

**UNIVERSITY OF KWAZULU-NATAL**

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**THE DEVELOPMENT OF AN  
INTERVENTION MODEL FOR  
MANAGING ABRUPT DEATH  
TRAJECTORIES  
IN KWAZULU-NATAL LEVEL I  
EMERGENCY DEPARTMENTS**

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By

**PETRA BRYSIIEWICZ**

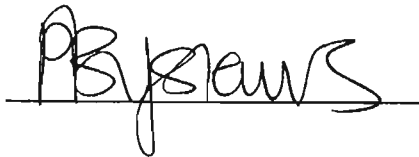
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fulfillment of the degree of Doctor of Philosophy

Thesis supervisor: Professor L.R. Uys

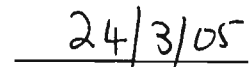
DECEMBER 2004

## DECLARATION

I declare that this thesis is my own, unaided work. It is being submitted for the degree of Doctorate at the University of KwaZulu-Natal, Durban, South Africa. It has not been submitted before for any other degree or examination at any other university. All sources of information utilized have been acknowledged.



**Petra Brysiewicz**



**Date**

## **DEDICATION**

**To all those health professionals who have to face the extremely difficult task of dealing with the dead or dying client and their bereaved family.**

## **ACKNOWLEDGEMENTS**

I would like to sincerely thank the following:

- The various institutions for allowing me access to carry out this research
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## **ABSTRACT**

**AIM:** The aim of this research was to describe how the health professionals manage sudden/abrupt deaths in the ED and to foster change in current practice by involving the clients (dead or dying clients and their families) and the health professionals.

**METHOD:** Action research was the approach used in this four year research project, and co-researchers (nurses) from three Level I ED's in KwaZulu-Natal were actively involved in shaping and guiding the project. The participants involved in the research were health professionals, bereaved families and mortuary staff members.

**FINDINGS:** An intervention model, the Dealing with Sudden Death Model, was developed in order to guide the therapeutic management of sudden/abrupt deaths in ED's. Along with this was the development of the family pamphlet, the Preparation Checklist and the Incident Evaluation Checklist. Following the implementation of this model the health professionals emphasized the fact that this model provided guidance and meaning to the care rendered to the dead or dying client, the bereaved families and fellow colleagues. The Dealing with Sudden Death Model had resulted in a production of knowledge and planned changes in the management of sudden/abrupt deaths in the ED's.

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# **LIST OF ABBREVIATIONS**

ED – Emergency Department

ATLS – Advanced Trauma and Life Support

ACLS – Advanced Cardiac Life Support

ICU – Intensive Care Unit

MVA – Motor Vehicle Accident

# CHAPTER 1:

## INTRODUCTION TO THE STUDY

*Stop all the clocks, cut off the telephone,  
Prevent the dog from barking with a juicy bone,  
Silence the pianos and with muffled drum  
Bring out the coffin, let the mourners come.*

*Let the aeroplanes circle moaning overhead  
Scribbling on the sky the message He is Dead,  
Put crepe bows round the white necks of the public doves,  
Let the traffic policemen wear black cotton gloves.*

*He was my North, my South, my East and West  
My working week and my Sunday rest,  
My noon, my midnight, my talk, my song;  
I thought that love would last for ever: I was wrong.*

*The stars are not wanted now: put out every one;  
Pack up the moon and dismantle the sun;  
Pour away the ocean and sweep up the wood.  
For nothing now can ever come to any good.*

**W H AUDEN**

## **1.1 Background to the study**

Nationally and internationally, trauma is rated as the leading cause of death for people aged between 1 and 34 years of age (Barret, 2001, cited in Redlinghuys & Van Rensburg, 2004). According to the 2002 National Injury Mortality Surveillance in South Africa, homicide remains the highest cause of non-natural deaths accounting for half of all injury deaths. Males account for 81% of all non-natural deaths and the average age of the victims is 34 years. Firearms were the most common external cause of homicide; accounting for 54% with sharp objects causing 30% of the deaths. Females accounted for 19% of the non-natural deaths and these were mainly due to road traffic collisions (33%). More than half of all road fatalities involved pedestrians (Matzopoulos, Seedat, Marais, et al., 2004). The mortality patterns of adult South Africans are influenced by the infectious disease burden, and the emerging chronic disease burden. HIV/AIDS is also having a large impact on the mortality profile of the country (Redlinghuys & Van Rensburg, 2004). The majority of the deaths amongst children younger than 14 years were attributed to burns, drowning or road traffic-related collisions (Matzopoulos, et al., 2004). HIV/AIDS is however, changing the mortality picture in children and HIV/AIDS infection is the leading cause of death in children under 4 years of age (Redlinghuys & Van Rensburg, 2004).

A sudden death - due to a fatal gunshot, stab or motor vehicle collision - exaggerates the reactions of grief and can result in a more pronounced development of Post Traumatic Stress Disorders (Kaltman & Bonanno, 2002). This

is because the loss is unexpected, senseless, and in many cases it may have been preventable (Wright, 1996).

Nationally, emergency health professionals are faced with the sudden/abrupt death of their clients on a regular basis. Added to this, is the fact that these often violent deaths are of young adults whom are in the prime of their life (MRC, 2001; Matzopoulos, et al., 2004). As difficult as caring for the dying emergency client is, there are many health professionals who would rather care for the client than face the problems with the bereaved family (Solursh, 1990; Wright, 1996; Iserson, 1999). The emergency staff who deal with relatives whom have just lost a loved one to a sudden/abrupt death, face an extremely difficult and emotionally draining task; although to date there has been little research done on its effect on the emergency staff themselves (Payne, Dean & Kalus, 1998). There is no time to prepare the family for the loss and the family seldom have past experiences upon which to draw that will enable them to cope. The death of their loved one is often a brand new experience (Wright, 1996).

Tye (1993) suggests that there are a number of actions that need to be taken into account when attempting to meet all the complex needs of the family members in the Emergency Department (ED). This starts from the initial contact with the family; providing facilities and information during the resuscitation of the client; and follows through the breaking of bad news, viewing the corpse, and follow up care. Mosenthal & Murphy (2003) suggest that caring for the dying and their

bereaved families is difficult in the ED as this is an area concerned with providing heroic life measures and death is often viewed as a failure. This is also an area of the hospital which focuses on caring for the client's physical injuries and is not geared to providing for the client's psychological needs. It has been suggested that if the health professionals are made aware of the impact that their initial actions can have for the families, much could then be done to improve the bereavement outcomes for the families (Wright, 1996). It has also been mentioned that health professionals who are specifically educated to meet the needs of a dying client and his/her family are likely to reflect a positive attitude towards coping with death (Corr & Doka, 1994).

### **1.2 Problem statement**

In South Africa, according to Schlebusch (1997), emergency health professionals are overburdened, as they have inadequate staffing levels and are often expected to work with insufficient and outdated equipment as well as inadequately trained colleagues. Emergency nurses have indicated that stress is also encountered in treating clients with minor injuries and complaints that could instead be treated at a Primary Health Care facility (Marais, 1999). The incidence of HIV/AIDS in South Africa is increasing at an alarming rate, which then places the emergency staff at great risk of contracting HIV/AIDS through exposure to various body fluids, as well as having to deal with an emergency patient who has added health complications. The doctor-nurse relationship has also been identified by

emergency nurses as being a source of stress, as doctors working in the ED's are generally temporary staff or undergoing rotation (Helps, 1997). There is at present little emergency training for health professionals being offered throughout the country. This places a burden on those few health professionals with training, as well as making the ED a very stressful area in which to work. Unresponsive nursing and hospital leadership as well as a lack of support from supervisors adds to the already stressed individual (Helps, 1997; Brysiewicz, 2000).

In South Africa at present there are very few debriefing programs available in order to support the health professionals involved in injured client care. These professionals are at risk of developing psychological symptoms in response to the distressing and traumatic incidents - which they face on a daily basis. They are especially vulnerable to the development of various stress disorders (Helps, 1997). An additional problem is that the health professional is often unaware that the emotional or physical problems that he or she may be experiencing are related to the stress factors in their life. (Sowney, 1996) Health professionals have been brought up in a tradition that has always expected them to cope with anything (Brauteseth, 1993).

Sudden bereavement is an extremely traumatic event which poses a crisis for both the health professionals and the family members (Hoff, 1984; Wright, 1996; Kanel, 1999), although it has been suggested that the violent nature of the sudden death is what contributes to more severe grief reactions (Kaltman &



Bonanno, 2002). A crisis is a state of acute emotional upset; where one experiences a temporary inability to cope using ones usual problem-solving devices (Hoff, 1984; Wright, 1996). Once these usual coping mechanisms fail, the person experiencing the upset functions psychologically, emotionally and behaviourally at a lower level than before the crisis began (Kanel, 1999). This can then result in restrictive functioning for the health professional and the family. (Kanel, 1999). Being confronted with their client's sudden/abrupt death and the grief of the relatives can leave the health professionals feeling victimized, alienated and powerless to do anything to resolve the issue (Whittle, 1999). The effects of this exposure can be cumulative, with an increase in traumatic experiences building up over time. In South Africa however, there appears to be a lack of death education for health professionals in the emergency arena and thus they are not prepared for this role (Brysiewicz, 2000). This does not appear to be unique to the South African situation (Socorro, Tolson & Fleming, 2001; LeBrocq, Charles, Chan , et al., 2003; Merlevede, Spooren, Hendrick, et al., 2004). The question was therefore how do the health professionals in the ED's currently manage the sudden/abrupt death of a client and the suddenly bereaved, and could this system be improved?

### **1.3 Purpose of the study**

The purpose of this study was to describe how the emergency health professionals currently manage a sudden/abrupt death of a client, and to foster

change in the management of this situation by the development of an intervention model. This model, as framework of reference, would possibly improve the current system and also make the system visible in theoretical terms.

#### **1.4 Objectives of the study**

I attempted to structure objectives and research questions for the proposed study although these remained open to changes suggested by the participants.

The objectives of this study were to:

- Identify the problems experienced by health professionals who confront abrupt death trajectories of clients in KwaZulu-Natal Level I ED's
- Describe the lived experiences of the health professionals and bereaved families confronting abrupt death trajectories of clients in KwaZulu-Natal Level I ED's
- Develop an intervention model for the therapeutic management of abrupt death trajectories in KwaZulu-Natal Level I ED's
- Implement this model in multicultural KwaZulu-Natal Level I ED's

### **1.5 Research questions**

- What are the problems experienced by health professionals who confront abrupt death trajectories of clients in KwaZulu-Natal Level I ED's?
- What are the experiences of the health professionals and bereaved families involved in confronting abrupt death trajectories in KwaZulu-Natal Level I ED's?
- What are the strengths and limitations with the current practice of handling abrupt death trajectories in KwaZulu-Natal Level I ED's?
- What psychological support and facilities were made available to the family members and the health professionals?
- What are the crucial concepts and processes or relationships (cause and effect relationships) between the concepts of an appropriate abrupt death trajectory intervention?
- What are the experiences of the health professionals in implementing an intervention model for the therapeutic management of abrupt death trajectories in KwaZulu-Natal Level I ED's?

### **1.6 Significance of the study**

There appears to be a gap in the literature available regarding the psychosocial aspects of South African emergency care, and it is hoped that this research will contribute to this limited body of knowledge. Extensive research has been carried out in other countries on various aspects of sudden death in the ED's (Lundin,

1984a,b; Tye, 1993; Wright, 1996; Payne, et al., 1998; Socoro, et al., 2001; Li, Chan & Lee, 2002; Le Brocq, et al., 2003; Hallgrimsdottir, 2004; Merlevede, et al., 2004) although there appears to be very little of this research conducted within the South African context. South Africa has a number of challenges and limitations within the emergency nursing arena, which makes our experiences here unique, and thus necessitates such research. Chesla (1996) is of the opinion that nurses learn to care for the suddenly bereaved relatives by trial and error and this is made more of a problem as they rarely benefit from feedback from those who have received their care. The dying client and their families may benefit from the development of an intervention model to ensure that the experience of an abrupt death is managed in the most therapeutic way possible for all involved. This would help to reduce the development of consequences for both the family members and the emergency health professionals. It was anticipated that the results from this study will shape the practice of the health professionals in the ED's and will also highlight any limitations in the current education curriculum.

## **1.7 Operational concepts**

### **1.7.1 Intervention model**

This is the development of a course of action to be taken to ensure therapeutic management of the dead or dying client, their families and the health

professionals involved in their care. A model is defined as "a representation of the interactions among and between concepts which shows the patterns of these interactions" (George, 1990:387). According to Cormack & Reynolds (1992:1473) a model

"causes nurses to perceive patients, their environment and their health/illness status in a specific way. It influences the way in which nurses understand and interpret the aetiology of pathology and of nursing needs, how these needs are identified, and how appropriate nursing intervention is selected to meet those needs, and the subsequent evaluation of that intervention".

This model attempted to provide a practical tool which the health professionals would be able to use to help them look critically at their own practice to improve the effectiveness of the care given (Clark, 1982).

### **1.7.2 Abrupt death trajectory**

Dying is a process that takes place over a certain period of time, and health professionals, families, and the dying client use many strategies to manage and shape the course of dying. When investigating a way to conceptualize this dying the term "trajectory" or "management of an evolving course" was developed around 1960 to 1961 by Strauss, Glaser & Quint Benoliel ( cited in Woog, 1992).

The death trajectory is the duration and shape of the dying process of the client and the bereavement process of the family. In an abrupt death trajectory, where a client dies a sudden/abrupt and unexpected death, the shape of the trajectory would plunge down suddenly and it would be of a short duration with acute bereavement (Glaser & Strauss, 1968). In this study, an abrupt death trajectory was defined as a case in which the client went from healthy to dead in one day. These deaths usually occurred out of hospital, in the ED, or shortly after handing the patient over to either critical care or theatre personnel. The study focused on how the dying, death and the bereavement process was managed.

### **1.7.3 Level I Emergency Departments**

Level I Emergency Departments (ED's) are nationally recognized as specialized departments due to the fact that they adhere to certain requirements. These departments have a minimum quota of emergency qualified and/or experienced staff (both nurses and doctors) as well as specialized resources and necessary equipment available to deal with severely physically traumatized clients and their families (Cardona, Hurn, Mason, et al., 1994).

### **1.7.4 Family**

This was used to refer to either relatives or close friends of the dead or dying client, who were living with the client at the time of the client's death.

### **1.7.5 Health professionals**

This was used to refer to all the categories of healthcare professionals working in the ED's namely the nurses (enrolled and registered with the South African Nursing Council), doctors and pre-hospital staff (usually paramedics).

### **1.8 Conclusion**

Dealing with a sudden/abrupt death is an extremely difficult experience for all involved and can result in long lasting consequences. The following chapter will outline relevant literature regarding sudden/abrupt deaths, as well as highlighting the present management of these deaths in the ED's. The research approach is described in Chapter 3 and the four cycles of the research carried out are explained in detail in Chapter 4. Chapter 5 concludes the study by emphasizing the strengths and weaknesses of the research and makes recommendations for service, education and research.

## CHAPTER 2: LITERATURE REVIEW

*Remember me when I am gone away,  
Gone far away into the silent land:  
When you can no more hold me by the hand,  
Nor I half turn to go yet turning stay.  
Remember me when no more day by day  
You tell me of our future you had planned:  
Only remember me; you understand  
It will be late to counsel then or pray.  
Yet if you should forget me for a while  
And afterwards remember, do not grieve:  
For if the darkness and corruption leave  
A vestige of the thoughts that I once had,  
Better by far that you should forget and smile  
Than that you should remember and be sad.*

**CHRISTINA ROSSETTI**



## **2.1 Perspectives on death and dying**

### **2.1.1 International perspectives**

Throughout history, death has been a mystery to mankind, which has evoked various myths, thoughts and ideas. Much has been written about death and dying and many people have different ideas as to what exactly happens at the point of death. When a person is dying, they or their significant others may for the first time seek the meaning of life and death and this involves the exploration of various philosophical and religious beliefs. Death is a reminder of human mortality and human impotence as one cannot know nor control the time of death (Raphael, 1984).

Earlier theoretical frameworks of death and dying made notable contributions to clinical practice by encouraging health professionals to reflect on important issues about death and dying. These frameworks provided the means for the scrutiny of the attitudes and conduct of the health professionals towards the dying client and their families. Kubler-Ross's (1969) model of the five stage response to death and dying has gained worldwide acclaim and acceptance, although also criticism about its accuracy and validity. Various other models concerning death and dying have been proposed which have attempted at addressing the criticisms of the Kubler-Ross model as well as to present new and refreshing approaches to the issue of death and dying (Raphael, 1984; Cardona, et al., 1994; Copp, 1998). Murphy (1988) is of the opinion that bereavement is a lengthy process, which may be influenced by numerous events and personal

factors and thus is not just simply moving through one stage of grief to the other. Thayer & Peate (2003) agree with this and suggest that the bereaved move back and forth between the different stages suggested by Kubler-Ross (1969), and that these stages should not be expected to occur in a set order.

Traditional rituals retained by some cultures have enabled them to overcome the fear of death and to optimize their lives. In a number of non-western societies, death is seen as a process and not as a single event. It is a rite of passage from this life into the next. It has been suggested that the lack of positive rituals in the modern western society has adversely affected dealing with death. The previous Puritanical approach of viewing death as something negative which needs to remain hidden and private, must be replaced. According to O'Gorman (1998: 1133) "society has endangered health by being unable to discuss death". Dillenburger (1992) notes that the shift away from the extended families towards a nuclear family has also adversely affected society's acceptance and experiences of dying. In the extended family children would have been exposed to older members of their family dying and would have learnt to cope with loss and bereavement early on (Dillenburger, 1992).

The medicalization of death has been introduced and it is suggested that this starts once the individual enters the hospital and the health professionals, who have developed their own rituals take over the situation. Death and dying is thus no longer seen as a family affair and this then provides the means for society to dissociate itself from the process (Dillenburger, 1992; O'Gorman, 1998).

There has, however, been a gradual shift in emphasis towards the recognition of the diverse nature of death and dying as well as its impact on the person dying, their families and their caregiver (Copp, 1998). It has been suggested that society's attitude to death and dying has recently changed a great deal as people have come to realize that society has lost touch with the meaning of life and are now adopting a more holistic view. Death and dying is now being viewed as something to be accepted rather than feared and that more needs to be done to care for the dying client and their family (O'Gorman, 1998).

Caring for the dying and their families is particularly demanding for the health professionals and it has been suggested that the personal attitudes we hold about death and dying strongly influence how we live our lives and thus our work (Payne, et al., 1998). Unless the health professionals are able to work through their own issues about death and dying, they will not be able to efficiently help their clients (Whittle, 1999).

### **2.1.2 National perspective**

There is a great deal of cultural diversity in South Africa regarding the issue of death and it is extremely important for the health professionals to be aware of his/her own cultural beliefs as well as acknowledging the cultural beliefs of others. The health professional needs to ensure that his or her own cultural beliefs are not forced upon their clients and that the clients own wishes and practices are

respected. These different cultures hold different beliefs and attitudes towards death and dying which need consideration as it influences the needs, the kind of care the family expects and the actual beliefs surrounding death and dying. It also determines the patterns and responses to grief and the role of the bereaved person (Penson, 1993). When considering the population in KwaZulu-Natal, one finds remnants of British colonialism mixed with Zulu, Indian and Afrikaans traditions which all make for an interesting cultural mix. These cultures all have differing views on death and dying.

#### 2.1.2.1 The Traditional African perspective

In the African culture, the deceased is believed to live underneath the earth and appear to the living in dreams. The deceased, referred to as ancestors, care for the living and bring warnings of danger or reprimand. As they are in spirit form they are able to protect their living relatives and act as a guardian angel. The African culture does recognize an untimely death, and this is seen as a product of witchcraft and sorcery, which demands that preventive measures be taken to strengthen ancestral protection (Mtalane, 1989).

It is viewed as better to die at home surrounded by family so that any last wishes or feelings can be expressed to the living. For the dying patient, it is extremely important to know that they are at peace with their ancestors, friends and neighbours, and to resolve any outstanding issues by animal sacrifice if necessary.

Death is viewed by the family as a great sadness and loss but it is also seen as a pathway to meeting the ancestors. Once the family member has died the neighborhood is available to console the family and various ceremonies are carried out to say goodbye to the deceased. Although many Africans have been converted to Christianity, their ancestors continue to play a large role in their lives. For the traditional African client dying in hospital, problems may be experienced when the client is from a rural community and thus unfamiliar with practices in the urban areas or hospitals (Jafftha & Shosha, 1995). The health professional needs to be aware of this and be accommodating and culturally sensitive to the client and their family.

#### 2.1.2.2 The Islamic perspective

Death is seen as something decreed by Allah and is the beginning of eternal life. For the followers of Islam, the family is of vital importance and visiting of the sick is expected. The body of the dying client must be kept in a constant state of cleanliness by ensuring that the genital area is washed with clean water after urination or defecation. The dying Islamic client needs to be allowed to die in dignity and peace, while remembering Allah by being encouraged to recite the confession and declaration of faith. The client must be positioned facing the Qiblah (a holy stone in Mecca) and loe-sticks are burned. No "unclean" individuals - e.g. menstruating females - are allowed near the client. Once dead, the body needs to be handed over to the family as soon as possible to allow for a rapid burial - on the

same day if possible. The body should not be washed by the hospital personnel, but rather left for the family to prepare (Ismail, 1995).

#### 2.1.2.3 The perspective of Hinduism

Hindus believe in cycles of birth, death and rebirth known as Samsara, and every soul must go through these cycles in order to attain Moksha or Absolution. Friends and relatives visit the sick and may take part in a joint prayer or read chapters from the Holy Book of Bhagavad Gita. In the Hindu religion once the immediate family has been informed about the death of their family member they will abstain from eating any solid food until the body has been disposed of. The body will be brought to the house where the family will wash it and prepare it to be taken to the crematorium (Madhoo, 1995). There is no special care required by the health professionals.

#### 2.1.2.4 The Christian perspective

There appears to be no single Christian point of view regarding suffering and death. This is important for the health professionals to be aware of when dealing with the dying Christian client. There is no special care required by the health professionals.

#### 2.1.2.5 The Jewish perspective

Visiting the sick is seen as a duty for all. The physical care of the dying client is very specific and the dying client is regarded as a living person in all respects. The client should not be moved (as it may hasten death), eyes should not be shut, noise at the bedside should be kept to a minimum and removal of the pillows or washing is not allowed. This is due to the belief in the sanctity of life and that everything possible must be done to prevent hastening death. Once the death has occurred, the health professionals must leave the body untouched but not unaccompanied. The body will then be washed by members of the Jewish burial society (Regensberg, 1995).

