 2) What are your thoughts regarding witnessed resuscitation?

- 3) Do relatives ask to be allowed to witness the resuscitation of their family member? If so,
 - a) how frequently?
 - b) what is your answer and why?

- 4) Have you been involved in a witnessed resuscitation, if so what do you think about the experience?

- 5) Does your department have any policies to deal with the relatives of a person being resuscitated? If so, what is the policy, who designed it, and is it practised?

- 6) If a member of your family was being resuscitated, would you want to be present and witness his/her resuscitation, and why?

- 7) How do you think you would feel if a member of your family was allowed to be in the resuscitation area while you were being resuscitated?

Appendix 2

Province of KwaZulu-Natal
Isifundazwe SaKwaZulu-Natal
Provinsie KwaZulu-Natal

Health Services Ezempilo Gesondheidsdienste

Office of the Deputy Director: Nursing



P O Box 977
Durban
4000

Your Reference

Our Reference

Tel: (031) 327 2000
Fax: (031) 327 2387

18 October 2001

Toni Goodenough
BY HAND

Dear Madam,

REQUEST TO CONDUCT NURSING RESEARCH

Your letter dated September 2001 in the above regard refers.

Please be advised that your request is supported by the Assistant Director Nursing, Addington Hospital.

The result and conclusion must be submitted to Matrons office, Addington Hospital on completion of your research.

Yours faithfully,

F. Dobivanyi

ACTING DEPUTY DIRECTOR NURSING
AC/cal

Appendix 3



St. Augustine's Hospital

107 Chelmsford Road, Durban 4001 * P.O. Box 30105 Mayville, 4058
Tel +27 (0)31 268-5000 * Fax +27 (0)31 201-4606
Web address: www.netcare.co.za
P.R. No. 5802563

8 October 2001

Miss Toni Goodenough
C/O University Of Natal
School of Nursing
DURBAN
4001

Dear Miss Goodenough

RE: RESEARCH PROJECT

We have no objection to you conducting a study on the attitudes and practices of the emergency staff toward resuscitation in the Trauma unit.

Please would you provide us with written feedback once your study is complete.

Yours sincerely

MS B HUDDLE
Nursing Services Manager

Appendix 4

PARTICIPANT: SIMBA
HOSPITAL : ADD
DATE : 18 OCTOBER 2001
FIRST INTERVIEW - VENUE: HOSPITAL

*WHAT IS YOUR POSITION IN THIS UNIT?

*I am a Medical Officer.

*HOW MANY YEARS HAVE YOU BEEN EMPLOYED IN THIS DEPARTMENT?

*Two years

*DO YOU HAVE ANY SPECIALISED TRAUMA TRAINING?

*ATLS, ACLS and APLS and I am busy with my E.M.C diploma.

*WHAT DO YOU UNDERSTAND BY THE TERM WITNESSED RESUSCITATION?

*Basically the family members or other members of the health team would be witnessing you and following you up to make sure that your resuscitation is up to standard.

*OKAY, FOR MY DISSERTATION I HAVE TAKEN THIS TERM TO MEAN THE SITUATION WHERE YOU HAVE A FAMILY MEMBER OR SIGNIFICANT OTHER IN THE ROOM WITH THE PATIENT WHILE YOU ARE RESUSCITATING. IT'S NOT NECESSARILY TO CHECK UP ON THE PROCEEDINGS BUT TO BE THERE FOR THE PATIENT AND TO SEE WHAT'S HAPPENING. THE DEFINITION I HAVE USED IN MY RESEARCH IS THAT IT IS ACTIVE MEDICAL RESUSCITATION OF A PATIENT IN FRONT OF THEIR FAMILY MEMBER OR SIGNIFICANT OTHER.

WHAT ARE YOUR THOUGHTS ABOUT THIS?