#### 2.1.2.6 The Jehovah's Witnesses

It has been suggested that at the time of critical illness or death it would be useful for the family if the health professionals were able to relate the terminology that the Jehovah's Witness feels comfortable with - namely paradise, resurrection and prayer. The religious leaders are referred to as "elders" and the members as "brother and sister". The Hospital Liaison Committee of the Jehovah's Witnesses is involved in dealing with the special medical needs, for example, discussing alternatives to blood transfusions with the medical staff. There are no official last rites for the health professionals to be aware of (Afrox Healthcare, 2002).

## **2.2 Making death more difficult to accept**

### **2.2.1 Age of the client**

The age of the client is an important consideration as the younger the client is, the more difficult it is for the health professionals to deal with the death. There are many health professionals who describe how they will try to avoid being involved in caring for the dying or dead child and their parents. This is due to the fact that children have not had a chance to experience life as yet, and thus their death is also viewed as a great waste of a life, an injustice. The death of a child is an extremely emotive one as adults see it as their role to look after and protect children, and parents do not expect to outlive their own children. An elderly person is expected to die in the near future and thus when they do this is then not viewed as such an injustice as they have already had a chance to live their life. This is however questioned by Cooke, Cooke & Glucksman (1992) who state that when dealing with the family who have lost an infant through a cot death, all the necessary resources are called in due to an appreciation of the severe psychological trauma suffered. These authors question why the death of an adult should not be seen as traumatic, and ask that the same level of care be extended to their relatives.

### **2.2.2 Family relationships**

The "affective loading" of the relationship refers to the relative positiveness or negativeness of the feelings of the persons involved for each other. Was the



relationship a loving one or was it marked with conflict? It is viewed as more difficult to cope with the death of a client that came from a loving, close family as the quality of this relationship is an important factor in the bereavement reactions experienced by the family (Lundin, 1984b). The trauma also impacts differently on the different family members depending on their position in the family, be the client a child or the parent. It is important to remember that the families are victims too (Solursh, 1990).

### **2.2.3 Time of the year**

The time of the year is another consideration. Deaths occurring during the Festive season are especially difficult as these are times when families should be together celebrating and not mourning the death of a loved one. For the health professionals this then puts a damper on their own celebrations as they are thinking of the bereaved family having to go through the time of celebration without their loved one (Wright, 1996).

### **2.2.4 Abrupt/sudden death**

An abrupt/sudden death implies a natural or unnatural death, which is unexpected, occurs without warning and in some cases, could have been prevented. The client and their family were unaware of the impending death and were unprepared for it. The family's reaction to their loved ones death is disbelief,

shock, grief, dismay, disorganization, hostility and fear (Iserson, 1999). Wright (1996) agrees that the "suddenness" of the death may cause the client's family to blame themselves or the health professionals for the death of their loved one. The family are often unable to comprehend that their loved one has died as the approach of death was immediate or over a very short period of time, and the last time the family saw their loved one they were alive and healthy (Raphael, 1984; Iserson, 1999). An abrupt/sudden death also allows no time for the resolution of family relationships, disputes or other problems, and there is no anticipatory mourning (Cardona, et al., 1994; Wright, 1996).

The families are often not present at the death scene or the ED. The cause of a sudden/abrupt death is most commonly due to homicide, accidents, suicide, disease or unknown cause (Iserson, 1999). A sudden/abrupt death often results in a damaged or mutilated body which then suggests to the family that the death was not peaceful or easy, and possibly caused their loved one pain (Wright, 1996).

Iserson (1999) also emphasizes that with a sudden/abrupt death the client is exposed to resuscitative measures and following the death, an autopsy is commonly performed. The suddenly bereaved families have been found to experience more severe grief reactions, (although Kaltman & Bonanno (2002) suggest that this may be due to the often violent nature of sudden deaths). It was also noted by Rubel (1999), that society has difficulty supporting those who have

lost a loved one to a violent death. This author emphasizes the fact that at a time when the bereaved need the most support they are left with people who don't know how to deal with the intense grief response resulting from a violent death. For the health professionals in the ED, managing a sudden/abrupt death is extremely difficult for a number of reasons. The health professionals may view the death as failure and experience difficulties in dealing with the death - especially if they identify with the situation. They have usually spent very little time with the family and have not built up a relationship with them. The short period they have spent with the bereaved family is usually an extremely emotional time. The health professionals often have to initiate very difficult discussions with the families after the death of their loved one such as organ donation and autopsy. In the majority of the sudden/abrupt deaths the health professionals are required by law to send the body of the dead client to the mortuary to undergo an autopsy. For the suddenly bereaved this can add to their distress as they may feel that the autopsy cannot do anything to change the situation as their loved one will still be dead.

### **2.3 Death trajectory**

Regardless of a particular individual's death trajectory, there are certain events or "critical junctures" that appear along the trajectory. Firstly, the client is defined as dying and the staff and family members make preparations for the death. There is nothing more to be done to prevent the death and the client's dying process

then leads into the final descent, the “deathwatch” by the staff and family and ultimately the death itself. When these critical junctures occur as expected and on schedule, all of the participants are prepared, however, if it is unexpected then they are unprepared. The death expectations are a combination of the certainty that the client is going to die and the time the individual will take to die. These differing expectations have varying effects on the interaction of participants in the dying situations. Specific areas of the hospital are prepared to handle particular kinds of trajectories. The unexpected death trajectory that occurs in an area of the hospital, which is able in terms of staff and facilities of coping with it, is considered an emergency. In other areas where the quick trajectory is typically unacceptable because the resources are not available to handle it, the advent of an unexpected quick trajectory constitutes a crisis. In spite of this however it should be mentioned that even in areas prepared to handle it, an unexpected, quick trajectory could still cause a crisis. This could occur when a necessary member of the health team is unavailable, or when the client being attended to is one of the staff members. Differential definitions of the client’s trajectory by two different doctors can also stall the management of the client and lead to a crisis (Glaser & Strauss, 1968).

### **2.3.1 Abrupt/sudden death in the Emergency Department**

Abrupt/sudden death from trauma is the leading cause of deaths in individuals between the ages of 1 to 44 years and these deaths usually occur in the ED

(Coolican & Pearce, 1995; Vassar & Grogan, 1995; Redlinghuys & van Rensburg, 2004). The United States of America is generally regarded as a relatively violent society. Their average annual violent deaths is said to be 10.1 per 100 000 population, between the years of 1991 to 1994.

Trauma is the second largest cause of overall national deaths in South Africa, costing an estimated R72 million per day (Theron, 1999) and involving one in every 15 people annually (Jacobs, 1998). Violence is said to be the leading cause of injury severity in South Africa (Matzopoulos, et al., 2004) and the 1996 homicide rate of 61 per 100 000 placed South Africa among the most violent countries of the world (Marais, 1998).

In a study carried out by Meumann & Peden (1997) in Durban, KwaZulu-Natal, it was found that 54.7% of the reported deaths were due to violence with the average age of the victims being 33.6 years (Meumann & Peden, 1997). In another study carried out in this region, violence was found to be the leading cause of injury in all age groups up to the age of 49 years, when non traffic "accidents" such as burns and falls predominate (Sukhai, Harris & Peden, 2000). In the Cape metropolitan area traffic injuries represented 11% of the caseload but generated 38% of the deaths. Violence, however represented 30% of the caseload but resulted in 53% of the mortalities (van der Spuy, 2000). Firearms were found to be the major external cause of non-natural deaths and accounted for 26% of the mortalities monitored in twelve mortuaries in six provinces in 1999 (MRC, 2001).

Road traffic collisions are also of great concern in South Africa, resulting in approximately 11 deaths per 100 million kilometers traveled, which is approximately ten times that reported in developed countries (van der Spuy & Peden, 2000). The reasons cited for these large numbers of deaths are numerous and include lawlessness on our roads, poor public transport and urbanization. The rapid urbanization has meant a large number of unsophisticated road users are now using the complex metropolitan traffic networks and there is also the problem of illegal driving licenses as well as un-roadworthy vehicles (van der Spuy & Peden, 2000).

The public transport system in South Africa is poor with a large number of people commuting daily by car and minibus. The minibus taxi industry has flourished in South Africa and this has placed a huge burden on the pre-hospital personnel. They are often called to a taxi collision where they then have to deal with front seat entrapments as well as multiple victims "on scene" (Boyd, Wragge & de Klerk, 1999).

Pedestrian road traffic collisions account for approximately 40% of the annual road mortality in South Africa and the main reasons attributed to this are due to alcohol abuse and poor road design (van der Spuy, 1998). The profile of the typical pedestrian victim in South Africa is a young Black male usually 20 to 29 years old. Most of the pedestrians were reported to be injured by motor vehicles although 11 % were injured while getting in or out of a minibus taxi (Peden, 1998). During 1997

a total of 610 children (0 to 18 years old) were killed and another 5507 were non-fatally injured in traffic collisions involving pedestrians (Venter, 1998). According to 1999 mortuary monitoring in six provinces, the leading external cause of fatal injuries in South African children under nine years are; burns, drowning and pedestrian motor vehicle collisions (MRC, 2001).

#### **2.4 Crisis and the Crisis Theory**

A crisis is a state of acute emotional upset, where one experiences a temporary inability to cope using ones usual problem-solving devices (Hoff, 1984; Wright, 1996). This crisis state does not last long and Caplan (1964) suggested that the majority of crises lasted four to six weeks. A crisis is self limiting and cannot be tolerated for long periods as it involves intense feelings of distress and disorder, which have the ability to cause emotional damage (Hoff, 1984; Wright, 1996).

What is perceived as a crisis depends on the individual and although, for example, emergencies and conflicts lead to stress which can then lead to a crisis situation, a crisis does not necessarily follow a traumatic event. The perception of the crisis event is crucial to identify as this piece of information is most easily and quickly altered by the counselor (Kanel, 1999). A crisis does not occur in isolation but is usually experienced in dynamic interplay with stress and illness in particular cultural contexts (Hoff, 1984). Caplan (1964) distinguished between different types of crises namely a situational crisis (that is accidental as in an

accident) and a developmental crisis (maturational, as in the loss of a marriage or death. Caplan (1964) suggests that a crisis should be seen as representing a turning point for the individual, i.e. towards or away from mental disorder. This highlights the dichotomous meaning of a crisis as it can be either dangerous or potentially beneficial for the individual (Kanel, 1999). Caplan (1964) goes further to suggest that without crisis, development is not possible.

Lindemann (1944) studied the bereavement reactions amongst the survivors of the "Coconut Grove Night Club fire" and developed the fundamentals of the crisis theory (Caplan, 1964). Lindemann (1944) was of the opinion that morbid grief reactions (which were the distortions of normal grief) could be overcome if the grieving individual was helped by various support persons in their own "grief work". By this it was meant that the clergymen or various caretakers help the bereaved to mourn adequately and not take control of the individual but rather to help them move into a normal coping process (Caplan, 1964; Wright, 1996).

Caplan (1964) expanded further on the work of Lindemann (1944) and suggested that an individual operates within a certain way in society, being faced constantly with certain stressors in life requiring the use of the individual's own problem solving and coping techniques. The individual is seen to be imbedded within a larger system in equilibrium. Each individual exists in a homeostatic balance between the affective and cognitive experience and this is said to differ from individual to individual. The primary characteristic of this balance is its stability for



that individual, which then becomes a frame of reference against which to evaluate changes in psychological functioning for that individual. Experiences which then disrupt the homeostatic equilibrium causes a rise in stress and thus causing the individual to use coping or problem solving mechanisms to re-establish the balance (Burgess & Baldwin, 1981). The individual can disturb this equilibrium by the system being faced by a force or situation which alters its previous functioning. During the short period before this "problem" is solved, the system can be said to be in a state of tension although this is not excessive, as the period is not longer than previously (Caplan, 1964). When the balances are disturbed the self-regulating mechanisms are triggered and these then help to return the balance to healthy levels for the individual (Burgess & Baldwin, 1981).

During a crisis this process is exaggerated because the problem stimulus is larger and the usual re-equilibrating forces are unsuccessful within the usual time period (Caplan, 1964). An accidental crisis, such as a sudden death, may throw the individual into a state of helplessness where coping strategies are no longer useful and the individual's defenses are weakened. A personal crisis occurs when the individual's usual style of coping with stressful events is inoperative or inappropriate. The individual is thus no longer able to deal successfully with tension and stress (Eddy, Lawson & Stilson, 1983). The individual turns to others for help and is more susceptible to their responses. The period of inconsistency of behavior patterns is longer than usual and when the equilibrium is achieved, the new pattern may be significantly different from the previous one (Caplan,

1964). The crisis state does not continue, but is eventually resolved leading to improved adaptation if the individual has coped with the problem successfully or; poor adaptation if the coping resources have failed. It is important to note that the crisis may trigger earlier experiences and the outcome may be very dependent on the quality of social support available to the individual during the crisis, thus this model has been used widely by the health care professionals (Caplan, 1964; Raphael, 1984; Littlewood, 1992). The crisis worker can help the individual to deal with the crisis by allowing emotional ventilation, gathering information, identifying the pattern of development, finding a solution and providing follow up (Eddy, et al., 1983). The goal of crisis work is to increase the level of functioning of the individual by changing the perception of the precipitating event and reducing the subjective stress (Kanel, 1999).

According to Burgess & Baldwin (1981) the classification of emotional crises has been a significant gap in the development of the crisis theory and this has posed problems in providing direction for intervention strategies. Hoff (1984), comments on the concept of equilibrium in the crises theory. This author is of the opinion that it is reductionist and attempts to explain people in a framework of psychology only, whereas she feels that the explanation of human behaviour demands more than psychological concepts. Regardless of these criticisms, Hoff (1984), regards Caplans' work (1964) as essential to explain the development and resolution of crises.

## **2.5 Resolution of the crisis**

During a crisis the usual coping mechanisms of the individual fail and thus result in a reduced psychological, behavioral and emotional functioning than before the precipitating event (Kanel, 1999). A person who does not receive adequate crisis intervention, but comes out of the crisis using ego defense mechanisms such as repression, denial and dissociation is likely to function at a lower level prior to the stressful event. Ego must then use its strength to maintain the denial of the anxiety or pain associated with the precipitating event. This effort takes away the individual's strength to deal with future stressors which then leads to another crisis state the next time a stressful event hits. The crisis state resolved by the use of more ego defense mechanisms after several weeks leads to an even lower level of functioning. This pattern can go on until the person's ego is completely drained of its capacity to deal with reality thus leading to suicide or a psychotic breakdown. The factors that determine the level of functioning that the individual reaches after the crisis are material, personal and social resources (Kanel, 1999).

### **2.5.1 Resolution by the family**

According to Lundin (1984a) a sudden and unexpected loss results in increased psychiatric morbidity for the family experiencing sudden bereavement and they should be identified as a high-risk group. Lundin (1984a) showed that suddenly bereaved relatives had an increased number of days off sick with a psychiatric

diagnosis as compared with relatives of clients whose death had been expected. Lundin (1984a) was of the opinion that, days off sick represent the individual's own assessment of their ability to work and thus may be regarded as a measure of health. Feelings of remorse, self reproach and distress were also more marked in these family members (Lundin, 1984b; Wright, 1996). Lindemann (1944) discussed the absence of the opportunity to anticipate grief which has been shown to lessen the effects of the bereavement after a loved one's death.

Sudden death according to Wright (1996) has the capacity to leave people damaged or to result in prolonged and painful grieving. Wright (1996) is of the opinion that the lack of time or preparation for the death leaves so much unfinished; "this in turn leads to a double kind of grief - grief for what is lost and grief for what might have been" (Wright, 1996:143). The suddenly bereaved may become angry with the whole grieving process as they want answers and in their search often come to an abrupt halt, thus holding up the process of grieving or prolonging it (Wright, 1996).

Raphael (1984) also describes the eternal search for the cause of death and the resultant blaming of others. Prolonged grieving then leads to resentment and guilt (Wordon, 1991).

## **2.5.2 Resolution by the health professionals**

### 2.5.2.1 High death anxiety

The emergency health professionals have been shown to have a high level of death anxiety, i.e. anxiety about dealing with the deaths of their clients. Emergency nurses work in the ED's because it is an exciting and busy area where they are involved in saving the lives of their clients and not in helping them die (Crowley, 2000). Emergency nurses have been shown in a study done by Payne, et al., (1998) to be more likely to avoid thinking about death and showed greater fear and less acceptance of death than hospice nurses. Suggestions for this may be due to the fact that the emergency nurses feel unprepared for death and the handling of the client and their family. It has been suggested that nurses who are specifically educated to meet the needs of the dying patient and their family are more likely to reflect a positive attitude towards coping with death (Corr & Doka, 1994).

In a study carried out by Tye (1993) the nurses reflected on their emotional response to the death of the client as being ranked 29<sup>th</sup> out of 35 of the most helpful action in meeting the needs of the newly bereaved. Thus they clearly did not see this as being very helpful to relatives despite reports to the contrary. Health professionals with a high level of death anxiety are more likely to use "avoiding" coping strategies (Neimeyer, 1994; Payne, et al., 1998). Many health professionals have just learnt to control and hide their feelings (Schwam, 1998)

and cope with the situation by avoiding it (either physically or emotionally), thus not having to come face to face and dealing with their emotions.

#### 2.5.2.2 Stress disorders

Nurses and other health professionals tend to spend their time helping those around them to the detriment of themselves. They put the needs of others before theirs and become less sensitive to their own needs or ignore them totally (Schwam, 1998). Wright (1996) carried out a survey of 100 sudden deaths, looking at the time spent by the nurse with the relatives of the client who had died. It was found that in 27% of the cases the nurse spent 0 to 1 hour with the relatives and in 46% of the cases the nurse was present for 1 to 2 hours. This is a long time to have to bear witness to others suffering (Wright, 1996). Being confronted with their clients death and the grief of the significant others, can leave the nurse feeling victimized, alienated and powerless to do anything to resolve the issue (Whittle, 1999).

It is well documented that the career of a nurse is an extremely demanding one, and this is intensified if one chooses the field of emergency nursing. The nature of the work exposes the individual to the development of stress disorders (Wooten, 1998). Many health professionals working in ED's experience the effects of long term or intermittent exposure to trauma. The effects of this exposure can be cumulative, with an increase in traumatic experiences building

up over time. A critical incident is viewed as an extremely stressful event that has the potential to cause unusually strong emotional reactions and it can lead to the development of Post Traumatic Stress Disorder (PTSD), although this occurs in the minority of people. Most people are able to survive these experiences without developing a serious medical disorder (Stamm, 1997).

Stress is defined as tension, emotional strain or as a particular relationship between a person and the environment, which is seen as taxing or exceeding the available coping resources of the individual, and endangering their well-being. Although a certain degree of stress is accepted as an inevitable part of our daily lives, it can become prolonged and debilitating. The individual emergency health professional may experience both physical and mental exhaustion as well as illness and depression. Severe stress can compromise the immune system and result in impairment of the body's ability to fight off disease, bacteria or viruses (Helps, 1997). There may be weight loss or gain, which can cause poor self-esteem. Negative responses and lack of support and encouragement from family, friends, colleagues and management to the symptoms of stress aggravates the situation and increases the sense of isolation experienced by the individual. Irritability, moodiness, a cynical or argumentative attitude are common emotional reactions to stress. Sleep disturbances, nightmares and fatigue are common complaints (Brauteseth, 1993). These symptoms often lead to the afflicted individual withdrawing from the family unit and experiencing changes in their personal and intimate relationships.

Compassion fatigue or vicarious traumatization is a phenomenon associated with workers who care for victims of traumatic events. It is a real and recognized risk of working in a stressful situation. It is the emotional burden that the health worker may experience as a result of overexposure to traumatic events that the patients are experiencing. The effects of this exposure can be accumulative, with the reservoir of traumatic experiences building up as time passes. Emergency health professionals are at risk of developing psychological symptoms in response to distressing and traumatic incidents which they face on a daily basis. They are especially vulnerable to post traumatic stress disorder. An additional problem is that often the health professional is unaware that the emotional or physical problems being experienced are related to the stress factors in their lives and thus do not seek help (Sowney, 1996; Helps, 1997; Gibson, Swartz & Sandenbergh, 2002).

In South Africa, emergency health professionals are often overburdened as they have inadequate staffing levels and are often expected to work with insufficient old equipment and inadequately trained colleagues. There is little emergency training for health professionals being offered throughout the country. This places a burden on those few with training as well as making the emergency unit a very stressful area in which to work. At present in South Africa there are very few debriefing programs available in order to support the health professionals involved in the care of the traumatized client. Numerous and varied stressors are faced by the emergency health professionals.



Shift work is extremely stressful as the natural biorhythms of the individual's body as well as his/her social interactions are adversely affected. Juggling family responsibilities and the lack of regular exercise and a balanced diet adds to the plight of this already stressed individual (Schlebusch, 1997). Health professionals have been brought up in a tradition that has always expected them to cope, discouraging them from seeking help, in case it showed psychological incapability (Brauteseth, 1993).

## **2.6 Experiences of confronting the crisis of an abrupt death trajectory**

### **2.6.1 Experiences of the client**

Finegan & Knott (1998) suggest that bereavement is suffered by the person dying as they make preparations for their own death, and this type of bereavement is often overlooked. Caring for the dying client is indeed a difficult and emotionally draining task, which is made more difficult if the client is aware of their own impending death (Brysiewicz, 2000).

There are a number of factors which influence the situation namely; the age of the client, the way in which the injuries were inflicted (e.g. violence) and the relationship with their significant others. Suicide also complicates the situation as the relatives are left with great feelings of guilt (Raphael, 1984).

## 2.6.2 Experiences of the family

The abrupt/sudden death may immobilize the family. They may feel shock, fear or disbelief, anger and guilt surrounding the circumstances of the incident. The family may also feel extremely vulnerable and helpless (McQuay, 1995). It is very hard to predict how the family will react because of 'all this stress being exerted on them. They may exhibit characteristics that are not normal for them, as this is an abnormal situation - the family are in crisis. The family loses control over the situation and they often had no control over the incident causing the death of their loved one. Their lives are shattered and the families feel anxious, powerless, confused, and helpless. (Solursh, 1990; Coolican, 1994). The health professionals need to be aware of a number of factors that can help to predict the family's response to loss and possibly how they may cope with the death of their loved one. These factors are:

- The relationship of the deceased to the survivor. How close was the relationship as the loss of a friend or the loss of a mother would be different?
- The nature of the attachment to the deceased and the intensity of the love. How necessary the deceased was to the sense of wellbeing for the survivor, the nature of the relationship and if there was any conflict between them may determine the grief?
- The mode of death - how did the loved one die? Was it a violent death e.g. murder?

- Historical antecedents - i.e. how did the bereaved person deal with grief in the past? (Lundin, 1984b; Solursh, 1990; Wright, 1996).

It is important for the health professionals to remember that people are individuals and thus may not respond in the same way to a similar situation. The bereaved families are in crisis and thus may respond to the situation in a way that would usually be totally uncharacteristic for them. Some families may lash out at the health professionals either physically or verbally and the staff must try not to take this as a personal attack (Wright, 1996). There are also a number of gender differences in coping with bereavement as women are noted to use more passive styles of coping. These were associated with better relationships with the staff. Men use more active coping strategies which brings with it the potential for problematic interactions with staff (Littlewood, 1992).

### **2.6.3 Experiences of the health professionals**

There are a number of specific challenges and limitations, which make the emergency care of clients in South Africa quite different from other countries in the world.

South Africa is a country of vast distances, with poor infrastructure and hilly topography, which results in problems with the communication systems. The population of the country is distributed unevenly with the majority of the tertiary

facilities in the cities resulting in a large part of the sparsely populated areas underserved (Simon-Meyer, 1998). This places a huge burden on the pre-hospital personnel in attempting to transport their patients to the relevant facilities in as quick a time possible. In many cases the ideal of the 'Golden Hour' in South Africa is just not possible. This creates difficulties for the emergency health professionals as they are often unaware of the impending arrival of a Red Code patient or have to deal with the added complications in their patient resulting from prolonged time on scene. The database for a large provincial hospital in the Durban metropolitan area showed that the mean injury to hospital time was 2 hours. The average hospital to theatre time was recorded as 4 hours (Muckart, 1997). It could be argued that this situation is not unique and perhaps paints the picture for many of the emergency units in KwaZulu-Natal, and possibly, the country as a whole.

The provincial health services severe financial restraints has resulted in too few emergency vehicles servicing a particular area so that the client is at risk of dying before being able to access the ambulance services. In 1992, the KwaZulu-Natal ambulance service had to deal with 270 cases per day in Durban. In 1998, the service had to deal with approximately 1000 cases per day and that was after being issued with a budget cut of 35% (Simon-Meyer, 1998). This is further aggravated by violence towards health workers with a number of emergency service vehicles being hijacked and stolen; a number of the pre-hospital personnel routinely wear a bullet proof vest to work every day.

The incidence of HIV/AIDS in South Africa is increasing at an alarming rate with the estimation that approximately two thirds of the 34 million people infected with HIV/AIDS worldwide are living in Sub-Saharan Africa (MRC, 2000). This poses a number of problems, as there is an increased risk of the health professionals contracting HIV/AIDS through exposure to various body fluids, as well as having to deal with an emergency patient who has added health complications. The burden of Tuberculosis on South Africa is enormous and statistics for KwaZulu-Natal for the year 2000 predicted that there would be 65 695 cases of tuberculosis, and of these approximately 64.6% would be HIV positive (MRC, 2000). The emergency setting has been identified as an area at great risk for the transmission of HIV/AIDS to the health care workers. This is due to the presence of a large amount of blood as well as the extreme urgency of the situation.

Emergency nurses have indicated that stress is encountered in treating clients with minor injuries and complaints, who could be treated at a Primary Health Care (PHC) facility instead. The problem is that the vast majority of injuries occur after office hours - once the PHC clinic has closed and thus the countrys shift of resources to primary care has had very little impact on the trauma clients. It was shown by Marais (1999) that of all the emergency clients attending a tertiary level facility, only 2% needed such facilities thus highlighting the need to make use of primary care facilities to provide first level emergency care. This would help to ease the burden on the already overflowing tertiary ED's.

The emergency health professionals have to contend with a large number of patients (with poor health and educational status) who generally present with a high level of penetrating injuries which is often due to interpersonal violence. Saving the life of a criminal while watching the innocent victim die can be an extremely stressful situation for the nurse (Helps, 1997; Brysiewicz, 2000).

## **2.7 Dealing with the crisis of sudden death**

### **2.7.1 Support for the family**

As difficult as caring for the dying emergency client is, there are many health professionals who would rather care for the client than face the problems with the family (Solursh, 1990). Dealing with the family of a client dying is very difficult, emotionally draining and overwhelming. There is no time to prepare the family for the loss and they seldom have past experiences upon which to draw to enable them to cope. The death of their loved one is often a brand new experience. The family needs to have health professionals with empathy, as this will make a lasting impression that will contribute towards emotional healing (Waters, 1987).

Tye (1993) suggests that there are a number of nursing actions that need to be taken into account when attempting to reflect all the complex needs of the family members in the ED. This starts from the initial contact with the family, providing facilities and information and follows through to the breaking of bad news and the cause of death, as well as viewing the corpse, and follow up care.

### 2.7.1.1 Initial contact with the family

Often the initial contact with the families is made by the nurse telephonically.

There are a number of issues for the nurse to be aware of when making this call.

- Get all the relevant and current information available and prepare for the telephone call
- Speak distinctly and clearly so that you are understood and repeat things if necessary.
- Verify to whom you are talking to and their relationship to the client before giving all the information
- Explain that the client has been brought into the hospital, or has suddenly deteriorated
- Reassure the person that everything possible is being done as this will convey the seriousness of the situation
- Ask that the family come in immediately and suggest that they bring someone with them. This will also convey the seriousness of the situation
- Ensure you have given details about the exact location of the client and directions on how to get there
- Ensure that the person on the other end has your name and your contact details before you terminate the call (Iserson, 1999; Thayre & Peate, 2003).

In a study carried out in the Greater London area, dealing promptly with the family as they arrive in the ED was identified by the emergency nurses as being

the most helpful for the family. (Tye, 1993). The health professionals need to start caring for the client's family from the moment they enter the hospital. A needs assessment should be done to investigate the family's support network and how much they know about the client's situation on entering the hospital (Vassar & Grogan, 1995).

In a letter to the editor of a medical journal, a parent spoke about the care of the family after the sudden death of their child. The parent suggests that the health professionals need to leave as much decision making as possible up to the parents because up until that point all the decisions in the child's life had been made by the parents. The parent, (Awooner-Renner, 1992:1566) explained that:

"in the event of sudden death their child is not only lost to them in life, she is lost to them in responsibility as the officials take over. The parents are doubly bereft"

The same author also suggested that when talking to the parents, the health professionals should ask simple questions and not questions containing alternatives which then lead the parents to wonder which would be the most appropriate response. The staff in the ED should also allow the parents to change their minds if they choose to do so. (Awooner-Renner, 1992). When their loved one is dying, the family's control over the experience is greatly diminished and the health professionals should realize that they need to regain this control although it is a completely uncontrollable situation. The families need to be full partners in the care of their loved one as well as being an active part of the decision making. It may be beneficial to allow the families the opportunity to



identify and participate in their loved ones dying and death. Families need warm, compassionate and empathetic care and need to be helped by a caregiver who provides support and understanding of the grieving process (Cardona, et al., 1994; McQuay, 1995; Thayre & Peate, 2003).

#### 2.7.1.2 Providing suitable facilities

The family should be allowed access to a private and secluded room where they can all gather and it should also be close to where their loved one is. This room should not be in a highly visible public area where family members might struggle to control of their emotions in front of others (Mangini, Confessore, Girard, et al., 1995). The room should contain comfortable seating, which also allows for the relatives to lie down should they want to. There should be toilet and washbasin facilities nearby as well as telephone and a current telephone directory. The room should have tissues, ashtrays and facilities for making something to drink, as well as including toys and books for children (Cooke, et al., 1992; Wright, 1996).

Wright (1996) is of the opinion that the relatives appreciate a room with windows so that they do not feel claustrophobic or isolated from the activities outside and Wells (1993) suggests that a window allows the family to keep watch for the arrival of other family and friends. The family others should also be asked as to

whether or not they require the services of a chaplain and information regarding the phone numbers for various religious support should be displayed in the room. In a survey to assess facilities for the newly bereaved in the A & E departments in England and Wales (Cooke, et al., 1992), it was found that most relatives were taken to a specific room by a nurse who's sole purpose was to care for them. However, many hospitals still used a multipurpose room to which untrained staff took the relatives and left them alone. This room was close to the resuscitation room in only 15 of the 78 departments, and in 19 of the departments the relatives had to walk through the waiting area to get to the room. When considering the facilities offered in the waiting room for the relatives, only 48 of the 78 departments had a telephone and about half had a washbasin or a toilet near by. Due to the suddenness of the situation one could imagine that parents may have to bring children with them although toys were available in only a quarter of the rooms surveyed (Cooke, et al., 1992).

#### 2.7.1.3 Providing information

The family needs to be informed of the condition of their loved one by being given honest, up to date information frequently and consistently. This information should preferably be given by the same person which then allows for the development of a relationship between the family and the staff member as well as the building up of trust (Coolican, 1994). Wright (1996) suggests that the

family do not like to be left alone and appreciate having a nurse with them all the time unless the nurse is needed to help with the client.

The family may benefit if they are afforded the opportunity to identify and complete tasks that will enable them to participate in their loved ones dying and death. Many of the families need to feel part of the death; just as they were part of their loved ones life (Coolican, 1994).

### *Witnessed resuscitation*

Witnessed resuscitation, according to Boyd (2000:171) "is the process of active 'medical' resuscitation in the presence of family members". There is huge controversy as to whether the family should or should not be present during the resuscitation of their loved one.

In a study carried out by Meyers, Eichhorn & Guzzetta (1998) 80% of the bereaved family others surveyed said that they would have wanted to be in the room during resuscitation. 96% of the respondents felt that they should have been with their loved one during their last moments and that their loved one should not have died surrounded by strangers. The majority of the respondents said that they believed their presence could have helped their loved one and that more importantly, being present during the resuscitation efforts would have helped their own grieving process. A study conducted by Robinson, Mackenzie-Ross, Campbell Hewson, et al., (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 towards lower degrees of intrusive imagery, post-traumatic avoidance behaviour and symptoms of grief was found. Another interesting finding of this study was that three of the clients that survived their resuscitation said that they had felt supported by the presence of family. The bereaved 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.

Mitchell & Lynch (1997) found that emergency health professional's views on witnessed resuscitation were predominantly negative. This finding is also supported by Osuagwu (1993). The reason for this is that there is a concern about sensory disturbance for the families, which occur as a result of the resuscitation of a patient. Life saving measures can appear painful and potentially harmful. Blood, secretions and certain injuries such as burns can produce upsetting smells, and an unconscious patient or a client in pain, can cry out. All of these experiences are perceived by the health professionals as being potentially upsetting for the client's family to witness (Cole, 2000).

Another concern is for patient confidentiality. Confidentiality cannot be maintained during witnessed resuscitation because the witnesses will also be listening to the discussions regarding the client, and in this way may receive information about the client without their consent (Cole, 2000). This problem was addressed in a study by Robinson, et al., (1998) where three survivors

of witnessed resuscitation expressed that they did not feel their confidentiality had been compromised.

Health professionals also have a fear of litigation by the witnesses should a comment, action or procedure during the resuscitation appear unacceptable to them (Eichhorn, et al., 1996; Cole, 2000). However, Robinson, et al., (1998) 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 present urging the team to continue trying (Cole, 2000). A study done by 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. Therefore, witnessed resuscitation brought staff's emotions closer to the surface and made the resuscitation even more stressful for them.

Contrasting this, is a study done by Chalk (1995) amongst medical and ambulance staff, which showed the majority of the staff to be positive about

witnessed resuscitation. The largest proportion were nurses, with doctors tending to be more reluctant. A study done by Back & Rooke (1994) showed that the majority of the staff agreed with the statement that family should have the opportunity to be with their loved one during resuscitation, provided appropriate professional support was available. Cole (2000) suggests that there is a need to respect the wishes of the family, and that by allowing them to see all that is being done, terrible imagery or anxiety may be alleviated. It is also suggested by Cole (2000) that due to the number of medical programmes on television, the family may not be as unfamiliar with the resuscitation process as believed.

Ardley (2003) suggests that the family presence during resuscitation brings a sense of reality to the loss of a loved one and avoids denial regarding the final death. Emphasis was also placed on the fact that families need to be assessed first in order to establish the appropriateness of offering them the option of witnessed resuscitation. Following this, the family need to be prepared for what they will see and need to be supported during the witnessed resuscitation.

#### 2.7.1.4 Breaking bad news (death-telling)

This is concerned with the manner in which the family is informed of the death of their loved one and this can have a profound effect on the bereavement process and the ultimate outcome of the family members. By using the proper method to inform the relatives of the death of their loved one, the family can begin their

grieving process and facilitate good healing (Tye, 1993; McQuay, et al., 1995). Finlay & Dallimore (1991) cited in Tye (1993) revealed in their study how parents viewed the handling of the death of their child. 34 of the 120 respondents in the study said that the news of the death of their child was badly handled or offensive and that the police were rated as being more sympathetic than the doctors and nurses. Traditionally, the role of breaking the news was left with the doctors although the way the news is broken and the interpersonal skills used in this situation greatly outweigh professional role demarcation. It does however, remain important for the family to talk with the doctor at some point to have all their medical questions answered (Cooke, et al., 1992; Tye, 1993; McQuay, et al., 1995; Thayre & Peate, 2003).

When discussing with the family the death of their loved one, it is essential that the health professional does not make use of vague terminology such as "he has passed on" as this can confuse the family. It is recommended that words such as "died" or "dying" should be used as this can help the family to accept the reality of the situation (Ptacek & Eberhardt, 1996; Wheeler, 1996; Wright, 1996). Flam (1999) however disagreed with this, and in the findings of this research carried out in Belgium it was decided amongst the nurses and doctors involved in the research that the term "passed away" was to be preferred. The participants of the research stressed that the families feelings and their ability to understand should always be considered when deciding on the terminology to use (Flam, 1999).

It is equally important for the health professional not to use cliches such as "I know how you feel" as these may be untrue and inappropriate. It is important to listen closely to what the family may be saying, to make eye contact with them and to encourage the family to talk about it (Wheeler, 1996; Wright, 1996; Levetown, 2004). The staff may end up crying more than the family and the client should always feel confident that the nurse is there to support them - not the other way around (Whittle, 1999). Coolican (1994) suggests that the family remembers staff that cry with them as this helps to validate their loss and let them know that somebody else cares. Details of the resuscitation process should be provided by the people who were involved and time must be allowed to answer any questions that the family may have. Families have been documented to be specifically worried about whether or not their loved one experienced pain and this aspect should be emphasized to the family (Coolican, 1994; Wheeler, 1996).

Wright (1996) discusses a study he carried out amongst relatives of clients who had died a sudden death, to ask about the way the news was delivered of the death of their loved one. The main criticism was, according to Wright (1996), the communication skills where one of the respondents likened the doctor to a bus conductor; "swaying on both legs with one hand on the door post and looking into the distance" (p.21). The majority of the most negative remarks concerned the doctor not sitting down, the lack of eye contact, how the news was given and the use of euphemisms which then lead to confusion at what the doctor was actually



saying. One of the respondents described how the doctor told him of his wife; "I am afraid we have lost her". The respondent then wondered how the hospital had managed to lose his wife when she was so ill! When the doctor then told him that he meant that she had died, the husband was very angry and asked why the doctor had not just said so in the first place (Wright, 1996). This study (Wright, 1996) also highlighted the length of time that the doctor spent with the family breaking the news and in 51% of the 100 sudden deaths surveyed, the doctor spent 0 to 5 minutes with the family. Flam (1999) carried out a survey amongst the nurses and physicians employed in the emergency department at a hospital in Brussels, Belgium concerning the suddenly bereaved. The majority of the respondents indicated that the relatives were informed of the death of their loved one in a private waiting room although a disturbing 12% of the respondents indicated that the waiting area or corridor was used.

#### 2.7.1.5 Viewing the body

Prior to viewing the body the health professionals should ensure that the family has been sufficiently educated about the altered appearance of their loved one so that it does not come as a shock when seeing the body for the first time. It is also suggested that the room should not be cleaned up or the equipment removed before the family has seen the body as this would make it apparent to the family that everything was done in an attempt to save the clients life. The staff must be aware that the family must be allowed as much time as they need

to say their good-byes and must be allowed to hold the body if they wish or take a photo or locket of hair. The family need private time with the deceased although the health professionals should be close by should the family need their services (Wheeler, 1996; Wright, 1996; O'Connor & Gervasini, 2001; Levetown, 2004).

Wright (1996) also stresses that the health professionals should let the family know that it is acceptable to talk to the deceased and to touch them should they want to as the family are not aware of what is acceptable in such situations. This is also due to the fact that their loved one appears distanced and dehumanized by all the machines and tubes (Raphael, 1984).

When the relatives were taken to see the body of their loved one, the survey by Cooke, et al., (1992) revealed a lack of private space, and relatives often had to ask to be given time alone with the body. The relatives had to insist to see patients who had mutilating injuries and only two of the hospitals in the survey had morticians on call who could prepare the body. These authors suggested the need for a purpose built room used to view bodies. Smith (1995), reported on the results of a survey conducted in England and Wales, which showed that if relatives wanted to view the deceased in the mortuary, they could only do so through a glass panel.

#### 2.7.1.6 Providing information and follow up

Once the family leaves the ED, it is perceived that the work of the emergency staff is over. It has been suggested that families need additional support and follow up after leaving the ED following the death of a loved one. During the relatives time in the ED, they may not be able to absorb much of the information given to them and thus should be given oral as well as written instructions (Cooke, et al., 1992; Wright, 1996). A booklet for the family outlining how to register the death and obtain a death certificate, the bereavement process and contact numbers of support groups could be extremely beneficial to the newly bereaved (Wright, 1996). Flam (1999) suggested that the leaflet given to the newly bereaved relatives should also contain an area where the names of the staff members involved in the care of the deceased could be filled in. This would then provide the family with the necessary nurses or doctors to contact later on should they require further information.

The clothing and property of the client should be given to the relatives during the immediate care of the client as leaving the hospital with the deceased possessions makes the bereaved confront the reality of the situation. The health professionals should also be aware that the manner in which the possessions are handled can also have hidden meaning for the bereaved and can reflect the sort of care that the deceased received (Wright, 1996).

Contacting the bereaved relatives after the incident can also provide the relatives with further help and information, this could be done over the phone or by letter (Ewins & Bryant, 1992). The follow up care of the suddenly bereaved leaves much room for improvement. Only 35% of the A & E departments in England and Wales had any written policy regarding the care of the bereaved and telephonic inquiries (Smith, 1995). In the survey carried out by Cooke, et al., (1992) in England and Wales, only four of the 78 departments surveyed contacted the relatives after they left the hospital, most departments seemed to presume that the relatives would contact other organizations if and when the need arose. The survey indicated a number of leaflets available to give to the family members although 25 of the 78 departments did not give out any leaflets and in many of the cases the information contained was incomplete. Few of these departments surveyed knew how the relative could find out the results of the autopsy, although it is of great importance for the family to be aware of the actual cause of death (Cooke, et al., 1992). Tye (1993) also showed in a survey of emergency nurses in the Greater London Area that the follow up services from the A & E departments needs to be improved.

## **2.7.2 Support for the health professionals**

### 2.7.2.1 Death skills

Death education, for example the proper identification of the stages of grief and the knowledge of appropriate interpersonal skills, will help the health

professionals in dealing effectively with the sudden death of a client. This would lead to a reduction in death anxiety and lessen the development of stress disorders amongst these professionals (Wheeler, 1996). It has been suggested that unless the health professionals have resolved his/her own feelings surrounding the "death issue", they will not be able to empathize with their clients and could result in the "counselor may become the counseled", (Whittle, 1999:1). The health professionals need to be educated about handling deaths in the ED as these are often extremely emotional and distressing - especially if the staff are not sure how to approach and effectively handle the family. It has been mentioned that nurses who are specifically educated to meet the needs of a dying client and his/her family are likely to reflect a positive attitude towards coping with death (Corr & Doka, 1994). Helping the families who have lost a loved one to a sudden death can be challenging although by understanding their needs and keeping ones "death skills" up to date, it can be extremely rewarding both personally and professionally (Wheeler, 1996).

The health professionals are not always adequately prepared for the complex role of dealing with the suddenly bereaved and are not aware of the needs of this particular group at a time of great crisis (Cooke, et al., 1992; Tye, 1993; Smith, 1995). There is a lack of relevant education for nurses in the field of sudden death. This was demonstrated by Tye (1993), in a study carried out amongst emergency nurses in three different general hospitals in the Greater London Area. Amongst the sample of 52 nurses, 58% had never received any form of

training to care for the suddenly bereaved and 13% indicated that they had received education in this area during their basic training only. Cooke, et al., (1992) found the same results when their survey of 78 Emergency Departments in England & Wales showed that 44 of these departments indicated that increased training was needed in order to improve the care of the bereaved relatives. Flam (1999) supported this finding in a study carried out in Brussels, Belgium where the physicians and the nurses involved in the study commented that they had not been taught how to notify people of bad news during their basic training. Tye (1993) suggests that training should be provided which focuses on psychosocial and interpersonal skills as well as exploring one's own experiences and attitudes about death and dying - and that doctors as well as nurses need to be involved. In a phenomenological study carried out by Brysiewicz (2000), amongst emergency nurses in South Africa, it was highlighted that death education is missing from the basic nursing curriculum, and this finding is supported by a number of studies (Socorro, et al., 2004).

In order to bridge the gap in knowledge concerning death, workshops could be held to educate nurses regarding this issue. Tye (1993) suggests that training should be provided which focuses on psychosocial and interpersonal skills as well as exploring one's own experiences and attitudes about death and dying. Doctors as well as nurses need to be involved. Workshops could also be held to educate health professionals about breaking bad news to clients. These workshops have been shown by Farrell, Ryan & Langrick (2001) to be very

beneficial as the participants reported increased awareness about breaking bad news issues and the identification of strategies which could promote effective clinical practice. These participants were of the opinion that one of the most beneficial aspects of the workshop was the sharing of personal and collective experiences. By getting the nurses together at workshops to increase their knowledge about how to deal with death, could help reduce their stress levels as well. These workshops allow people to talk about experiences they had which were particularly distressing and let others learn from their experiences.

In the work environment it may be helpful for the nurse to draw up protocols to be used when dealing with death. These can be tailor made to suit the environment where the nurse is working be it a clinic, hospital or in the client's home. These protocols can then be used to guide the nurse in caring holistically with the dying client, their families and their nursing colleagues.

#### 2.7.2.2 Identification and management of stress

The most important aspect of coping with the intensity of the work in the emergency field is learning to accept that it will affect the healthcare professionals involved (Nelson, 1998). The health professionals working in the ED need to be aware of how to prevent the stresses inherent in the work and thus how to protect him or herself. In so doing, this will ensure that the profession does not lose an extremely experienced professional to one of the stress disorders. Ignorance on the part of the emergency nurse regarding the presence

of stress serves as a major limitation on the part of the South African emergency health professional who generally feels he or she is immune (Brysiewicz & Dickson, 1999). Consistent monitoring and attention to stress amongst staff needs to be done to be able to identify stress before it gets out of control (Stephens, 1997).

Critical Incidence Stress Debriefing (CISD) has become extremely popular in overseas Emergency Medical Services systems in an attempt to decrease the stress of the emergency staff. CISD is a process of educating and preventing the effects from an exposure to a critical event. It requires the formation of a well-trained team who lead the debriefing process, which then aims to reduce the stress caused by an extraordinary event. If this process is over-used, it can decrease its efficacy and cause it to be far less helpful when it is really needed (Burns & Harm, 1993). CISD alone is not effective in preventing adverse outcomes but should rather be viewed as trauma recovery over a long-term period of around two years (Stephens, 1997).