*My thoughts are, I totally disagree with allowing family members into the resuscitation room itself because in our country with the amount and the type of trauma we face, family members or significant other, they tend to get in the way - and the mourning - and it changes the mood of the room. It also impacts on the people trying to do the resuscitation. What we tend to do in our department is that we allocate and form a team of resuscitation and that resuscitation team handles the resuscitation to the maximum benefit of the patient according to our protocols of resuscitation. We also then allocate a nurse to actually deal with the family, so the family is getting correspondence of what is happening from the waiting room or the area where they are being asked to wait. At the end of the resuscitation one of the doctors go through and talks to the patient's family but that is as far as we go, there is no active witnessed resuscitation as such. Because in our department it's actually quite small, the other thing is that we have very limited space and we are very short of staff - the amount of trauma that we get is quite a lot - we can get up to 6 resuscitations in our department and we can't actually handle 6 - we can actually handle 2 at a time - the maximum that we have had is 4 at one time. Witnessed resuscitation as such won't actually work it was tried once where a family member was allowed to be there and that particular person broke down because that patient actually died. We can't predict the outcome of a resuscitation, some people come back from an asystole and then somebody might have a normal sinus rhythm and die - not because of any malpractice but just because of the magnitude of the injuries. We've had people who have been hit by trains and people with 60% burns - and as you know in South Africa 30% burns means 100% mortality. Family members still expect that particular person to live - you can't find a vein, you can't put in a

CVP, the skin is too taut..... so in those types of patients, with patients of a GCS of 3/15, or 5/15 or even 9/15 we can't allow the family there.

***DO RELATIVES ASK TO BE ALLOWED TO COME IN TO THE RESUSCITATION ROOM?**

*No.

***YOU MENTIONED THAT YOU HAVE BEEN INVOLVED IN AN INCIDENT ONCE WHERE A RELATIVE WAS IN THE ROOM AND BROKE DOWN.**

*Yes, it was an M.I. situation - the patient had had a severe M.I. and had gone into an asystole, he was on an adrenalin infusion and by the time the patient had got here, he had had 30 minutes of active resuscitation.

***HAD THE FAMILY COME IN WITH THE PATIENT?**

*Yes and they had refused to move when they were asked to wait in the waiting room, and we couldn't keep focussed on the family when the patient is ... So we concentrated on the patient and continued with the resuscitation as far as we could but the patient actually was already dead and the moment the family heard that we were stopping, they want you to continue - there is no time with the family and of course losing their loved one is quite traumatic the question is, do you want to be in the room when your family member dies? I don't want to be there at that moment and I don't want to be there watching all that.

***IS THIS THE ONLY TIME THAT YOU'VE HAD TO RESUSCITATE THE PATIENT WITH THEIR FAMILY MEMBERS IN THE ROOM?**

*Yes, I would say there is hardly any It's an odd occasion where you definitely have somebody asking to be in the room. Family members obviously come into the resuscitation area, they want to see the patient - most of the trauma has not occurred at home or with the family members, with the mother or the father. You'll find young children have gone out, and then some trauma occurs and you get a whole lot of people rushing into hospital not knowing where their child is and they want to know the extent of the injury and while you resuscitating a patient you can't have somebody tapping you and asking you what is the problem or what has happened - that sort of thing. We have taken into consideration that people are human, we all have feelings, we all have loved ones and we'd like to know....It's the basic tender of information that is most important, there should be somebody that gives information to them - that constantly during the resuscitation tells them what is happening, family members then will understand - be kept at bay, are okay with the idea that something is happening, something is going on - the doctors are doing their thing, the resuscitation team is actually working. Unfortunately there are times when you get people that, when the patient demises...then you get the problems that come about when the family members are in such a traumatised state because of the news, that they start, you know, becoming hysterical - and I say that, not that they don't understand resuscitation but they are traumatised by the death of their loved one.