There are a number of steps involved in the debriefing process:

1. Introduction: The group is told about the situation to be addressed and group rules to be followed during the debriefing process are discussed and decided on. The issue of confidentiality needs to be emphasised as the members of the group need to feel comfortable within the group.



2. Fact phase: Members of the group describe the facts surrounding the situation, what exactly happened.
3. Thought phase: The group members are asked to describe what was going through their minds before, during and after the specific incident.
4. Reaction phase: Emotions are shared about what happened.
5. Symptom phase: The team counsellor describes to the group members the signs and symptoms of stress, both physically and mentally.
6. Teaching phase: The team counsellor provides information on when the members of the group may need further help in dealing with their stress responses. This then allows the members to self diagnose and identify their own needs for follow up counselling.
7. Re-entry phase: Constructive suggestions are made for dealing with a similar situation in the future. Time is also allowed for questions or comments (Rich, 2002).

In order for debriefing sessions to be useful it is vital that they do not become a “witch hunt”, a means for finding out who was to blame. These sessions are aimed at allowing the members to verbalise their thoughts and fears and to help resolve any outstanding issues.

Psychotraumatology has also been adopted in some ED's in the USA with some success. This advocates the use of specially trained workers who are skilled in the handling of the emotional and psychological results of trauma. They work with both the families as well as the health professionals of the ED's in an

attempt to do on-the-spot crisis intervention. They counsel the families and provide assistance to the staff as well as carrying out trauma debriefing sessions at the end. This appears to be a most promising area for future development in reducing the "psychological casualties" of trauma (Solursh, 1990).

The initiation and development of formal and informal stress management teams needs to be encouraged. The stress management team has become invaluable in dealing with those personnel who think that they ought to be able to handle anything. According to Harvey (1996), cited in Stephens (1997), individuals exposed to traumatic events expressed a preference to talk with colleagues who had shared their experiences in their own time and resented compulsory group debriefings.

### **2.7.3 Coping strategies used by the health professionals**

The death of a client is a very traumatic situation to deal with and making jokes or laughing can make terrible situation seem less so. It can also bolster ones courage (Maeve, 1998). Humor and laughter can be effective tools to cope with the stress of the situation. It can improve the function of the body, mind and spirit and provide an opportunity for the release of uncomfortable emotions which can create biochemical changes, that are harmful to the body. The ability to laugh at a situation gives one the feeling of superiority, power and feeling of control. It can

foster a positive and hopeful attitude and give one a sense of perspective on ones problems (Wooten, 1998).

Alcohol and drug abuse may be used by the health professionals in order to escape the reality of the traumatic situations experienced at work each day. These inappropriate coping strategies are evident when in a survey carried out by Cole (1992) cited in Sowney (1996), it was revealed that 30% of the nurses researched resorted to alcohol, 21% to smoking and 43% of the respondents drank numerous cups of tea or coffee. Drugs or alcohol abuse can be seen as an attempt to escape from the reality of the situation, and it an attempt to reduce the stress the worker is experiencing.

Another coping mechanism is avoidance. A number of health professionals mention avoiding the situation at all costs, and they will find themselves a task which then removes them from the situation and thus they are able to avoid it (Wright, 1996; Brysiewicz, 2000). Main (2002) mentioned that the nurses spoke about "passing the buck"- which was rather fetching another member of staff to deal with the bereaved families than having to deal with them themselves.

## **2.8 Conclusion**

There are many aspects that influence how the bereaved families and the health professionals deal with sudden/abrupt deaths, although it is evident that the way

the death of the client is managed determines the long term outcomes. The suddenly bereaved may experience prolonged grieving and are unable to achieve closure whilst the health professional may choose to leave the profession due to various stress disorders.

## **CHAPTER 3:**

# **THE RESEARCH APPROACH**

*Can't escape, the way that I'm feeling  
Tomorrow will never be the same  
How I wish that I could wake up from this dream  
I want to start all over again.  
And I fall asleep  
And I dream you're here '  
Forever I'll love you  
You'll always be my angel  
And all my dreams of you and me  
I'll hold till we're together  
Nothing will ever take your place  
And the things we had in your time  
All your smiles warm in my heart  
Like when you would put your hand in mine.*

**ADRIAN SHANNON**

### **3.1 Introduction to the research approach**

Action research was the approach used in this study as it attempts to "analyse problems, devise programmes of action designed to solve problems or improve standards, carry out and evaluate these plans, and learn more about research in the process" (Webb, 1989:404).

Action research has been traced back to the work of Kurt Lewin whose focus on a practical problem has remained a central characteristic of this method. It has however been suggested by Corey (1953, cited in Meyer, 1993) that Collier, a Commissioner for Indian Affairs 1933-1945, was another founder of action research. Action research has in the past and continues to be used in many different disciplines, including nursing (Meyer, 1993). This author suggests that action research appears to rely heavily on the skills of the researcher and that the approach is more personal and interpersonal than methodological. It is a philosophical approach to research which is based on a humanistic view of nature (Meyer, 1993).

The scientific merits of action research have been questioned and Meyer (1993) suggests that this is due to a male-dominated society with a historical tradition of positivist science. Susman & Evered (1978), on addressing this issue, draw on various philosophical approaches and suggest that action research can be legitimized as a science if its foundations are based on philosophical theories which differ from those used to legitimize positivist science.

There are a number of characteristics of action research. Action research is future orientated and deals with the practical concerns of people. A problem is defined and assessed, solutions to this practical problem identified and plans are made to implement change to alleviate the problem. The degree of participation in the problem identification is important for the success of the change process. Once the change has been implemented the outcome is then evaluated to make modifications and to start the change process again (Susman & Evered, 1978; Holter & Schwartz-Barcott, 1993; Holloway & Wheeler, 2002). This process is flexible and responsive to the situation thus the research design is quite imprecise at the beginning, with each cycle resulting in better action and better research (Dick, 2002). This method of research does however require time due to the cyclic nature.

There appears to be consensus that action research does not require special methods of data collection, although qualitative methods are mainly used. One of the most important characteristics is that of collaboration between the researcher and the practitioner (an individual who knows the workplace "from the inside"). The researcher is the "outsider", the individual who has the research knowledge, but who does not have in depth knowledge of the environment. The degree of collaboration between these two differs greatly and depends on the research orientation and goals of the researcher. This is the characteristic essential to differentiating the various approaches to action research. The final goal of action research is the development of theory where the researcher either develops a

new theory or makes changes to an existing one. (Susman & Evered, 1978; Holter & Schwartz-Barcott, 1993).

Action research is typically described as a cyclic process involving a number of stages, which involve planning, acting and reviewing or reflecting the outcome. This methodology is particularly relevant to the study of nursing issues as the knowledge gained is "grounded" in the actual practice and is validated and revised through its practical application. It can also be used to bridge the gap between theory, practice and research (Holter & Schwartz-Barcott, 1993). McKibbin & Castle (1996) also suggest that action research can lead to the emancipation of nurses. Hart & Bond (1996) have identified a number of criteria which they say differentiates action research from other methodologies. Action research is educative and deals with individuals as members of social groups. It involves change and aims at improvement and involvement. It is a cyclic process in which research, action and evaluation are interlinked and it is based on a research relationship where the participants involved in the research are also part of the change process.

According to Holter & Schwartz-Barcott (1993) there are three different approaches to action research. The technical collaborative approach is where the researcher pre-plans and carries out the research with the practitioners, and acts as a facilitator. This approach results in predictive knowledge and is primarily concerned with the refinement and validation of existing theories. The mutual



collaborative approach attempts to be more democratic with the researcher and the practitioner working and planning together as equal partners. They collaborate to identify a problem, plan the intervention and change together. The knowledge generated from this approach is usually descriptive and moves towards the development of a new theory. The limitations with this approach is that the practitioners may stop the change process once the researcher has left the area. The third approach described is the enhancement approach and this strives to lead to the emancipation of all the participants. The goal is to bridge the theory and practice to solve problems and explain them, and then raise awareness so that the practitioners can identify the problems and make them explicit (Holter & Schwartz-Barcott, 1993; Holloway & Wheeler, 2002).

Hart & Bond (1996) however suggest that action research should not be linked to one approach but rather that the research moves through the different approaches at the different stages of the project. Hart & Bond (1996) suggest that limitations of Holter & Schwartz-Barcott (1993) typology is that it presumes that action research is static and rational, and that it is the philosophical orientation of the researcher which guides and determines the approach to the action research and its goals.

Hart & Bond (1996) go further to offer their own action research typology. They suggest there are three key criteria of action research, namely re education, problem focus and improvement and involvement, which these authors use to

differentiate between four approaches. Their action research approaches are experimental, organisational, professionalizing and empowering. This research study has characteristics of the experimental type as well as the professionalizing type. The experimental type is apparent due to the fact that this research was conducted primarily for attaining a higher degree and thus was researcher focused. I was primarily in control of the research and in defining it. The professionalizing type was also evident due to the fact that I attempted to encourage reflective practice of the health professionals. The practitioners (health professionals) were geared towards improvement in practice defined by these professionals on behalf of the dying client and his or her family (Hart & Bond, 1996).

I endeavoured to follow the mutual collaboration approach to action research as described by Holter & Schwartz-Barcott (1993) and Masters (1995), by including the practitioners in generating a model, relevant to issues in practice, and ultimately arriving at a change in the practice of managing sudden or abrupt deaths in the ED. Holter & Schwartz-Barcott (1993) stated however that when evaluating action research studies, the majority of nursing research falls under the technical collaborative approach, with very few studies following the mutually collaborative approach. These authors stated that they had been unable to find any evidence of nursing research which could be described as following the enhancement approach.

## **3.2 Cycle 1**

### **3.2.1 Research questions**

The specific research question for this cycle was:

- What are the problems experienced by health professionals who confront abrupt death trajectories of clients in KwaZulu-Natal Level 1 ED's?

### **3.2.2 Research approach**

I set out a tentative framework for the study as it was being conducted for doctoral studies. This was subject to any changes and suggestions made by the participants. This original plan was however based on the findings of an earlier study which had explored the phenomena of violent death in the ED's. The findings from this research, carried out in the same Level I ED's as the present study, suggested that the health professionals had extreme difficulties in managing deaths in the ED's and had suggested that guidelines may be necessary to help them improve their management.

For the initial cycle of the research group discussions (focus groups) were used to establish if there was support for the proposed research, and if so, what changes should be made. This approach was chosen as it allowed for me to explore the participants feelings and ideas surrounding the proposed research, and to identify any interested co-researchers.

### **3.2.3 The participants**

The emergency health professionals working in the four Level-1 ED's were asked to volunteer to participate in the research, as it is very important for the participants of action research to be enthusiastic and interested in the project as motivation to change is needed (Webb, 1989). No specific emergency medical qualifications or courses were necessary for inclusion in the research and the researcher targeted management and clinical staff of the departments.

### **3.2.4 The setting**

The four Level 1 ED's (private and provincial institutions) in the Durban metropolitan area were involved in this phase of the study, after consultation with the hospital management.

### **3.2.5 Data collection process**

I negotiated access to the health professionals working in the ED's through the hospital and department management. I explained that the purpose of the research was to investigate possible support for the development of an intervention model to deal with abrupt death trajectories, or to make appropriate changes to the research, as suggested by the participants. The participants were requested to take part in a focus group (see Annexure A for the questions guiding the discussion) involving managerial and clinical staff, and to possibly be

involved in the research as co-researchers. I attempted to create an action research team from two of the four units (one private and one provincial institution) to be involved in the research until completion. I attempted to ensure that the members of the research team were involved in all aspects of the planning and implementation of the research. It was anticipated that by the end of the research they would have increased their knowledge of research techniques and would be able to continue the process of refining the model without the researcher's presence (Dick, 2002) as they would be committed to the process.

### **3.3 Cycle 2**

#### **3.3.1 Research questions**

The specific research questions for this cycle were:

- What are the experiences of the health professionals and bereaved families involved in confronting abrupt death trajectories in KwaZulu-Natal Level I ED's?
- What are the strengths and limitations with the current practice of handling abrupt death trajectories in KwaZulu-Natal Level I ED's?
- What psychological support and facilities were made available to the family members and the health professionals?

### **3.3.2 Research approach**

A qualitative approach using a phenomenological type of interview was chosen for this cycle of the study as this allowed me to gain a full view of the experiences of the participants. Phenomenological inquiry focuses on the meaning of people's experiences in regard to a certain phenomenon, and relies on in-depth interviews with the participant to enable them to describe their lived experience of the phenomenon (Polit & Beck, 2004).

### **3.3.3 The participants**

Purposive sampling was used to identify the families who had lost a loved one (who lived with them in the same house) to an abrupt death. This death should have occurred within a day, that is, the last time the family members saw the deceased they were healthy and then suddenly died unexpectedly in short space of time. The sample was to be obtained from referral of the health professionals working in two of the four Level I ED's, or from participants known to me who have had such an experience. I applied the principle of theoretical saturation. Any family members who did not speak Zulu or English were excluded from the study.

Purposive sampling was also used to identify health professionals who were willing to participate and had worked in a Level I ED for at least six months to one year. This was to ensure they had been exposed to the sudden/abrupt death of clients. Initially I started off with two participants in each of the two departments

although theoretical saturation was applied, for all the interviews. An interview with the ED manager from each of these departments was also to be included, as well as mortuary staff. See Annexure B, C, D and E for the interview guides used.

#### **3.3.4 The setting**

Two Level I ED's (1 private and 1 provincial) were to be involved in this cycle.

The participants, involved in the research study were interviewed at whatever location they preferred. I attempted at all times to make the families and the health professionals feel comfortable and secure, during their interviews. Privacy was also maintained.

#### **3.3.5 Data collection process**

Posters were to be displayed in the waiting room of the ED's (with the permission of the hospital management) drawing attention to the fact that research was taking place in the department, and providing the contact details of myself. In the ED and Critical Care Departments "research packs" were made available to inform the family about the research taking place. With the advent of a death in the ED or within 2 hours after handing the patient over to theatre or Critical Care personnel, the health professionals were to be asked to provide the family with an envelope (research pack) on their departure from the hospital. The cover of the envelope advised the families to open the envelope after a period of time

(approximately two weeks). The covering letters then advised the families about the nature of the research and ask that they contact me should they wish to be involved in the study.

At the start of the first interview I explained the nature of the research, its purpose, objectives and significance to the participants. The participants were asked to take part in two consecutive and relatively unstructured interviews. The second interview was the verifying interview where I used the time to verify the participants responses from the first interview. Time was allowed for debriefing the participants after the interview. I had the necessary counselling skills in order to do this and was able to identify participants who needed professional counselling and refer them. At the request of the families I would also follow up on information that the families felt was missing regarding their loved one, by liaising with the hospital staff and facilitating this exchange of information. The interviews were audio-taped with the participant's permission and then transcribed. Initial biographical data was requested from the participants during the first interview. For the family interviews I had a research assistant, who was responsible for interviewing the Zulu speaking family members. These interviews would then be translated into English for analysis, although this was not necessary as all the interviews were carried out by myself in English.



### **3.4 Cycle 3**

#### **3.4.1 Research questions**

The specific research questions for this cycle were:

- What are the crucial concepts of an abrupt death trajectory in the ED?
- What are the crucial processes or relationships (cause and effect relationships) between the concepts of an appropriate abrupt death trajectory intervention?
- How can the situation be handled in a more therapeutic way for both the health professionals and the client's family?

#### **3.4.2 Model development approach**

The co-researchers and myself, used literature and data collected from Cycle 2 to identify the experiences of the health professionals and the bereaved families, and also endeavoured to become familiar with the theoretical and empirical work already carried out in the area of interest. While developing the model I established a clear understanding of the concepts within the model and delineate relationships between these concepts (Fawcett, 1984; Chinn, 1986). The model development followed the steps outlined by Stember (1986) by describing what the model was trying to represent, the concepts active in this domain and analysed them in relation to the phenomenon of interest. The order of occurrence was identified and relationships delineated between the variables, and a visual representation of the model was then developed and refined.

### **3.4.3 The participants**

The health professionals (clinical and managerial) working in the two Level I ED's were asked to volunteer to be involved in the focus groups. The co-researchers from the different ED's were also involved. There were no inclusion or exclusion criteria used as anyone interested in the research was asked to participate. Bereaved families (identified in Cycle 2) were also asked to provide comments or suggestions to the developed model.

### **3.4.4 The setting**

Two Level 1 ED's (private and provincial) were to be included in this cycle. The focus groups were held in which ever venue chosen by the participants.

### **3.4.5 Data collection process**

Once the model was developed focus groups were to be held in each of the two ED's involved in the research, and the members of the research action team were also included. All interested ED staff (doctors, nurses and pre-hospital personnel) as well as department and hospital management were invited to participate. This was carried out in an attempt to validate the model by using a group of the practitioners who would be using the model. I introduced myself and the co-researchers and establish the rules for the group as well as the purpose and objectives. The model was presented and feedback requested from the participants about the developed model and any other suggestions or comments.

A semi structured interview format was followed which will allow for the group to talk about the most pressing issues for individuals by allowing a degree of meandering discussion. I was listening for similarities and differences, and asked the group to reflect back on these (Terre Blanche & Durrheim, 1999). Refer to Annexure F for details of the interview schedule of this focus group. These focus groups were taped with the permission of the participants. The findings from the focus groups were used to refine the model.

### **3.5 Cycle 4**

#### **3.5.1 Research questions**

The specific research questions for this cycle were:

- What are the experiences of the health professionals in implementing an intervention model for the therapeutic management of abrupt death trajectories in KwaZulu-Natal Level I ED's?
- What are the problems and prospects of implementing such a model?

#### **3.5.2 Research approach**

Focus groups were to be held in the two ED's implementing the model, in order to explore their experiences of implementing such a model.

### **3.5.3. The Participants**

The participants involved in the cycle were to be all the interested health professionals (clinical and managerial) working in the two ED's, where the model had been chosen for implementation

### **3.5.4 The setting**

This cycle of the study was to be carried out in two of the four Level I ED's who were willing to implement the model.

### **3.5.5 Data collection**

Workshops involving all the ED health professionals and management were held to explain the model being implemented, and to discuss any potential obstacles and concerns. While the implementation was underway the co-researchers and myself attempted to be aware of any problems or difficulties experienced. Regular contact was maintained with the implementation team in order to discuss the model implementation and any problems encountered. Focus groups were held one month after the model implementation, in order to identify problems with implementation and to find solutions.

### **3.6 Data analysis**

The data analysis was aided by the use of a software package specifically designed for qualitative research namely; Non-numerical Unstructured Data Indexing Searching and Theorizing (NUD\*IST 4). With the aid of this computer package the researcher organised the data from the interviews and focus groups by identifying meaningful units, which were then categorized and coded (Creswell, 1998). All the data within the same category was then grouped and sub-categories developed as needed. Manual data analysis was also done. During data analysis I attempted to identify interpretations in the data, which test or challenge the emerging interpretations, that is seeking "disconfirming evidence". This conflict between the original data and the exceptions can then be resolved, which leads to a deeper learning of the experience and can result in bringing about change (Dicks, 2002).

### **3.7 Trustworthiness**

Trustworthiness refers to the quality value of the final results and conclusions reached in a qualitative study (Lincoln & Guba, 1985), and is comprised of credibility, transferability, dependability and confirmability.

Credibility is concerned with the credibility of the data and the interpretations of them. This was done by prolonged engagement. I ensured that I had sufficient time for the data to be collected as this study took place over four years, and I

continued to collect data until no new data was being discovered. This prolonged engagement also allowed me to establish trust and a good rapport with the participants, thus making it more likely that rich, useful data were collected. Member checking was also used as a method for establishing the credibility of the data collected. I provided feedback to the participants regarding the themes emerging from the data in order to obtain their reactions and to explore if these interpretations were a good representation of the participants reality. This was either done during a second interview with the participants or during the second support group meeting. The data and the categories uncovered were discussed regularly with my research supervisor to ensure the accuracy of the themes and categories derived from the data (Polit & Beck, 2004).

Transferability refers to the application of this study's findings to the context in which the data was developed from into a similar context, the generalizability of the data. To ensure this, I provided thick descriptions of the research process in an attempt to demonstrate that the knowledge acquired could be relevant to a similar situation or participants (Polit & Hungler, 1993; Holloway & Wheeler, 2004).

Dependability is concerned with the stability of the data and this was ensured by the long time over which the data was collected. I also attempted to describe the decision-making processes of the research study in detail as well as the context of the study (Holloway & Wheeler, 2002).

Confirmability refers to the degree to which the data confirms the findings. I attempted to become immersed in the data collected and reflected on the data collected in different ways (interviews, focus groups and observation). The findings contained rich descriptions in order to give the reader a sense of "being there" so that the readers are able to follow the path I took and trace how I arrived at my interpretations (Holloway & Wheeler, 2002). The model developed emerged from the data that was grounded in the participants own experiences.

In order to improve rigor in the action research I combined collection, interpretation, literature review and reporting. Brief cycles were used to ensure there was adequate iteration, and multiple data sources were accessed. The participants in the research were actively involved in the process by acting as co-researchers and interpreters of the data (Dicks, 2002; Polit & Beck, 2004).

Waterman (1998) is of the opinion that validity regarding action research needs further exploration, as the acceptance of general criteria for qualitative research are not sufficient. Three types of validity, namely dialectical validity (tensions and processes), critical validity (moral responsibilities) and reflective validity (valuing ourselves) are described by this author.

The importance of examining the inherent tensions of an action research project is emphasized. The researchers should pay attention to and provide descriptions of the process as well as highlighting the conflicts and tensions between practice,

theory and research (Waterman, 1998). I attempted to do this throughout the four cycles and details are provided in Chapter 4.

Waterman (1998) discusses the moral responsibility of the researcher to be aware and to take into account the problems of people in the setting. The researchers need to appreciate that decision-making includes action but also knowing when not to take action, and the researchers have to provide substantive rationale for their actions. I endeavoured to remain open and aware to problems being experienced by the participants although I relied a great deal on the advice of the co-researchers and was guided by them as to what might be the correct course of action to take. Clear and detailed descriptions were provided throughout the cycles in order to offer rationale for the actions taken or for not taking any actions.

The third type of validity is that the reflective nature of action research is acknowledged. The researchers must ensure that the final report reflects a variety of examined perspectives. The researchers need to examine their own practices and assumptions and whilst valuing themselves they must be aware of their own biases and limitations (Waterman, 1998). I attempted to ensure that a wide variety of perspectives were examined, that is, bereaved families, mortuary staff and health professionals (both clinical and managerial). Throughout the research I also attempted to be aware of my own biases and limitations and how these could influence the research.



### **3.8 Ethical considerations**

Due to the sensitive nature of this research, namely sudden death, the ethical considerations were of extreme importance. It was also important due to the fact that action research is carried out in the "real world" and involves close communication with the participants involved (O'Brien, 1998).

Permission to conduct the research was obtained from the Ethics Committee of the University of Natal. See Annexure G and H. Permission was also obtained from the Department of Health, Superintendents of the provincial hospitals and the Board of Management of the private hospitals, prior to entering the hospitals. See Annexure I, J, K and L. Permission to conduct research in the state mortuary was given by the Superintendent in charge of the Police, and permission to attend the support group was given by the leader of the support group.

The selection of participants was done on a voluntary basis and they were informed of their right to withdraw from the research at any time. Verbal consent was given for their participation in the research. The participants were informed about the purpose and objectives of the research, as well as the anticipated significance. I ensured that my contact details were available so that any of the participants were able to contact me if they wanted to.

I ensured that the interviews and focus groups were carried out in private, at whichever location chosen by the participants. Support was given to the participants where necessary and enough time was scheduled after the

interviews to allow for the debriefing of the participants if needed. I had sufficient counselling skills in order to do this and was aware of additional support services available to refer the participants to for further help.

I attempted to establish a rapport with the participants and also discussed the issue of secrets and maintaining confidentiality. I also emphasized to the participants that whatever was said during the interviews would be confidential and not discussed with others or their unit manager. The participants were asked to choose a pseudonym so that the data could not be traced back to an individual.

The hospitals participating in the research were also given another name by me. The recording of the interviews was done with the permission of the participants and they were informed that another person would be responsible for transcribing the tapes. Once the raw data was imported into the computer package I secured the tapes, which would then be destroyed once the research was completed.

The issue of ownership of the data was negotiated with the co-researchers at the beginning of the study, and their role in the research was carefully explained (O'Brien, 1998).

### **3.9 Conclusion**

A tentative research design was set out in order to explore the experiences of dealing with sudden/abrupt deaths from the perspectives of the bereaved families and the health professionals. This data was then to be used to develop an intervention model to guide the health professionals when managing sudden/abrupt deaths in the ED.

## **CHAPTER 4 :**

# **FINDINGS OF THE RESEARCH AND DISCUSSION**

*Death is nothing at all  
I have only slipped away into the next room.  
I am I and you are you,  
Whatever we were to each other, that we still are.  
Call me by my old familiar name,  
Speak to me in the easy way which you have always used  
Put no difference in your tone,  
Wear no forced air of solemnity or sorrow  
Laugh as we have always laughed  
At the little jokes that we enjoyed together.  
Pray smile, think of me, pray for me.  
Let my name be ever the household word  
That it always was  
Let it be spoken without effort  
Without the trace of a shadow in it.  
Life means all that it ever meant,  
It is the same as it ever was  
There is unbroken continuity,  
Why should I be out of mind  
Because I am out of sight?  
I am waiting for you  
Somewhere very near  
Just around the corner.  
All is well.*

**HENRY SCOTT HOLLAND**

## **4.1 Cycle 1**

### **4.1.1 The setting and participants**

The first two departments to be involved in the research were two private institutions (Hospital C & D). The group interviews for Hospital C were held in the staff tea lounge or at the “duty room” counter, whereas the focus group for Hospital D was held in a hospital boardroom. The focus group for Hospital E, a provincial Level I ED, was held in the staff tea lounge. All the staff (managerial and clinical staff) working in the ED’s were invited to participate in the research, thus the sample consisted of the unit managers, registered nurses, enrolled nurses, enrolled nursing assistants, student nurses (Hospital E) and paramedical staff (Hospital D). No specific emergency medical qualifications or courses were used as exclusion criteria for the participants, and any interested health professionals were invited to participate. All the participants at Hospital C and E were interviewed in their “on duty” time, as arranged by the unit manager, whereas the focus group held at Hospital D had “on” and “off” duty staff.

### **4.1.2 Data collection**

Initial interviews (30 to 40 minutes long) were held individually with the unit managers of the three departments in order to explain the research in general, and specifically the procedure to be followed in the focus groups for Cycle 1. At these meetings the unit managers were enthusiastic regarding the proposed research and the unit manager of the one private hospital (D) stated that her staff

had already identified this area as a weakness in their department. The unit managers then made arrangements for me to have access to their staff.

Hospital D had a staff meeting for the ED in the evenings, on a monthly basis, and I was invited to attend. Hospital E had weekly staff meetings at lunchtime and I was invited to talk to the staff at one such meeting. The unit managers chaired these meetings and introduced me at the start of the meeting, and I was then invited to talk to the staff about the research.

Hospital C did not have any opportunities where all the staff met together so the unit manager suggested that I hold separate group meetings with the various shifts. This was done and I visited this institution on five separate occasions in order to hold group interviews with the staff members of the different shifts, including night duty staff. In Hospital C and E I made notes as the participants answered the various questions whereas a research assistant was used to take minutes of the focus group in Hospital D. The participants were aware of this note taking and had no objections

At all the institutions, I explained the proposed research and ethical considerations, and then asked the participants to answer questions according to the guide for focus groups in Cycle 1 (see Annexure A). A great deal of time was spent discussing whether or not the proposed area of research was actually important to the staff, or if they had other areas of interest for research. I explained the research methodology to be used, i.e. action research, and that I

wanted to ensure that the health professionals were actively involved in all aspects of the research. The department staff were very enthusiastic and eager to be involved in the research and a number of the participants volunteered to be co-researchers.

### **4.1.3 Findings**

The data were analysed manually and were organised according to the questions that were asked.

#### 4.1.3.1 Is this important research?

All of the participants seemed to agree that this research was needed and that they as staff would be interested in it and the changes it could bring about regarding their current practice. A number of the participants were very enthusiastic and vocal in their support for the research. The one unit manager (Hospital C) said that the proposed research was fantastic as there was nothing available at the moment. Another of the participants mentioned to me that it was *"about time someone is interested in investigating this area!"* Some of the staff also mentioned that they had spoken to their unit manager about the fact that they were not able to cope with the deaths in the department, and the staff from Hospital E said that despite this, management had done nothing to help them. They went on to explain to me that they were not sure how to look after

themselves and other colleagues in such stressful situations. A participant from Hospital E said that the problem was that the staff became "*immune*" to the deaths as they saw them on such a regular basis, and this resulted in the staff appearing "*hard and unemotional*". A participant went on further to explain that this also resulted in problems for the staff of the departments themselves as if they have lost a loved one the staff show sympathy for a very short time and then expect them to "*get over it.*" In Hospital D during staff appraisals, the staff identified this area as being of concern for themselves in the department and together with the unit manager they had decided that this would be their focus area to work on.

The participants said that this research was very necessary as more people were dying suddenly and staff did not know what they were doing when dealing with death in the department and often just worked off '*gut feeling*'. The participants from Hospital E said that the doctors in their department took the responsibility of dealing with the families and breaking bad news. The staff acknowledged that the reason for them not being involved could be due to the fact that they were uncomfortable about facing such situations and just did not know how to handle it. Another incident that was brought up by the staff of Hospital E was in dealing with families who came looking for their loved one days after their death. The participant said this made her extremely uncomfortable as it was a shock for her and the families and she had forgotten the situation surrounding the death. These families were referred to the doctors to deal with.



It was mentioned to me at Hospital E that their department was very busy and the staff were often just too busy to spend time with the family. Another issue was that there was no room available where the staff could speak to the families privately.

The staff also questioned me about when the research would start and the model become available to them as they felt that they needed the information now. No other areas for possible research were highlighted.

#### 4.1.3.2 Concerns regarding the proposed research

The major concern voiced by a number of the participants pertained to the proposed method for accessing families of the suddenly bereaved. A number of the staff members said that they would feel uncomfortable about handing the family members a letter prior to them leaving the department. This was because the families at that point are in a crisis and disturbing them with research would be unsuitable. A participant said that her own mother had died suddenly and that she would have been very upset to have received such a letter and thus felt from her own experience that she would not participate in this.

The idea of having a poster in the waiting room to tell the families about the research going on in the hospital was also rejected as the participants felt that the families would take no notice and would probably not see it. A participant

explained that from her own experience she just shut off to everything around her and would definitely not have noticed anything on the walls. Other concerns were that the family would lose the letter, throw it away or forget about opening it in three weeks time. Some participants also felt that the family might not wait three weeks before opening the letter and then might get angry and feel that the staff did not care that they were very upset about the death of their loved one.

All of the participants felt that it would be much better to post the letters to the families some time after their experience in the department and they felt that approximately three weeks later would be good enough. The letter would then contain my contact details and it would then be up to the families to contact me should they wish to be involved in the research. A participant suggested that the hospital management might be interested as this could then be seen as a way to rate the service offered by the hospital to the families and then make improvements where necessary.

At Hospital E consensus was not reached on how to approach the families to participate in the research. The problem raised was that the clients often gave fictitious contact details, which then made tracing them problematic. A participant explained how a while back she had to contact a client urgently as she had been given the wrong medication to take home, and there was an added urgency as this patient was blind. The nurse then had to try and find the client and this took a great deal of time and effort, as all her contact details were incorrect.

Some of the participants were also concerned as to which categories of staff would be involved in the research as they felt that they (nurses and pre-hospital staff working in the department) were the ones that needed the support. It was also highlighted that nursing students should be involved in the research.

#### 4.1.3.3 Will this change current practice?

When I asked if the participants felt that this research would change current practice there was a resounding "yes"! The participants said that they would then know what they were supposed to be doing and would know the right way to proceed in such a situation. They felt that they were not sure of the correct way of managing death and dying in the department, and that their management was often just 'trial and error'. This research was thus seen as a way to rectify the present situation.

#### 4.1.3.4 Suggested changes to the research project

The participants came up with a number of suggested changes for the research. They suggested that death education workshops be held in the departments when implementing the model so that the staff could gain information about death and dying. The research study should start in the ED but all nurses could make use of this information, specifically the ICU staff as they have a great

number of patients dying there. A number of the emergency staff were very concerned about their colleagues in ICU and how they would benefit from the research project. Pamphlets for the families should be developed so that they could be given to the families when they leave the department. This pamphlet could give the families information on autopsies, documentation to be completed and support services etc. Nursing students should also be involved in the research as they are often the ones left with the families during this time and thus need skills in order to cope with the situation while waiting for the sister to come and talk to the families.

#### 4.1.3.5 Staff needs in this area

The participants identified a number of needs. Guidelines on how to manage sudden/abrupt deaths in the ED were needed. The participants said that they were usually very busy and did not have the time to think about what they should be doing. They did not have time to spend with the families and a participant said; "*we just give them a cup of tea*". The participants wanted guidelines on how to break bad news and suggested that a checklist could be useful so that the health professional would know that all had been done. The participants suggested that the proposed model could be used as a frame of reference and thus make the staff feel that they did all they could thus making them feel better.

Another important aspect highlighted was that the health professionals needed to know how to cope with their own feelings about death and dying. The participants also felt that they needed information on how to cope with the different cultures ideas and beliefs on death and dying. Social support for the health professionals was emphasised as they felt they are just expected to cope and take much 'baggage' home to their husbands and families. One participant said that she felt that the staff are "*left to cry in a corner*".

It was suggested that the doctors need to be involved as some are able to deal with this situation better than others. The participants told the researcher that the doctors were lacking in death skills and often just broke the bad news to the family and then just walked away. It was mentioned that some of the doctors are very affected by particular deaths.

The unit managers participating in the research wanted the other staff members to become involved in dealing with bereaved families as it is very emotionally draining for the same person to keep doing it. The other staff members however saw these senior nurses as having the necessary skills and as these senior nurses did not seem to mind doing it, the other staff members just left it up to them. A junior participant said that she left this job for the seniors as "*they are better at doing it*".

#### 4.1.3.6 Volunteers for co-researchers

The unit managers agreed to be co-researchers in the project as they felt it was important research and recognised the role they could play in this research. In Hospital C two clinical staff members (registered nurses – 1 day duty and 1 night duty) volunteered to be part of the research and supplied me with their contact details. In Hospital D and E none of the staff volunteered to be co-researcher during the focus group and they asked if they could approach me later on privately, or inform their unit manager. Subsequent to that a number of the staff at Hospital D approached me and said why they were of the opinion that they could not be co-researchers. One of the participants volunteered to be a co-researcher as she felt that this would be a good way for her to make use of a research module she had recently done as part of her Nursing Diploma course.

#### **4.1.4 Discussion of the findings**

##### 4.1.4.1 Inadequate management of sudden death in the ED

The participants were of the opinion that sudden/abrupt deaths were not being handled in the most therapeutic way in their departments. The participants highlighted limitations with their own “death education”, lack of protocols and policies to guide practice, lack of follow up and limited staff support. The participants also emphasised to me that dealing with these sudden/abrupt deaths was extremely difficult for all the health professionals involved and after reflecting on their current practice, they were ready for change. These findings were

echoed in a number of studies carried out around the world (Cooke, et al., 1992; Flam, 1999; Brysiewicz, 2000; Socorro, et al., 2001).

#### 4.1.4.2 Carrying out sensitive research

Due to the sensitive nature of this research the participants had a number of concerns regarding making contact with the suddenly bereaved families. There was a great deal of discussion and suggestions were made in an attempt to ensure that the bereaved families would be handled in the most sensitive way possible. Murphy & Nightingale (2002) agree that when exploring sensitive issues in the ED, the researcher needs to ensure that their research safeguards the participants, and that the participants are not exposed to harm in any way.

## **4.2 Cycle 2**

### **4.2.1 The setting and participants**

The health professionals (clinical and managerial) from four Level I ED's in KwaZulu-Natal were involved in this cycle of the research. This comprised of two private institutions and two provincial institutions in the Durban area. I attempted to access suddenly bereaved families from a number of sources namely the hospitals, churches, support group and organ transplant managers (these details are provided). Mortuary staff from one of these hospitals, as well as a state mortuary were included later on in this cycle.

#### 4.2.1.1 Health professionals

All the registered nurses working in the ED's of three of these hospitals (1 provincial and 2 private) were invited to participate in the research, as well as the doctors working permanently in these departments. These participants were not required to have specific emergency medical qualifications or courses, although they needed to have been working in the department for at least six months to one year. I interviewed the unit managers, clinical staff and the doctors in these departments. The nursing managers from two of these hospitals (1 provincial and 1 private) were also interviewed.

#### 4.2.1.2 Families

I attempted to make contact with the suddenly bereaved families through a wide variety of means and over an extended period of time, approximately one year. This proved to be extremely difficult and the result was that the majority of the bereaved families I accessed were through The Compassionate Friends support group. More details are provided further on in the text.

#### 4.2.1.3 Mortuary staff

After starting in the interviews with the bereaved families it became apparent that there was a need to involve mortuary staff. This was due to the fact that these sudden deaths are viewed as unnatural deaths and thus have to have an



autopsy performed on the dead client. This means that the families come into direct contact with the mortuary staff and this can have a great impact on them. Both the families and the health professionals advised me to involve the mortuary staff. I obtained participation from mortuary staff at private as well as provincial institutions.

#### **4.2.2 Data collection**

A qualitative approach using a phenomenological type of interview was chosen for this phase of the research study. This then allowed me to explore the phenomenon of sudden/abrupt death, as experienced by the different participants (health professionals, bereaved families and mortuary staff). See Annexure B, C, D and E for the different interview guides used, and Annexure M for an example of one interview.

I asked for volunteers to participate in the study and then arranged for the interviews to be held at a time and place which was convenient for the participant. I attempted to ensure that the location used for the interview was private and free from interruptions due to the sensitive nature of the research. The participants were informed of their rights and were asked to choose a pseudonym. The interviews were taped with the permission of the participants and lasted approximately thirty to forty minutes long. I also spent some time with the participants after the interview in case they had questions or were upset with what they had been remembering and needed to be debriefed. I spent a great

deal of time with the bereaved families as they often wanted to talk about their loved one and show me pictures of their loved one.

I also made use of a questionnaire based on the Revision of the Critical Care Family Needs Inventory for the Emergency Department (Redley & Beanland, 2004) to obtain information from the bereaved families. The questionnaire developed by Redley & Beanland (2004) by adapting the Critical Care Family Needs Inventory to suit the families of the critically ill in the ED was then altered by myself to address the needs of the suddenly bereaved in the ED. This was used as an attempt to obtain information from the bereaved families, as they were proving to be extremely difficult to obtain. The questionnaire administered to the bereaved families had a covering letter explaining the research objectives, maintaining confidentiality and the right to withdraw at any time. I asked the families to volunteer to complete the questionnaire and return of the questionnaire was seen as consenting to participate. I also spent a day at a state mortuary and carried out observations, which were added to the data collected.

#### 4.2.2.1 Health professionals

A total of 14 health professionals were interviewed over a period of approximately seven months. This sample comprised of 1 nursing service manager, 4 unit managers, 2 Medical Officers who work permanently in the ED and 7 registered nurses. See Table 4.1 for a profile of the participants.

**Table 4.1 Profile of the participants (health professionals)**

<b>Pseudonyms</b>	<b>Position in the department</b>	<b>Emergency nursing experience</b>	<b>Other comments</b>
<b>Jane</b>	Registered nurse - private institution (unit manager)	11 years experience, 3 years managing the department. Has done numerous short emergency courses and a Diploma in Emergency Nursing	Married with children. Has had her own experience of losing a loved one to a sudden death.
<b>Louise</b>	Registered nurse- private institution	7 years experience and is a Basic Life Support instructor	Is the mother of a young child.
<b>Rebecca</b>	Registered nurse- private institution	3 years experience and has done the ATLS course. Is about to start the Diploma in Emergency Nursing	Married and has experienced the death of her father
<b>Beth</b>	Registered nurse - private institution (unit manager)	13 years experience and 5 years managing the department. Has done some short emergency courses.	Has experienced the sudden death of friends.
<b>Dawn</b>	Registered nurse- private institution	2 1/2 years experience and has not done any emergency courses.	Married and she has a young child.

<b>Jenny</b>	Registered nurse-private institution (acting unit manager)	12 years experience and has completed the Trauma Diploma.	Has two young children and her father died when she was young
<b>Annette</b>	Registered nurse-private institution	18 to 20 years experience and has some pre-hospital qualifications	Is married with children and works permanent night duty.
<b>Ben</b>	Registered nurse-provincial institution (unit manager)	10 years experience and 4 to 5 of those years as the unit manager. Is working towards a Diploma in Emergency Nursing.	Is married with children
<b>Pam</b>	Registered nurse-provincial institution	10 years experience and is completing the Diploma in emergency nursing.	Has a young child and is pregnant with her second child.
<b>Sibongile</b>	Registered nurse-provincial institution	Worked in the Emergency Nursing field for 5-6 years. Has not done any emergency courses	Unable to conduct the follow up interview as she was hospitalized.
<b>Annie</b>	Registered nurse-provincial institution	Worked in the Emergency Nursing field for 4 years. Has done a basic first aid course.	Is married with a young child

<b>Ouboet</b>	Medical Officer – private institution	10 years experience and has done the ATLS, ACLS courses and a Diploma in Primary Emergency Care.	No personal details given
<b>Susan</b>	Nursing service manager in charge of the ED	Worked in the outpatients department as a unit manager for a number of years before being promoted to Nursing Service Manager.	Has experienced the death of a loved one
<b>Stuart</b>	Medical Officer - private institution	Has done numerous trauma courses and is an ATLS instructor.	Is married with young children.

Initial interviews were held with the unit managers in order to explain the cycle of the research and to request access to the staff in order to hold the individual interviews. The staff was then reminded about the research taking place and were asked to volunteer to be interviewed. Permission was granted by the unit managers for all the interviews to take place "on duty" time. I made use of the tea lounge, store-room or whatever room was not being used to conduct the interviews. A number of the interviews were interrupted by other staff members but the participants answered the query and then continued immediately with the interview.

#### 4.2.2.2 Family members

Making contact with suddenly bereaved family members proved to be extremely difficult and very time consuming due to the sensitive nature of the research. Due to the lack of participants, I included any suddenly bereaved families and not only those who lost their loved ones in the ED's. I was able to interview seven bereaved families and Table 4.2 shows the profile of these participants. The interviews with the bereaved families proved to be very difficult for me, as I found myself close to tears at times. A number of the families made a point of showing me pictures or describing their loved one in detail so that I was able to "know" a little about their loved one. After the interviews I made it a point to discuss aspects of the interview which had been emotionally difficult, either with colleagues or family members. As I had recently given birth to my own son, the painful stories from parents who had tragically lost their own child were particularly difficult for me.

**Table 4. 2 Profile of the participants (bereaved families)**

<b>Pseudonyms</b>	<b>Interview venue</b>	<b>Brief details of their loved one who died</b>	<b>When the death occurred</b>
<b>Jabulani</b>	Interviewed telephonically	His father died unexpectedly in the radiology department following a urology procedure	Two and a half years ago

<b>Thandi</b>	Interviewed telephonically	Her aunt died in Johannesburg	Ten years ago
<b>Zodwa</b>	Her workplace	Her sister died when the taxi she was travelling in was involved in a motor vehicle collision. Zodwa was at the scene of the collision and visited the mortuary.	One year ago
<b>Shaun and Carol</b>	Their home	Their 19 year old son was killed in a motor vehicle collision. They had to identify him at the mortuary.	Three years ago
<b>Chantelle</b>	Her workplace	Her 10 year old son was killed in a motor vehicle collision. She was in the ED with her other children injured in the same collision.	Eight months ago
<b>Jasmin</b>	She was interviewed at a hospital while waiting for her appointment as she did not think that I would be able to find the way to her home.	Her son was killed after falling out of a bus. She was with him at the scene of the accident and went with him to the ED.	Three years ago

Amy	Her home	Her 19 year old son was killed in a motor vehicle collision and her husband died after a motorbike accident. Both of them died in ICU.	Son died four years ago and her husband 17 months ago.
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### *The hospitals*

I initially planned to ask the health professionals to hand out letters at the ED's to the bereaved families when they left the department - different ED staff had various thoughts about this. As the study was based on action research I listened to the suggestions from the co-researchers in each ED and plans were then made together with them regarding the way forward. Two of the private institutions (hospitals C and D) were of the opinion that this would not be a suitable thing to do. They thought the families might think them cruel and unfeeling if they addressed research when the family was in shock and did not consider their feelings at this time. A staff member who had lost her father through a sudden death said that she did not want anything to do with handing out letters as she felt this was not the right thing to do. She felt she would have taken offence at this should someone have approached her with a letter at her time of bereavement.



I had also planned to have a poster displayed in the ED waiting room detailing the research taking place and my contact details. The health professionals felt that this would not be useful as the families experiencing such a crisis would not notice what was on the walls, and so this was not done. The letters were therefore handed out in the one institution.

In one of the private hospitals (Hospital C) the hospital management refused to allow me to approach the families in any way, as they felt it might infringe on the client's confidentiality. Some of the staff members spoke to me informally about this, and thought that it was a pity as they felt I was missing out on important information, which would directly impact on the quality of care that they would be offering at their institution.