***DOES YOUR DEPARTMENT HAVE ANY POLICIES TO DEAL WITH THE RELATIVES OF A PATIENT THAT IS BEING RESUSCITATED?**

*I am personally not familiar with that policy, however what we do is that we ask the family members to actually go into the waiting room, we have a resuscitation team that goes into the resuscitation room, 2 registered nurses, a nurse and a doctor depending on the type of resuscitation. The nurse or sister is actually responsible to actually convey information to the

family. In the hospital the relatives shouldn't necessarily be in the resuscitation room with the doctors, there's a lot of our patients' that have very hysterical relatives. Families come in droves - and they don't come in one or two, they come in ten, twelve, twenty! And there's certain cultures and religious beliefs that actually(hesitated)in South Africa we are very diverse with a whole lot of cultural systems where some of them want to come in at twenty - and you can't allow that...I mean we do allow that in the time after the resuscitation when the patient has demised and they see...Umm, we don't remove any of the instruments of resuscitation from a resuscitation that we have tried, and everything is documented down so whoever looks at the patient thereafter knows what has been done. It's not as if there is secrecy - we don't believe in secrecy. The family must know exactly what is happening and only then will they be satisfied or come to terms with the death.

*YOU MENTIONED THAT IF A MEMBER OF YOUR FAMILY WAS BEING RESUSCITATED THAT YOU WOULDN'T WANT TO SEE THE RESUSCITATION, THAT IF YOU YOURSELF WERE BEING RESUSCITATED AND A MEMBER OF YOUR FAMILY WERE TO BE IN THAT ROOM WITH YOU, HOW DO YOU THINK YOU WOULD FEEL ABOUT THAT?

*It would have been nice to have known that they would have been there, but I wouldn't want them to see what was happening to me - that in itself would be a cause of post-trauma, it can cause flash-backs. There are a number of patients that after having seen a patient being resuscitated on the roadside, they complain of having seen that person being resuscitated in their flash-backs and that's part of the trauma you know you can't just think of just one situation of the resuscitation and you allow the family members in, you have to think about the situation we are placed in and in which we work, it's amazing how short staffed we are, we can't be attending to the whole family all the time, people are breaking down, they become hysterical. You could get someone who falls and faints and lacerates their head and you would have to stop that bleeding - we rather allow the people to wait outside, calm them down with information that is being given out. After every resuscitation the doctor will see the family about the resuscitation and what the outcome or prognosis of the patient is.

*OKAY, IS THERE ANYTHING ELSE YOU WANT TO ADD?

*No, no. I think that's everything.

Appendix 5

I worked and studied my Masters degree in Trauma Nursing in a private level one emergency department for a year in the year 2000. I also did work with a variety of ambulance services and in a provincial level one emergency department. During my experiences I was frequently faced with relatives wanting access to their loved ones during resuscitation, and I refused them access. In the department in which I was employed relatives were only granted access to their family members once the patient was stable or had died. There was no written policy to regulate this, our actions were based on an understanding between the doctors and the nurse in charge of the unit. I know that if a member of my family was being resuscitated that I would want to be there, just to talk to them, reassure them and see them for what may be the last time. So when I was asked by relatives for access to the resuscitation area, I wanted to let them in; but because of the ward 'policies' I did not feel at liberty to do so. On one occasion I did let the father of an injured child in and received disciplining from the doctor attending to the patient. The doctor said that she couldn't perform at her best with relatives there and that patient confidentiality was being breached. By the end of the year I was very interested in witnessed resuscitation and found interesting studies that had been done internationally on the subject, but found none that had been carried out in South Africa. This is what guided me into doing this research, a basic study exploring what the emergency staff feel about witnessed resuscitation, what they practice and why. I expect to find that witnessed resuscitation is not practised, as has been my experience, but I am interested to hear the staff's opinions about it. I don't condemn the people that don't allow witnessed resuscitation, and I don't believe it is necessarily the best thing for everyone. However, I would like this practice to become an option for those people who do want witnessed resuscitation in KwaZulu-Natal and South Africa, and I have done this research to that end. I have found this to be a very new idea amongst the nurses that I have spoken to socially about witnessed resuscitation.