In Hospital D, (private institution) the hospital management was happy to allow the unit manager to contact the families. It was already established as a policy that the unit manager would contact the families two to three weeks after the sudden death in the department to see how they were coping. It was then arranged that the unit manager would also tell the families about the research being conducted and ask if she could send them a letter with more information. No families made contact with me by means of this approach.

Hospital E emphasized that they often had a problem with fictitious contact details being given by the patients and so the only way to access the families

would be to hand out a letter to them detailing the research, once they were ready to leave the department. The hospital administrators and unit manager were happy to do this. I had to contact the co-researchers on a regular basis to ensure that they did not forget about the research study and to hand out the letters. When contacting Hospital E, I was told that all the letters had already been handed out and if I wanted to I could bring more. No families made contact with me by means of this approach.

In Hospital F, management was happy for the families to be accessed either through handing out the letters in the department or through posting them; since the research was seen as something that would ultimately end in improved clinical practice. I was referred to managers in charge of two clinical areas and arrangements were made to either hand out the letters when the families left the department or to post them later – depending on the discretion of the managers. No families contacted me via this approach. Letters, approximately 90 of them, detailing the research in English and Zulu, were addressed to the suddenly bereaved families and were provided to three of the hospitals. No families made contact with me by means of this approach

### *Churches*

I also contacted a wide variety of churches in the Durban area and supplied them with a poster detailing the research being carried out and providing my contact

details. The church was then asked to display the poster on their notice board in the hope that interested families reading the poster would then contact the researcher. No families contacted me.

#### *Transplant coordinators*

One of the co-researchers suggested contacting the Transplant Co-ordinators and through discussions with one of these health professionals I was put in touch with The Compassionate Friends Support group. I also asked the Transplant Co-ordinators to inform any of the suddenly bereaved families they came into contact with about the research study, and to provide them with my contact details should they be interested in taking part. No families were contacted in this way.

#### *Other*

An advert was also placed on the website of a local radio station. I did receive two telephone calls, although both their loved ones had died in the hospital wards after being admitted for a few days. I also became aware of a member of staff who had experienced the sudden death of her sister. This colleague was interviewed although she had not been involved in the hospitals and only saw her sister at the scene of the collision.

*"The Compassionate Friends" support group*

After contacting the group leader I was invited to speak at the group's next meeting and to explain the research study and ask for any interested participants. There were approximately 30 people present at this meeting which took place one Monday evening, and when I arrived I discovered that I was the only speaker for the night. I explained the research study, the reason for starting the research and its purpose, and what would be expected from the research participants. Time was also spent discussing the questions that would be asked of the participants and the data collection procedure to be followed. The support group members also had a lot of questions to ask about certain aspects of the care that their deceased loved ones experienced. I attempted to answer these questions to the best of my abilities. After the meeting a number of the group members came to me to obtain contact details and mentioned that they would be in contact as they felt that they would like to discuss their experiences. I waited for the members to make contact but this did not occur. I then contacted the leader and asked her to remind the members, and two families were then referred to me and interviewed.

I also asked to speak about the research again at a subsequent meeting and the group leader agreed. This followed the same format as the previous meeting and there were 28 people present. Due to the extreme difficulties faced contacting bereaved families, I decided to administer a questionnaire to the support group members on this second visit. Three more families agreed to be interviewed and

they gave their details to me and plans were made for the interviews. I only conducted two of these interviews as one of the families was very difficult to schedule for an interview as they lived a considerable distance away. The bereaved families who participated were interviewed wherever they preferred; work or home, and even during a doctor's appointment.

#### 4.2.2.3 Mortuary staff

When I met with the bereaved families at the support group meeting, I was told that they had to deal with the mortuary staff and found this extremely difficult, as the staff did not seem to care about their loss. The bereaved families suggested that I include the mortuary staff in the research and the co-researchers (health professionals) agreed with this. I then interviewed mortuary staff at a state mortuary and at one private hospital mortuary.

I received a very warm, somewhat surprised welcome from some of the staff who said that it was very good that someone was concerned about the area that they are working in. They went to great lengths to emphasize that a large number of the practices being carried out at their institution were not ideal, but were being done due to a lack of resources. They even went so far as to invite me to come and spend a day with them to see what their working life is like as they felt that this would add to the data being collected. They also thought that this would provide me with an opportunity to talk to other mortuary staff members as well as

the bereaved families. I did return to carry out observations for a morning and watched three autopsies taking place. See Table 4.3 for a profile of the mortuary staff who participated in the research.

**Table 4.3 Profile of the participants (mortuary staff)**

<b>Pseudonyms</b>	<b>Position in the mortuary</b>	<b>General comments</b>
<b>Niveen and Lushen</b>	Members of the police services	Have both been working in the state mortuary for over twenty years
<b>Jack and Siphon</b>	Security staff	Security for a private institution and are responsible to transferring the deceased to the small mortuary in the hospital.
<b>Raj</b>	Mortuary management	Has been in the state mortuary for around 30 years

#### **4.2.3 Data analysis**

All the interviews were conducted by me, taped and then transcribed by a research assistant. Any interruptions to the interview (INTERRUPTED), silences (SILENCE) or a pause in the interview (...) were indicated in the text. Due to the large volume of data NVIVO 2, a computer package designed to aid with the organisation of qualitative data, was used. I read through all the transcribed interviews a number of times and attempted to become immersed in the data. With the aid of this computer package, I attempted to organise the data from the

interviews by identifying meaningful units, which were then categorized and coded (Creswell, 1998). All the data within the same category was then grouped and sub-categories developed as needed. The research questions provided a framework to start the organisation of data. I attempted to identify descriptive, interpretive and explanatory codes (Burns & Grove, 2000). Additional information was added from the field notes written during the interviews, group meetings and observation. Reading through some of the interviews proved to be quite an emotional task due to the raw grief and pain which was evident in the interviews with the bereaved families.

The questionnaire was analysed manually. Due to the very small sample size (eight completed questionnaires returned) I was unable to carry out any statistical tests although the information obtained was added to the qualitative data. Many of the respondents made full use of the section for comments at the end of the questionnaire and wrote a detailed description of their experiences. This proved to be rich data and was added to the data obtained from the interviews.

#### **4.2.4 Findings for the health professionals**

##### 4.2.4.1 What makes the situation difficult?

###### *Certain circumstances*

The health professionals described a number of situations which made the sudden death more difficult for them to deal with. The age of the client was a very

important factor as younger clients deaths were viewed as more disturbing for the health professionals to deal with, especially the death of a child. When the clients who died were older, it was not viewed as the same, the younger clients *"had everything to live for"* (ANNIE). One of the health professionals elaborated; *"it's usually the younger, younger population that, you know you can always deal with the older one that had their life already that's to say that they have experienced it all, where the younger, the kids especially they haven't even seen half of life"* (JANE). ANNETTE mentioned that the death of a child was a waste and that it was extremely difficult to have to tell a parent that their child had died as parents do not expect to outlive their children.

The "suddenness" of the death also made it difficult as the families had not expected the client to die and they were totally unprepared for the death, *"he just said goodbye and he was going to work and was supposed come back, and now there's these people come and tell you that your husband has died and your father is dead and he didn't complain of anything in the morning. He's been fine and all of a sudden someone comes and tells you that so and so died. It is, you know, you just imagine for yourself, how would you react, it is like unbelievable"* (SIBONGILE).

In a number of cases the health professionals also mentioned that the deaths were unfair, that the person did not deserve to die as they were fit, young and healthy, and they felt the injustice of the death. The time of the year that the



death occurred had an impact on the health professionals as dealing with deaths during holidays, for example Christmas, was all that more difficult and this also put a dampener on the festive occasion for the ED staff. One of the participants (ANNETTE) described how the festive holiday mood in the department had suddenly changed after the death of a child.

Due to the fact that these sudden deaths are unnatural, an autopsy is required and this made the situation more difficult for the health professionals and the families. For the staff there were two areas of concern surrounding this issue. The families were often very distressed at the idea that their loved one now had to undergo an autopsy and they wanted to know why and what would be the point; *"they was (were) not too happy about it (the autopsy) because they said why worry – she has died, she is not going to make any difference"* (ANNETTE). The second issue was that the autopsy took some time to be completed and the families would often come back to the ED staff and ask them if they could not hurry up the process as they wanted to bury their loved one. In one of the hospitals it was identified that the documentation was often delayed at the hospital with the deceased then waiting in the hospital mortuary to be released for the autopsy. This delay caused a great deal of stress for the bereaved families and the ED staff often spent some time trying to help sort out the problem.

### *Dealing with the family*

The reaction of the family made an impact on the health professionals. If the family members were very emotional, screamed or were very aggressive the staff found this uncomfortable and difficult to deal with. One of the ED health professionals (STUART) described an incident during which one of the suddenly bereaved family members picked him up and threw him across the room when he came to tell them their loved one had died. He is now a little apprehensive when he approaches the bereaved families as he felt that their response to such a situation can be very unpredictable.

REBECCA went on to explain that sometimes the health professionals are left feeling a little unappreciated; *“a lot of people get quite aggressive. They immediately start blaming the nursing staff and the doctors that the patient died. And, I mean, what can you say? You have done your best. That often gets me off guard, because you don't want to hear things like that, you have done your best and then to be accused of not doing your best. It is not nice and they often do that. They lash out to the person who is closest to them”*. Another participant, OUBOET, explained that one of the most difficult reactions from the bereaved families is when after you have done all you can to save the life of the client and failed the family then appears to be looking to find fault and possibly sue the doctor; *“after all the work you have done, all he is bothered about is can he nail the doctors. It just gets to me – that type of thing. It really does”* (OUBOET).

The relationships between the families and the client who died were also viewed as very important by the health professionals. If the client came from a very loving, close knit family this then made their death all that more difficult for the staff to deal with as they felt sorry for the great loss felt by the family. This was also true in the situation where the health professionals knew that the families relied heavily on their loved one for financial support and now that they had died, the staff were left wondering how the families would survive. The situation was made more difficult for the nurses and doctors if the relatives came to the department expecting their loved one to have minor injuries and then had to be told that they had actually died. ANNETTE mentioned that it could be quite traumatic for her having to explain numerous times to the families about the death, autopsy etc as the members of the family arrived.

The health professionals mentioned that establishing a rapport with the suddenly bereaved families in the ED's was very difficult to do as the staff only got to know them for a short space of time. There was no time to build up a relationship; *"it's very hard to try and establish a rapport with in a very short uhm, space of time.... and to build up that trusting relationship"* (JANE). SIBONGILE said this is; *"the first time you are seeing them (the bereaved families) and you cannot just go and hug them"*.

Another health professional also mentioned that the gender of the family members present in the department was important. She (LOUISE) felt that it was

more difficult for her to deal with males than females. She said that she felt more uncomfortable with men being emotional and that she never knew how to help them. She could hug a woman to show she cared but not with a man;

*"I don't, specially if it is a guy, I don't know why that is. You can't go and give him a hug because they are very – they don't show their emotions as well as a female. A lady you could just do it and you know, so when it comes to a male, I find it more difficult than a female, in general".*

#### *Issues for the health professionals*

The staff mentioned that dealing with the death of a patient known to them made it harder to deal with because; *"it is a lot more personal"* (BETH). When they identified with the patient who died this also proved to be very difficult, i.e., if they have a child of the same age at home, or the death reminded them of their own fathers death; *"we identify with the patients – with the fathers – with the mothers – with the brothers and sisters and with our husbands and our children... because a man came in with an MI and well just died and you know at that age? And you feel that because your parents are that age"* (ANNIE). The ED staff knew that the same things could happen to their own family and they reported that *"sometimes in the resusc (resuscitation) we run quickly to see if it is your husband and children"* (ANNIE).

If the staff had any guilt surrounding the situation, if they felt that more could have been done for the patient or if the resuscitation did not go as smoothly as it should have, this then made the situation more difficult for the staff to deal with; *"We didn't do anything more and we didn't really intubate her and keep her alive and ventilate her and send her to ICU. Somehow that gives you a little more time to deal with a sudden death"* (ANNIE).

They were often left with the feelings that they had failed the patient by letting them die; *"when I left I felt I had let him down. I hadn't been able to fulfil my part of the bargain. I knew that we had done everything possible for him. But I still felt I had let him down"* (BETH). One of the participants also described a situation dealing with a dying patient where they were unable to grant her last wish and this left them feeling guilty; *"She came in after having been involved in a MVA and she was alive when she came in. We eventually resuscitated her and she died. But before she died she asked for some water. Now you know when a patient comes to you with conditions that can be operated on, we don't necessarily give them water. So we explained to her that we can't give you water and after about ten minutes later, she deteriorated and then she died. And that was a blow for us all. We felt that we didn't grant her last wish as such, and that was quite traumatising"* (BEN).

#### 4.2.4.2 What makes the situation worse?

##### *Avoiding the situation*

A number of the health professionals reported that they tried to avoid being involved in situations dealing with sudden death where possible. They felt that they were not able to deal with the family and thus preferred to do something that removed them from the situation; *"No I didn't. I didn't go near them. To tell you the truth I didn't. Um, I did whatever else was needed to be done around the patient and that was it. So, normally what happens is that the doctor always goes and maybe one of the other sisters (registered nurses). Maybe if I didn't take it personally, maybe I would have went. I can't say"* (DAWN).

A number of the participants also mentioned that they felt there were other staff members who coped with the situation and did a good job of it, so they felt that these staff members should then be the ones to deal with the families. *"Well, I think we just look up to her (the unit manager) to do it. She is more comfortable doing it. Um, I haven't been all that comfortable doing it. If I am in a situation where I have to, I try my best to speak to them, but if (the unit manager) is here, then she can do it. She is comfortable doing it. She doesn't mind doing it and she does quite a good job of it"* (REBECCA).

In two of the ED's the person elected to deal with the families was the unit manager and although neither of them minded dealing with the bereaved families both of them expressed concern as to what happens when they are not available.

The one unit manager said that *“all the other nurses can’t cope, so they all just disappear and hide away”* (JANE). A participant did acknowledge that she needed to make herself available during these difficult times as she needed to learn and would not be able to run away and avoid the situation forever.

Mention was also made of the doctor avoiding the situation – this was mentioned by both the doctors themselves and the nurses. JANE said; *“the doctor disappears as normal and then the nursing staff must pick up the pieces”*. The doctors interviewed also acknowledged to me that they did try to avoid spending much time with the bereaved families as they often felt that the nurses were able to provide the necessary support and they found the situation very uncomfortable. One of the doctors (OUBOET) said that it was important to remember that they were also responsible for the other patients in the department and so were often not able to spend much time with the family as they were very busy.

#### *Poor death-telling*

The participants generally agreed that the doctors who treated the patient should be the ones who broke the news to the bereaved families; *“generally we try to get the doctors to do that, because I feel that is not our responsibility”* (LOUISE). A number of the participants felt that the doctors working in their department were not very effective when it came to breaking bad news to the families; *“You find in*

*this department nursing staff very often break the news to the family. They take the relatives aside and we have got to virtually support the doctors in breaking the news to the family. I must admit that there have been occasions when the doctors have fumbled and then the nurses often chip in there and break the news to the patient's relatives, the bad news"* (BEN). BEN went further to suggest that this may be due to the fact that doctors did not receive much death education in their training as doctors – OUBOET agreed with this.

A participant (JANE) found the doctors to be quite blunt when giving the bereaved relatives the information, and then the doctor just walked away. OUBOET, a doctor, stated; *"I kind of leave them (the nurses) with the 'hot potato', because I divulge the information and, but I won't stick around"*. The reason he gave for leaving was that he was often busy with other patients in the department.

BEN and BETH had conflicting views as to which approach was best to follow when breaking bad news. BEN complained about an incident he had been involved in where the doctor said "I'm sorry I have got bad news for you, your relative has just died". BEN felt that this doctor should have first spent time explaining everything that had happened, *"building up"* and then said that the patient had died. BETH disagreed with this as she felt that it was better to tell the relatives the bad news *"up front"*.



Another issue raised was that of where to break the bad news. The participants all agreed that it should be done in a private area but this was often not possible at the institutions. BEN described an incident of seating the bereaved family in one of the examination rooms in order to give them a little privacy but *"they were there for half an hour to forty minutes-five minutes when the doctor came to them and said they needed the room to examine a patient and trauma was busy"*. Other departments had to use procedure rooms or the staff tea lounge. The participants suggested that this was not the ideal and that a proper room should be available to take the families to and talk to them. One of the institutions had a bereavement room, or *"crying room"* as the staff referred to it, but it was very cold and stark and was in the process of being redecorated to look more *"homely"*.

#### *Unemotional staff*

Some of the nurses mentioned that they found the doctors very *"cold"* and unemotional when dealing with the families; *"they (the doctor's) are not emotional. They just say it and that's it"* (SIBONGILE). OUBOET suggested that; *"the assumption is there from the doctor's side that they have to fix whatever comes in. There is nothing wrong with that. You should be driven to make a difference. But you cannot always. And I think the ability to handle that actually improves as you do more. You get used to it. Maybe you train yourself to get more distance between you and the situation"*. The nurses were also seen as being unemotional and JANE explained that; *"you've got to try and hold back on*

*your emotions and feelings". BEN explained to me; "I have developed a thick skin if you may say, you know. I have had to put on that hard front so that I don't get personally involved with the death of the people in the department". SIBONGILE also mentioned that due to the fact that she often does not know the bereaved families she cannot just go up to them and hug them, "it is the first time you have seen them. So you must have a professional way of dealing with them, or speaking to them".*

#### 4.2.4.3 Psychological support for the families

##### *Preparing the body*

The participants mentioned that they thought it was very important for them to try and make the body of the deceased as presentable as possible to the family; *"it is very important to make the patient look – I mean the accident situation you can't make them look perfect, but I mean you can neaten them up. Take away the blood from the face because you have seen them in the morning when they left home – all nice. And then you come in here – you are not a medical person, or even if you are, you still have, you can't deal with something like that"* (ANNIE). SIBONGILE agreed and went on further to explain why the body should be cleaned up; *"so that by the time the family comes, you know, they don't get more scared. To see last part of their relative looking like that – having blood all over – most of the time they have tubes coming out of their mouths. So we just want to make them look presentable to them.... They are crying, they are*

*horrified but they don't need to be horrified more, because most people are scared of blood. When they see blood it is like scary stuff*'. The nurses then spent time after the patient has been declared dead cleaning up the body, while the doctor was busy speaking to the bereaved families.

### *Viewing the body*

The families are then asked if they would like to see the body and are led to a private area where the prepared body of their loved one was waiting, after they had been informed by the doctor or the nurse as to what they could expect to see. This was due to the fact that these deaths were often unnatural and would have to undergo an autopsy, thus the peripheral lines, endotracheal tubes etc had to be left in the patient. JENNY explained;

*"They still have their ET tube, if it is an unnatural death, we still have to leave all these things in. But, like we tidy up the patient and get the family to see the patient before we shower them and put them in the body bags. Just a final goodbye. When we do that I believe that the family has an opportunity to see and view the body, then they can see that is the tube in the mouth – they might have tried to help him to breathe – this is a drip, they have given him medicine. I believe that that makes a big difference seeing your family, but it is just a personal view"*.

JENNY thought this was important so that the family could see that the ED staff tried to save their loved one. The families were usually accompanied by the

nurses or doctors and were also asked if they wanted some time alone with their loved one. It was also emphasized to me that the families were not hurried, and were allowed as much time as they needed with their loved one, *“they must be ready to say goodbye and to be willing enough to walk out the door”* (JANE). In one of the institutions this was a problem at times as the room where the body was may be needed to see other patients, thus the family had to be asked to leave.

### *Caring staff*

The health professionals thought that it was very important for the bereaved families to know that the staff cared about their loss and this was demonstrated in a number of ways. The health professionals described how they would stay with the families if possible and offer support and information about their loved one while the team was still working on the patient. Once the patient had died they would offer support by being with the family and answering questions they had, phoning other family members, offering them tea or coffee, holding their hand, hugging them and trying to give them privacy; *“maybe to pray with that person which is very important at that time for a lot of families”* (ANNIE). It was also suggested that the staff never look as though they are too busy to help the family; *“they don’t need that, to feel that you are rushing around. They need that someone who could sit down, even if just for half an hour, just talk to them and answer their questions”* (REBECCA).

#### 4.2.4.4 Psychological support for the health professionals

##### *Lack of support*

A number of the participants (nurses) felt that they did not receive psychological support; either from the doctors or hospital management. The nurses felt that the doctors could take time to ask them if they were coping, and the doctors felt that they often neglected themselves. If any formal counselling was arranged for the department, this would only include the nurses and not the doctors. The participants mentioned that it was up to the individual to cope on their own.

Management was seen by LOUISE as being unsupportive and not able to understand the nature of the work in the ED. She felt that they were there to see when the staff were not busy, sitting around after a case but they did not see the staff when they had a really busy time and went without a break for most of the day – she felt that the whole hospital did not understand the work in the ED. LOUISE stressed that the ED staff did not mind the busy days when they did not have a break but they did mind when management came to take staff away when they were not busy as a case could come in suddenly and then the staff would be running around, now with less staff!

##### *Informal support*

The participants mentioned that they often received their psychological support informally. After dealing with the case the staff might have a cup of coffee in the

tea lounge and talk about what was worrying them, or what went well with the resuscitation. This was described by BETH;

*“after every single death we try have some form of a debrief – um, pretty informal, while we are doing the packs. We find that it is better for the girls on a one-on-one situation – to deal with it at the time: “Are you guys alright? Do you need to talk about it?” “You did everything possible – let’s go through over it again”. We normally do that when we have a chance. When we are having a cup of coffee afterwards”.*

REBECCA found this helpful because; *“it’s nice to know how your colleagues feel. It is not just you feeling like that”.* The staff also mentioned that if things in the department were really busy they could call off duty staff and they would come in to help – the nurses were quite supportive of each other.

The unit managers were sometimes also seen as a source of support as the staff could go and talk to them – although this was mentioned more from the managers themselves.

Another great support for a number of the participants was to be found at home. Some of the participants described how they would discuss the day’s events with their husbands or their families, and even though they could not understand, just having them listen helped a great deal.

#### 4.2.4.5 Facilities available for the families

##### *Structures available*

The participants mentioned they tried to provide privacy for the families and have a staff member or counsellor with them during the resuscitation process and to keep them updated regularly with information about their loved one. A number of the participants stated that they found the organ transplant coordinators to be a great help. These staff members were used to dealing with families in crisis and could often relieve the staff member who was sitting with the family even if the patient was not a potential organ donor.

The families are offered beverages, access to the telephone and spiritual advisors if wanted. If the families needed to then receive medical treatment themselves due to the shock of the situation this was then arranged for them. Some of the participants mentioned that they tried to offer some kind of psychological support for the families when they left, sometimes by just giving them a card with the details of the hospital's psychologist. Another of the departments had a list which they gave to the families on discharge which gave them details on what documentation was required and from where. This was done because the staff felt that the families were unable to absorb all the details given to them in the department just after the death of their loved one. The families were also told to contact the department should they have any queries later on. Some of the participants said that the families had contacted them some

weeks or even years later, although this seldom occurred. The families then asked questions about the patient or explanations about the treatment.

#### *Follow up*

Some of the departments had attempted to conduct a follow up with the families. One of the departments routinely phoned the bereaved families approximately three weeks after losing their loved one. The family were reported by the participants to view these calls as being very positive. JENNY described an incident; *"I phoned the family just after the funeral....and the family was just so grateful for the fact that you took time to phone"*. BETH agreed that the families were generally quite positive about receiving the call and appreciated it. She said that she never had anyone say; *"I don't want to talk to you, or you are insensitive"*.

#### *Lack of facilities*

A number of the health professionals mentioned that a weakness of their department was that it did not have a private area where the bereaved families could have a little privacy or be counselled; *"there is no really private waiting area as such, that is bad because I think they (the families) do need to grieve in peace without the rest of the public looking on"* (LOUISE). One of the departments who did have a bereavement or "crying" room found it too stark and institutional. They



felt that it needed to be made more homely. In another department when private space is needed for the families, the staff tea lounge is used; *"it would be nice if we had a little room we could take them privately and let them cry and do everything. We usually bring them in here (the staff tea lounge) but it is awkward if there are people out here, because we have to take them out here else we can't come to lunch. It would be nice if we had a little room where we can talk to them – which we don't have"* (REBECCA).

Another participant mentioned that at times they did not have any cups available to offer the families coffee or water and then the staff had to go and fetch their own cups from the staff tea lounge. Another problem mentioned was that after hours it was often difficult to access resources such as a social worker to talk to the families. This was also when the unit manager was not around and thus the staff then had to deal with the bereaved relatives themselves. SIBONGILE stated that;

*"No, there is nothing in this hospital. When a patient has died we just tell the family the procedures to follow and then they are out of our eyes. We don't have family support. Maybe they can decide on their own to go to their own counsellor or psychologist or things like that. But there is nothing in this department or in the entire hospital that provides for support for the family afterwards".*

A number of the health professionals mentioned that they wished there could be a staff member allocated to just sit with the family but due to limited staff

members this was often not possible, especially in the provincial institutions. During one of the presentations to the bereaved families support group, one of the members suggested that she would be available to sit with families in the hospital to give them support during this difficult time. She said that she would not be there to do anything but just to lend support as she had lost a loved one in the hospital and she would have appreciated having someone sit with her. After hearing this a number of the other group members said that they too would be interested in helping and they could set up some sort of list.

When asked about any follow up care for the families a number of the health professionals mentioned that nothing was available. ANNIE went further to say that; *"they (the families) cannot even phone us and ask us because we're too busy, phone me later, phone me in five minutes, they cannot even phone us and ask for any support"*. LOUISE summed up her feelings by saying; *"the nursing staff, that is all the family have got, so, besides them and us, that is it"*.

#### 4.2.4.6 Facilities available for the health professionals

One of the unit managers had developed a checklist, which the staff then used to ensure that all the procedures were followed after a death in the department, this the staff found to be quite useful. The staff had to tick off once they completed the components of the checklist and hand it to the unit manager to check.

### *Debriefing*

Some of the ED's had arranged for formal debriefing sessions in the past although at present none of the departments had anything ongoing – a number of the unit managers said that they were busy trying to arrange something for their staff. One of the doctors interviewed, STUART, wanted to start up a mortality meeting, which he had been part of at another hospital, although he mentioned that one had to be very careful that *"it doesn't become a witch hunt"*. Some of the participants said that they did have access to counselling services should they feel that they needed it. All they had to do was approach the unit manager and ask for it to be arranged. Other health professionals said that there was nothing available to help them cope. This differed a great deal between the different ED's, although it was mainly the unit managers who mentioned the services available.

### *Lack of facilities*

The health professionals mentioned a number of facilities, which they felt were lacking. They mentioned that they felt they needed some death education i.e. being educated on how to deal with death in the department. ANNETTE said; *"it would be nice to have guidelines, to give you an idea of what to do and what not to do during that time"*. The health professionals felt that they would like more psychological support services and that these must be available when it was

needed and not weeks later when they had forgotten about the incident. LOUISE elaborates on this;

*"If we say we would like counselling, you know, I feel we should get it within a week of asking. Not two to three months down the line, and it has gone – we have dealt with it. It is like we are supposed to be getting heard two weeks ago, and we are still waiting. We don't need it now. I don't think we do, but we, most of us, we feel we don't need it now. We want it when we ask for it".*

#### 4.2.4.7 "It's a personal matter"

*It's up to the individual to decide how to deal with the situation.*

The participants explained how they have to decide for themselves how they are going to deal with the situation and how best to approach the family. Much of this is based on trial and error, what you may have found in your previous nursing/medical experience to have worked or, what other staff members have done which you then watched and perceived to have "worked". JANE mentioned; *"it is from live, learn, and experience. You know. Do one, see one, do one"*. Some participants said that this could be a problem as you may end up learning the incorrect things without knowing.

ANNETTE also felt that one was able to deal better with the situation as you got older as you then had more life experience. ANNIE felt that you were able to

decide how much of yourself you wanted to invest in the relationship with the family. In her experience of working in the ED, if you wanted to help the family a great deal – you did, and if you were feeling lazy or didn't care then you did not. She also found that she had learnt a great deal on how to deal with death and dying from watching her mom and dad deal with relatives or friends who had died.

The participants also mentioned that if you experienced such a death of your own family member, you remember what worked for you in that situation and you may then use it on others. Many staff mentioned that this was useful for them and so that's why they now do the same with the bereaved families. JANE mentioned how she never rushed the bereaved families to leave the department as in her own experience having enough time to say goodbye was very important to her. Other participants mentioned that they made a point of remembering the last words the client said or their last actions as they would have liked this information themselves.

ANNETTE went further to say;

*"Nobody has said to you try to make the family comfortable, you know, this is how you deal with the family. I think if you did not have a personal death in your own family, you actually have to go through it. It is not easy to understand from the patient's point of view and the family's point of view, but I think the sad part is to learn by error".*

There were no formal department guidelines or protocols available to the health professionals on how to deal with the deaths in any of the ED's, and indeed I was told of a variety of methods by the different participants. A number of participants kept asking if there were any protocols available and that they would be very interested to use them. Throughout their discussions, a number of the participants kept on repeating to me that they were not sure what they should be doing, and wanted confirmation if what they had been doing was correct.

The participants mentioned that they did not receive much death education and that the limited education regarding death and dying received during training had no practical application. They were only given basics or theories on which to base their actions. This lack of "death education is supported in the literature (Brysiewicz, 2000; Socorro, et al., 2001). It has also been proposed that nurses who are specifically educated to meet the needs of a dying client and his/her family are likely to reflect a positive attitude towards coping with death (Corr & Doka, 1994).

#### 4.2.4.8 "What is caring?"

*Participants describe how caring should manifest in this situation.*

A number of the participants discussed how caring the ED staff were with the bereaved families and that this was vitally important. Some of the participants

went on to say this was the greatest strength of the department and that at times this was all that the family had!

Wiman & Wikblad (2004) described caring encounters in emergency nursing and these were mentioned by the participants when dealing with the bereaved families. "Being open to and perceptive to the needs of others" is described as being sensitive to clients and anticipating their needs (Wiman & Wikblad, 2004). This was seen by many of the participants as being extremely important and was expressed as providing some kind of psychological support for the families by sitting with them, praying with them, offering them something to drink or allowing them somewhere private to sit. Allowing the families all the time they needed to be with their loved one, staying with the families, showing support and giving them all the information they needed was also mentioned.

Some of the participants (ANNIE, BETH) displayed genuine concern for the client, by showing compassion and displaying goodwill for the families (Wiman & Wikblad, 2004). There were times in the interviews where the participants were extremely close to tears relating a family's experience of loss. ANNIE spoke about wanting to be close to the families as she felt that she needed to be there for them.

It was also apparent to me that a number of the participants reflected caring behaviour by "being truly present" when dealing with these sudden deaths.

Wiman & Wikblad (2004) describe this as being attentive to the present moment by actively listening and responding. A number of the participants related stories concerning the sudden death of a client where they were able to describe in detail exactly what was done and said by all. They showed evidence of paying attention to what was going on and of being “truly there” for the client and their family.

Along the continuum of caring described by Wiman & Wikblad (2004), “being dedicated and having courage to be appropriately involved” is seen as the highest level of caring encounters. This was described by BETH;

*“She (7 or 8 year old girl) died in the morning at about 10, and her mom basically stayed with her the whole day. We laid her out in that little room and I just sat with the mom the whole day while she talked to her child. And, um, she sang her songs and she spoke about all the dreams for her. Eventually a minister came ..... and, um we asked the mom if she would like to bath her one last time – and myself and the minister and the mom, we bathed her and washed her hair and we put her in this little dress, um, and the mom laid a little flower on her chest and that made a huge impact on me. Just watching the mom’s anguish. It was unbelievable.”*

Wiman & Wikblad (2004) mention that some of the uncaring encounters in emergency nursing is “disinterest” (inattentiveness to the client) and “insensitivity” (where the nurse acts indifferently which is destructive for the



client). DAWN was concerned about the families perceiving this when she mentioned that one of the necessary tasks in the department after a death involved a great deal the paperwork to be completed and signed by the family. It really worried her having to disturb the bereaving family to ask them to sign forms; *“the fact that the paperwork shouldn’t be important.....but you have to have that, it s important. It is being a bit pushy at the time and it is like we need to get this done. Can you just put your fingerprint and sign here, We need to get the body out”*. She was worried that this then seemed to the family that the staff did not care about their loss and just wanted to complete the documentation and be done with it.

ANNIE was however quite sceptical about what other staff member she worked with viewed as caring. She said that some of the staff just did not seem to feel the need to do that extra bit for the family, they did the bare minimum and this she then viewed as being uncaring.

#### 4.2.4.9 “Where is the time?”

*The emergency department is a time pressured environment.*

Work for the health professionals in the ED is very fast paced, as one has to work extremely quickly while trying to save the life of a client. During a resuscitation of a client who is critically ill, the staff need to think and act fast. There is no time to sit around and discuss what to do with your colleagues. If you

are too slow or don't know enough about what you are doing, you let the team down, get shouted at by the doctor, or are the cause of a deterioration in the condition of the client. Iserson (1999) agreed that the ED staff have limited time, need to treat other patients and may be interrupted to make other decisions. The backlog of clients who were neglected during the resuscitation need to be attended to, thus the families are often given little attention. It is a very unpredictable environment as the health professionals have no idea what their next client will present with.

It was described to me that due to such a work environment the health professionals may appear unemotional or cold to families. This is due to the fact that while they are busy working on the dying client, the staff have to be thinking ahead about the other critical clients waiting for them and they may be planning how to allocate resources. During a resuscitation, all the staff are busy usually rushing in and out of the room collecting equipment and contacting other members of the health team. The staff often rush past the families who are waiting for news of their loved one. A number of the participants thought that it was better to avoid talking to the families at this time as they did not have anything to tell them and also due to the fact that they had no time to talk to them. Some of the participants mentioned that at this stage they did not have the time to get involved with the families and if you say "hello" and initiate contact then you need to follow it through. If you then break off the contact abruptly it is much worse than never initiating the contact in the first place. A participant went

further to state that if there was a protocol she could follow on how to deal with death in the ED this could be of help as she would not have to waste any precious time planning or thinking about what she should be doing. Most of the participants agreed that dealing with bereaved families at such a time is a very lengthy exercise and that sometimes how you care for the families is dictated by how much time and staff members are available.

#### 4.2.4.10 "What is coping?"

*To show as few signs of distress as possible.*

A participant explained that at work she had to be strong to look as though she was in control. She felt that this was because she was a senior member of the department staff and if she was not seen to be coping, then how could she expect the other staff members to cope? She went further to say that if she became emotional, she then felt as though she was not in control of the situation would then make mistakes and not do the best for her clients. REBECCA mentioned that if she was having problems coping she would not feel comfortable discussing this with management. She explained that as she worked in the ED she was expected to cope and that she would not like to have to admit that she was not coping; *"you don't want to do it because you think your colleagues are coping so you don't want to say anything"*. Brauteseth (1993) agrees that many health professionals have been brought up in a tradition that expected them to cope. A number of the participants mentioned that they thought

it was okay to cry in front of the family as this showed you were human. These same participants however went on to say that they tried not to cry and rather walked away for a short time to regain control of their emotions.

A number of coping strategies used by the participants were described. Many participants stated that they tried to avoid being involved in situations dealing with sudden death where possible. They felt that they were not able to deal with the family and thus preferred to do something that removed them from the situation. A number of the participants also mentioned that they felt there were other staff members who coped with the situation and did a good job of it, so they felt that these staff members should then be the ones to deal with the families. In the ED's the person elected to deal with the families the majority of the time was the unit manager. The one unit manager said that "*all the other nurses can't cope, so they all just disappear and hide away*" (JANE). A participant did acknowledge that she needed to make herself available during these difficult times as she needed to learn and would not be able to run away and avoid the situation forever.

Mention was also made of the doctor avoiding the situation; JANE said; "*the doctor disappears as normal and then the nursing staff must pick up the pieces*". The doctors interviewed also acknowledged to me that they did try to avoid spending much time with the bereaved families as they often felt that the nurses were able to provide the necessary support and they found the situation very

uncomfortable. One of the doctors (OUBOET) said that it was important to remember that they were also responsible for the other patients in the department and so were often not able to spend much time with the family as they were very busy. STUART mentioned that the way he copes with his job is to ensure that he has regular holidays away from work. He described how he makes sure that these holidays are in remote parts of the country so that he feels that he has “got way from it all”. The participants indicated to me that they avoided thinking about what they had witnessed at work. ANNETTE described how once she walked through the doors of the hospital she made herself forget about work. It was as though she lived two separate lives – her professional and her personal life.

Some of the nurses mentioned that they found the doctors very “cold” and unemotional when dealing with the families; *“they (the doctor’s) are not emotional. They just say it and that’s it”* (SIBONGILE). OUBOET suggested that;

*“the assumption is there from the doctor’s side that they have to fix whatever comes in. There is nothing wrong with that. You should be driven to make a difference. But you cannot always. And I think the ability to handle that actually improves as you do more. You get used to it. Maybe you train yourself to get more distance between you and the situation”.*

The nurses were also seen as being unemotional and JANE explained that; *“you’ve got to try and hold back on your emotions and feelings”*. BEN said; *“I*

*have developed a thick skin if you may say, you know. I have had to put on that hard front so that I don't get personally involved with the death of the people in the department".* A number of the participants were very factual and distant when talking about these extremely traumatic deaths they had witnessed.

Use of humour was noted a number of times during the interviews. When describing a particularly tragic death to me, LOUISE started laughing about how the client's brains were oozing out of his ears and head! She mentioned to me that it was not funny but she was still laughing!

When attempting to decide if the above coping strategies are successful or not it is important to view them together with the goals they were trying to achieve. Adaptive coping mechanisms are able to allow the individual to meet these goals whereas maladaptive strategies do not (Garland & Bush, 1982).

#### 4.2.4.11 "Which group are you in?"

*People tend to only look at the situation from their own perspective.*

The nurses did not seem very interested in the coping of the doctors or in supporting the doctors as they did not seem to consider that the doctor also needed support. When asked if they went with the doctors when breaking bad news to the relatives the nurses seemed quite surprised to be asked. One participant said that she had never thought of going with the doctor,

*“Actually I never thought about it – you just expect them to cope and expect them to deliver the news. I am sure they also have their emotions and things they go through, but – you know – it is not like with your colleagues, you don’t sit down and discuss it with the doctor and how he feels and all that. So I actually don’t know how they cope. I am sure they also go through a few emotions” (REBECCA).*

In the departments the doctors have their own offices and often spend time in there alone, separated from the rest of the ED staff. Another participant, ANNIE, mentioned that she was quite upset after a traumatic case where the patient had died that the doctor had not bothered to ask if the staff were coping; *“I don’t appreciate that he didn’t care to ask us if we were also okay”*. She went on further to say that she felt this was necessary as *“we nurses, we clean people. We see them at their worst, worst, worst”*. When discussing what psychological support was available to them in the ED the doctors said that they have to look after themselves and that they are not involved in any of the counselling offered to the nurses.

In order for the health professionals to function effectively as a team in the ED’s it is necessary for them all to understand that each member of the team is important and has a vital role to play in dealing with sudden deaths. Instead of emphasising the differences between the staff members and allocating blame if things go wrong, the members of the team need to celebrate their differences

and use their various strengths. All members of the team need to feel appreciated and that they are fulfilling a useful role within the team (Northcott, 2003).

Another group conflict seemed to occur between the doctors and the transplant coordinators. The nurses were often not allowed to call in the coordinators without the permission of the doctor. LOUISE described an incident where she wanted to call them in but the doctor in charge of the patient refused and thus healthy organs were lost and the next day the family asked why they had not been told about organ donation. This was very upsetting for LOUISE as she felt that she had failed and should have tried harder to convince the doctor whom she was sure said no to calling in the coordinators due to personal differences he had with them.

Management was seen by LOUISE as being unsupportive and not able to understand the nature of the work in the ED. She felt that they were there to see when the staff were not busy, sitting around after a case but they did not see the staff when they had a really busy time and went without a break for most of the day – she felt that the whole hospital did not understand the work in the ED. LOUISE stressed that the ED staff did not mind the busy days when they did not have a break but they did mind when management came to take staff away when they were not busy as a case could come in suddenly and then the staff would be running around, now with less staff!



#### **4.2.5 Discussion of health professional's findings,**

Organisation culture is the shared beliefs and values within an organisation and this plays a great influence on the success of the organisation (Huber, 2000). This research illustrates the lack of collaboration and cohesiveness of the staff in the ED. They appear to be very individualized, following their own ideas and beliefs and forming their own culture.

According to Adshead & Dickenson (1998) there are differences between doctors and nurses due to a number of issues and this influences the individual and group beliefs and values. The doctor has a limited relationship with the client due to their limited interaction as opposed to the nurse who spends more time with the client and is seen to be closer to the client in status terms. The nurses are therefore more likely to empathise with their clients. Doctors tend to lack psychological skills and are often not well equipped to communicate with their clients. Adshead & Dickenson (1998) describe a cult of "macho toughness" in doctors where expressing pain or distress is frowned upon and is seen as more acceptable for nurses. The majority of doctors are still male and the majority of nurses female and the different genders tend to have different outlooks. Medicine is also viewed as being curing as opposed to nurses being caring. These differences were apparent during the interviews.

The staff appear very isolated with the doctors sitting in their offices away from the nurses, and the nurses not involving the doctors in staff support programmes

or in thinking that they might need support. The staff, as individuals are isolated as they don't want to show others that they are not coping. They feel threatened to do this and rather hide the fact and put on a "brave front" to show that they are coping. There does not appear to be much collaboration between the members of the health team – the doctors give the orders which the nurses are expected to follow. The ED is an environment of great pressure and complexity and Keenan, Cooke & Hillis (1998, cited in Huber, 2000) suggest that collaboration between the health professionals would improve effectiveness.

The health professionals working in the ED are working in an environment which brings them into contact with individuals in crisis on a regular basis. During this period of disequilibrium, the dead or dying client and their family are helped to solve problems which may have far reaching consequences for their mental health. Although the type of intervention offered by the health professional is guided by their professional roles, the individual's "human" qualities also greatly influence this interaction. The tone of voice used by the health professional, the use of touch and nonverbal gestures are dependant on the individual's personal and professional experiences (Caplan, 1964), and this individuality was apparent amongst the health professionals interviewed. Hoff (1984) suggests that the health professionals involved in crisis intervention recognise that everyone has a vast potential for growth and that a crisis is a point of opportunity as well as danger.

## 4.2.6 Findings for the bereaved families

### 4.2.6.1 When we got there

None of the participants mentioned being met by the staff on their arrival to the hospital but rather that they ran through to the department looking for their loved one. CHANTELLE describes her frantic search for her children;

*"when I got to the Emergency Room I ran straight in and I ....I called out for my daughter, then she called for me and I saw these people on the body boards, you know, and they were all strapped up and they were bloody and you could hardly recognise them. And I went over and said, 'oh my girl how are you?' and she said 'no I'm fine – I'm so happy you are here'. And then my son on the other side called for me so I went across to him and I checked on him. I was so horrified the way they looked...and then...I looked for KARL, this was the youngest one and there was a child in between and I said 'oh KARL there you are' and this child was also all bloody and....and this child opened her eyes and it was a girl and she said; 'no I'm not KARL ....and I sort of said 'Where's KARL ...?'"*

Some of the participants mentioned that on arrival to the hospital they experienced barriers between themselves and their loved ones. JASMIN described to me that she arrived at the hospital just moments after the ambulance and as she was running into the ED she saw that the floor was covered in fresh blood and she just knew it was her son's blood. When she rushed through to the ED to ask about him she was told by the staff to go and

fetch his file. After fetching her son's file she said *"I gave them the file and I didn't wait, I asked them 'how's my son', no one answered me so I went towards the examination room"* and the doctor then came towards her, held her and told her that her son was dead. JASMIN was angry about having to fetch his file and said that this wasted the precious time that could have been spent with her son telling him that she loved him.

AMY said that

*"they made us fill out forms, and ask for details and run around to the reception desks and things like that when you wanted to spend that time with the family that were critically ill"*. AMY went further to say that *"so it turned out that my husband then, when he went into theatre he was never conscious again....so those were the few moments that one could have spoken if you wanted to"*. AMY was of the opinion that the staff use the excuse of getting the families to complete documentation as a distraction, to get the families out of the way.

AMY also explained to me that it is important to be as close to your loved one as possible. She described that when her husband was injured she was allowed to sit in the same room along the side of the wall so that she could see him but was not close enough to talk or to touch him. She appreciated that she needed to be out of the way while the health professionals were working on him but she said that even when they finished and he was just lying on the bed she was kept in her area for quite some time before being allowed to his bedside. When her son

was critically injured four years previously she told me that she was so thankful that the staff allowed her other two sons to stay with him until she was able to get there;

*“they allowed them (the two sons) to sit there through the night. That to me was very important, knowing that, you know....and they said they’d say ‘Mom’s on her way’ and he’d squeeze their hand. So to me it was.....because by the time we got there he was not conscious anymore, so it to me.....it’s something that I hold on to, that they allowed them to sit there”.* (Please note that this was taking place in the Intensive Care Unit).

#### 4.2.6.2 Meeting the staff members

##### *Caring staff*

CHANTELLE described how caring she had found her experiences with the health professionals to be. She said that the paramedics on scene at the accident had allowed her daughter to use their phones to call her and she was extremely grateful for that. The health professional who broke the news of her son’s death was extremely sympathetic and asked her if he couldn’t get her something to drink. She remembers that even though she said “no” he went and bought her an orange “Fanta” with his own money. She recalled how she took it home and that it stood in her fridge for a few weeks and that whenever she saw it she was reminded of his kindness.

### *Incompetent staff*

The incompetence of the staff was noted by JASMIN as she described the scene of her son's accident and the way in which the pre-hospital staff member was having great difficulty in putting on her gloves and then driving so slowly to the hospital. JASMIN wondered if this staff member actually knew what she was doing and felt that she was wasting precious time which could have been used helping her son. She also mentioned that there had been a doctor on scene and wondered why he had not gone in the back of the ambulance with her son to hospital. She felt that the accident scene was not properly handled and this made her angry as she was left wondering if her son would still be alive if he had received different treatment. AMY described the behaviour of the staff and felt that the staff appeared to be taking the situation very casually, they did not appear to see the urgency or appreciate the gravity of the situation. She said;

*"that 'golden hour' that everyone speaks about...was long gone you know, they were very slow and there was no hurry.....eventually specialists were called and they took their time, and they walked in and... had a cup of coffee...and you know it's not what you see on TV".*

### *Being avoided*

A participant (JASMIN) also described the "cold reception" of the staff and most of the staff had not been particularly sympathetic and did not seem to care about her. She was also left alone with her son's body and no one was around to offer

support. She described the nurses as “*evasive*”. AMY described her experience of being avoided by the staff while they concentrated on what they were doing “*there were quite a lot of people working on him all the time. But they, they didn’t speak to us and they kind of just kept concentrating on what they were doing, there was no communication whatsoever*”. She goes further to say that “*even if they told us anything at least if we felt that we were someone, that we were family, at least if we felt that we were being cared for*” (AMY). She was very distressed watching people going past and avoiding any eye contact with her until a medical student came to her “*and she just said ‘could I sit with you, it looks like you are going through a lot of trauma’ and we’ve like become firm friends since, she just sat*”.

### *Getting information*

The participants described how during this time of crisis they felt that they had to be pushy in order to get any information about their loved one. This made them feel angry as they felt that during these difficult times the health professionals should be helping to make the situation easier and not harder. It was also emphasized to me that the information given must be the truth as lies told were remembered with anger later on. AMY went further to say that it was the doctors who lied and that “*the nursing staff knows about death and dying and they will tell you the truth*”. Even if the truth was very bad the participants stressed that they wanted to know as this served as a type of preparation for what was to come.

#### 4.2.6.3 When we were told about the death

Some of the participants said that they could not remember the details surrounding the time that they had been told about the death of their loved one. They said that they had been hysterical at the time, JASMIN said that she was not herself;

*"I finally get his file and give it to them...and then this doctor comes to me, a lady doctor and she came and held me, I can't even remember what her words were, she said she was sorry you know and I just collapsed and she was holding me....I couldn't make head or tail, I was just hysterical, I think I was devastated".*

CHANTELLE described her experience of being told about the death of her youngest son;

*"I can't exactly remember what he told me but I just remember the whole office being white. His gown was white, his desk was white, a cup on his desk was white – it was like a white cloud enveloping you.....it was like a white cloud suffocating you".*

JASMIN mentioned how she appreciated the support she was shown by a female doctor but that she felt angry when the woman said she understood her (JASMIN'S) loss as she had lost her brother in a similar way. JASMIN felt that this was not the same as losing your own child and she said; *"she couldn't know what it was like for me".*



The lack of privacy was described as a problem although some participants said that at the time of their loved ones death they had not been aware of this. It was after thinking about the experience that they thought more privacy would have made the situation a little better. JASMIN had not been in a private area when she was told about her son's death and she was worried about the impact that her grief had on the other clients and their families in the ED that day. JASMIN also described how she was left alone with her son's body on the trolley in the examination area of the department, screened from the other clients by a curtain. She had also felt rushed to leave the body of her son as she was holding up the space in the ED and eventually her husband had to drag her away.

#### 4.2.6.4 Afterwards

Most of the participants described how they were not offered any psychological support or counselling and over time they had to find their own support system. JASMIN mentioned that after speaking numerous times to the ED doctor who had looked after her son, he gave her the contact details of a support group as he felt that she really needed some support. Some of the participants found support in the church, support groups and professional counselling. A number of the participants said that they would have appreciated being given details of counsellors or support groups when they left the hospital as one was not in the right frame of mind to have to do this for yourself and this caused delays in finding the necessary support.

One of the families (SHAUN and CAROL) described how disturbing it was to receive their son's blood stained clothing and that it was just handed to them in a large black rubbish bag. It was also mentioned to me that it is very disturbing for the families to have to keep returning to the hospital or mortuary to collect various things that were not returned and if possible the staff should make an effort to return everything at once. The possessions of the deceased were seen as being very precious to the bereaved, as a link to their loved one who is now dead.

#### 4.2.6.5 Unresolved issues

##### *The lack of closure impedes the bereavement process*

Marrow (1996) suggests that uncertainties linger terribly and this makes the bereaved family's adjustment to loss very difficult and prolonged. Poor policing was mentioned by a number of the participants with much anger. SHAUN & CAROL stated that they had to do their own detective work to uncover the many unanswered questions surrounding their son's death. They even went so far as to arrange blood tests to be carried out and then supplied the police with the results. A number of the participants described how they felt that justice would never be served to the person responsible for their loved ones death and that this made them very angry as the person responsible is free to enjoy their life while their loved one is dead.

It was also mentioned that it is extremely difficult to get answers from health professionals and one participant from the support group focus group suggested that the *"only way to get answers is to get a lawyer"*. Most of the participants seemed to be involved in trying to get answers to a number of questions concerning the circumstances of the death of their loved one and the treatment they received. They mentioned that they have to go searching, trying to find people to answer their questions and that this search can take up a great deal of their time and energy.

They mentioned that the staff were difficult to get in contact with and that eventually after tracking them down they were often unhelpful and reluctant to provide them with details. AMY explained that these details are of vital importance as *"you just don't settle until you know all those details"*.

A number of the participants described the lengths they had to go through to get a copy of the autopsy performed on their loved one, although once they were in contact with the pathologist they found them to be extremely helpful. SHAUN mentioned that after hearing the findings of the autopsy from the pathologist *"that gave us peace because we knew that he didn't actually suffer"*. Oppewal & Meyboom-de Jong (2001) discovered in their research regarding family members experiences of autopsy, that the families felt reassured after hearing the results of the autopsy and that there was nothing that could have been done to prevent the death.

#### 4.2.6.6 How the staff can help us

##### *Suggestions for the health professionals to improve the situation*

The families said that they wanted to be acknowledged by the staff and kept informed on the progress of their loved one. The families were aware that there was often not enough time for the staff to talk with them, but they said that just a brief word "he is still critical" would suffice. The participants also asked that they be kept as close to their loved one as possible. The participants also stressed the importance of not being lied to as they were then left very angry when promises made by the staff did not come true.

Small simple gestures were highly valued by the bereaved such as being offered tea or being asked if there was anything that could be done to help. CAROL on viewing her son in the mortuary said "*I just thought he looked so beautiful. You could see they had combed his hair, wet his hair and combed it back*". This made her feel that someone had cared that her son had died. "*The tiniest little thing that's done for you is so important. You'll never forget that nurse giving you that cup of coffee - it might seem absolutely insignificant, but it's just - it's important, I think, for families*" (AMY) .

Having someone to offer support was viewed as being extremely important – either a health professional or not. This person should just be there for a period of time, sit quietly or offer tea or meals. This then made the families feel that they were not alone and that someone cared about their loss.

It was mentioned to me that the specific details of the last moments that the client was alive are of extreme importance to the bereaved families. They need to know if there were any last words or did they experience pain? The health professionals need to make a point of remembering these specific details and to communicate these details to the families.

It was suggested that the health professionals be very aware of the terminology they use as it is very hurtful for the participants to be told that "he is now safe in the arms of Jesus" as this is of no consolation when you would much rather your loved one was here with you. The participants suggested that just saying "sorry" or not saying anything at all is much more beneficial to them. CHANTELLE felt that her experience of being told about the death of her son could have been made better by being in a room that was more homely with plants or warmer colours on the wall, and not stark white.

The participants suggested that information should be offered about from where they would be able to receive support or counselling so that they don't have to spend a great deal of energy looking themselves. Written information would also be useful; especially the names of the health professionals involved in the care of their loved one. This way, the bereaved would easily be able to contact the staff should they have questions. JASMIN said that; *"I think it would have been much nicer if there was some pamphlets or something that says look that when you really need someone to talk to there's a couple of names you could call up*

*because I used to have these sleepless nights*". These findings were also supported by a number of studies conducted in ED's around the world (Flam, 1999; Jurkovich, Pierce, Pananen, et al., 2000; Redley, Le Vasseur, Peters, et al., 2003).

#### 4.2.6.7 Level of suffering

*How the loss of a loved one has affected the bereaved*

*On impact*

JASMIN described how she was following the death of her son; *"I was probably like insane for those, I think for a whole week I was insane after I lost him"*. She said that at the funeral she wore clothes that she would normally never wear;

*"the clothes I was wearing wasn't even me on the day when I look at it I said I don't wear things like that my sister - she bought me shoes that don't even fit me and I think back I was really insane. I look at the shoes today and think I can't wear shoes like that. If I walk from here to there my feet start paining and but I never felt anything and the clothes was awful my sister bought me a black skirt and a black top that's not me. I wouldn't wear it,.... it's an awful tragedy I wouldn't wish on anyone."*

Paul (2001) described a number of common emotional reactions to the sudden/abrupt death of a loved one. This can include shock, fear and anxiety,

guilt or anger. A number of the participants mentioned how angry they were at the time of their loved ones death.

JASMIN was angry at her perceived incompetence of the health professionals, and by being sent around the hospital when she should be spending last precious minutes with her son. She was also angry that the doctor lied and said her son would live. SHAUN and CAROL felt very angry when meeting the mortuary staff and viewing the body of their son. SHAUN said that he realised that this anger was there before he met the mortuary staff, he says; *"I had quite a bad experience at the mortuary because I walked in - the bad experience was probably partly my fault because I was angry and I wasn't happy to go and see my son in the state that he was..."*. CHANTELLE was extremely angry with her ex-husband for being so careless and irresponsible with their children as she saw him as contributing to the death of her son and the injuries to her other two children. Raphael (1984) suggests that anger and aggression are common in the experience of bereavement. The bereaved may be angry about being deserted by the deceased and this may be displaced onto those who are in some way connected with the death.

CHANTELLE mentioned that to not have a body to see (her child had been burnt beyond recognition) *"that was the hardest part.....I actually for a while denied anything having happened to him"* and she thought he was with her ex husband as this had happened in the past. Raphael (1984) suggests that the bereaved

may find it difficult to accept the finality of this separation until a period greater than the previous period of absence has passed. This author also notes that the bereaved still needs to say goodbye and talk through their feelings etc with the last human remnants of their loved one in some way. CHANTELE describes how she did this;

*“about three days later, on the day of the funeral, we went up there (to the scene of the collision) and so we actually went with a wooden post and flowers and a little name plaque that I’d made with a message and we put it up there. ....and I found my son’s shoe there....and it wasn’t even burnt, I was surprised...but that meant a lot.....that I attached it to the post with the flowers, that’s still there actually”.*

#### *Current distress*

JASMIN was aware that she was now at a stage where she needed professional help to cope with the loss of her son almost four years ago. She had been feeling very weepy, depressed and unable to work. CAROL was also very weepy when talking about her son and appeared to be yearning for her son when she described;

*“ja, it's better than three years ago, but we haven't pulled ourselves together yet you know and it's never going to be... at this stage it's a longing and a missing, we've understood that he's gone but we miss our boy terribly - we loved him to bits”.*



SHAUN and CAROL described how they felt alienated and isolated from society following the death of their son; *"you know, that is a very sad thing. And then we've had a lot of people that just, when they see you walking in a supermarket they actually turn around and walk away"*. SHAUN and CAROL felt that people were just not very understanding and they have subsequently lost many of their friends.

*"We had a very special relationship with a couple and this guy actually preached in the Church. He actually came here one day and ....we were chatting .....we actually said that DAVID (youngest son) had to write an essay about his hero and he wrote this beautiful essay about that time before the accident and about how well WILLIAM (the deceased son) used to look after him and about how he hero worshipped him through high school - and then he wrote about the evening before the accident and then he wrote about the police coming... And this friend of ours actually sat in that chair and said, "My son actually did the same thing when my daughter went to university - he wrote a letter". Carol just said, "You know Jeff you can't compare the two", and he took exception to that and has never spoken to us again. Our minister said to us after a month, "Guys, you've got to get back to your cell group", and he was right that's where you find happiness... We went back to our cell group and at the cell group the first thing they'd talk about is the ice breaker and the ice breaker was as follows: the head of the cell group said, "Guys, what is the worst experience you've ever had and how have you overcome that?" And*

*everybody sort of went into stunned silence - nobody spoke - and then the guy said, "You know I've been in so many car accidents and I have overcome them all"... We have never gone back to a cell group" (SHAUN & CAROL).*

SHAUN also described how his father told CAROL "to pull herself together" before the memorial service – *"It was just his kind of way of trying to say, "Listen guys I'm trying to help you", but actually he messed up a relationship because there is not really a relationship between her and my father at this point in time - and really after something like that you really need the family to sort of be together"* (SHAUN). SHAUN and CAROL also described how their family had come with them to the mortuary to offer support. However, SHAUN and CAROL did not find their presence a support and they now wished that they had gone alone. (More details are available in the mortuary findings.)

A participant, (JASMIN), felt that it was her that avoided other people and did not want to talk about the loss of her son because *"I can't inflict this upon anyone, sometimes I feel its too much pain"*. She went further to say that; *"people don't want to know about pain, my friends would want to avoid the subject, my family knows how devastated I am, they are devastated they don't want to speak about him"*. Raphael (1984) suggests that when friends and family stop the bereaved from talking about the deceased and tried to orientate them to the future and denies their affects, a poor outcome is likely and the mourning is blocked.

SHAUN said that he talked to his father about speaking about the death of his son and asked him not to avoid the subject, and he said that *"you've got to actually say these things or else you just withdraw and you don't want to go out and mix with people"*.

Flashbacks were described by some of the participants. CHANTELE explained that *"now often if I sit and think back I get this flashback, it's like this white cloud"*. ZODWA said that if she watches something on TV that triggers her to remember the incident it's *"like a TV in my head"*. SHAUN said that; *"it hasn't been easy, I mean anybody that thinks that it's easy... Carol cries in her sleep every night, every night I've got to pat her and love her and those are the things that those people don't actually realise"*. Nightmares about his son in the mortuary were mentioned by SHAUN who said that *"I still have nightmares, funny enough in this last week two nights I actually dreamt about him, but I continually get ...I can actually see it right now, him lying on this stainless steel bed and it had a big glass dome"*.

Some of the participants were still very angry about the death of their loved one. JASMIN was extremely angry with what she saw as the injustice surrounding his death and said that *"this guy is still walking free and my son is not here. He was on the threshold of his life"*. SHAUN and CAROL were angry about the way in which the person responsible for their son's death handled the situation. This person was actually their son's friend who initially lied about their son being the

driver of the car. He later told the truth but was driving recklessly a few months later and does not appear to have learnt his lesson in any way.

#### 4.2.6.8 Ways of coping?

##### *Trying to put something back by helping others?*

The participants mentioned on a number of occasions how they are now driven to help others after experiencing the loss of a loved one. JASMIN mentioned that she would like to be available to counsel other bereaved parents as she felt that you can only start to understand once you have experienced such a loss. She felt that she would have benefited from some counselling herself and she found the support group for bereaved families to be a great help.

AMY described how she makes herself available to sit with families in need of support in the ICU. She explained that sometimes a friend might phone her and tell her about a family who had a critically ill family member in ICU. She said that she goes to the hospital and just sits with the family, she doesn't tell them about her own losses until they ask her. She said that; *"sometimes its weeks later that they say 'how did you know to come?' but they don't seem to even ask, they just accept that you are there for them."* Both of these participants said that they knew to some extent what these families are going through and know what helped them.

CHANTELLE has a little boy, similar age as her deceased son, from a nearby orphanage who she takes home for the weekend and she says that *"it's put something back in my life being able to help someone else"*.

#### **4.2.7 Discussion of bereaved families findings**

The bereaved families highlighted that fact that they needed to feel cared for by the health professionals. Jurkovich, et al., (2000) supported this in their study which revealed that during death-telling the families valued a caring and sympathetic caregiver. The findings from the families suggested that the bereaved families saw very small gestures from the staff as showing they cared. These gestures did not have to be grand and require a great deal of money and resources. The families mentioned being bought a cool-drink, combing their dead sons hair, showing kindness, offering support and just acknowledging the family and their loss as being signs of caring. The families were often acutely aware that the staff were under a great deal of pressure and did not want the staff to look after them when they were busy trying to save the life of their loved one. These very small things let the families know that the staff were aware of them and acknowledged their loss, thus they did not feel isolated. Instead they were involved, felt important and were being cared for. Li, Chan & Lee (2002) suggest that the health professionals in the ED need to provide sensitive care according to the unique needs of the bereaved as grief is a highly individualised experience.

When attempting to deal with the crisis they are facing (the death of their loved one), the bereaved families are seldom alone as they have friends and family around them to help or hinder (Hoff, 1984). The family or group will support the individual by choosing ways of handling the problem based on their own experiences and culture. A well organised group with open communication and collaboration will provide more support for the individual by less conflict resulting when deciding how to handle problems. The activities of this group should be directed towards helping the individual in crisis deal with their problems by some form of activity rather than to avoid the problem (Caplan, 1964).

The bereaved families described how lonely the grieving process can be and Oliver, Sturtevant, Scheetz, et al., (2001) agree and describe the detachment of the bereaved families from the relationships they previously enjoyed.

JASMIN described how this loneliness was self inflicted as she did not feel she could share her grief with her family as it was too painful for them. She did this in an attempt to protect them. This finding was also reported by Oliver, et al., (2001) who emphasized that the families may not share their grief due to pain or embarrassment, withdrawal out of fear that another loved one will also leave them or because they were trying to protect others - especially the bereaved children. CAROL AND SHAUN described how their friends and family avoided them or the subject of their son's death and how difficult this was as these were

the very same people who they should be getting support from. Oliver, et al., (2001) agree that the bereaved family's friends and family are essential in supporting them through their grief, and that in their research these authors discovered that the bereaved families were often surprised as to which friends and family emerged as supporters and which did not. This was also mentioned by CAROL and SHAUN who were particularly upset that their religious support network had not turned out to be very supportive to them. The study by Oliver, et al., (2001) also supported this finding as their participants described that their most disappointing experience occurred when clergy or the community of faith failed to meet the participant's expectations of care. These authors suggest that the clergy may not view themselves as grief counsellors, but rather as being necessary for the grief rituals (funerals etc) This may be the reason for the disappointment on the part of the bereaved families. Oliver, et al., (2001) mentions that the supporters of the bereaved families need to remember the loved one and appreciate the bereaved family's grief. These supporters also need to be available to the bereaved for a length of time. These authors caution that unresolved grief of the bereaved families places them at risk for a number of mental disorders as well as alcohol abuse and violence (Oliver, et al., 2001).

Post resolution of the crisis may result in the individual achieving resolution of the crisis or major disorganisation. This major disorganisation may present as a breakdown where the individual has a complete emotional breakdown and withdrawl from reality, or maladaptation. Maladaptation describes the individual

functioning at a lower level than previously (Infante, 1982). Post Traumatic Stress Disorder is a common and severe health problem that the suddenly bereaved families can face. The symptoms include re experiencing symptoms (flashbacks etc) avoidance or numbing symptoms (avoiding reminders etc) and arousal symptoms, e.g. problems sleeping (Wortman, Battle & Lemkau, 1997). These symptoms were described by a number of the participants.

## **4.2 8 Findings for the mortuary**

### 4.2.8.1 How the body is

The bodies of the deceased are stored in a large fridge inside a shroud or wrapped in yellow plastic bag. While observing the autopsies, I became aware that these bodies may freeze and then need to be thawed before an autopsy can be performed. The bodies are naked in the bag/shroud and may have label stuck on their forehead or tied to their toe. All the bodies lie in the fridge together awaiting the post mortem or to be fetched by the families or the funeral parlours. There are a large number of young people who have died due to gunshot wounds or motor vehicle collisions and then need to have an autopsy carried out. A pathologist said that some of the staff experience difficulties in carrying out an autopsy on a child, although the decomposed bodies were the most unpleasant for him. NIVEEN and LUSHEN mentioned that they often have to work with decomposed bodies and they said: *“working with decomposed bodies, a body that has been totally rotten with worms and its very distasteful work”*. They said



that the smell is terrible and RAJ agreed that this often affects their appetite. Due to the lack of autopsy facilities in the province, many of the bodies come to the mortuary from distant areas and this cause transport problems for the families.

#### 4.2.8.2 The environment

While carrying out observations of the mortuary I had great difficulty in finding the mortuary and finding parking. This was echoed by SHAUN and CAROL. On entering the mortuary the families would be met by police officers and directed to the waiting room. All the autopsies occur first thing in the morning so only very few staff members are available to the families at this time. Many of the families would then have to wait to be seen. The waiting room for families is small with a few chairs. The walls are bare and it looks very cold and institutional. Toilets are the only facilities available for the families. There is no privacy as all families waiting to be attended to would have to sit in the same room and there are no private cubicles. These families could include people who know about the death of their loved one and are coming to view or fetch their body, but they could also be families whose loved one is missing and they have come to check if they are one of the unidentified bodies in the mortuary. The Australian National Pathology Accreditation Advisory Council (NPAAC) guidelines for forensic mortuaries (2004) advises that families should have a waiting room located near the viewing area and that this should be fitted out in a dignified manner and that easy access to toilets should be possible.

I was shown the area where the families are taken to see the body of their loved one. This is currently a passage way which is right next to the receiving area where the bodies are brought into the mortuary. It is located near to the fridge, where the bodies are kept. Here the families would need to huddle together to stand around the steel trolley containing the body of their loved one and there is no privacy. They might also see the receiving of another body or its removal while they are there. This area is also close to the dissection area and the families might see a body coming out of the dissection room naked and needing to be stitched up! This area also smells of disinfectant and one may be able to smell fresh blood from the autopsies which have been performed. NPAAC (2004) suggests that the viewing and identification area be a distance from the dissection areas so that the visitors would not have the possibility for seeing or hearing an autopsy in progress. NIVEEN and LUSHEN both agreed that their facilities used presently for the viewing of bodies by the families was unsuitable. After the morning spent observing, I carefully washed all clothing which had been worn as it smelt like the mortuary.

The mortuary staff also complained that the environment was not a suitable one for them to work in; *"If they will just change the working environment for us - give us a better, decent environment to work because for the years that we have been working here we have never had luxury working in this place. Although you (are) working, occupational health and safety wise and... It wasn't a good place"* (NIVEEN and LUSHEN). The manager of a state mortuary, RAJ, agreed and

mentioned that top management were not interested in the staff working in the mortuary as long as they did the job. He mentioned that the only time the staff hear from top management was when something went wrong. At present, money was being spent to upgrade the mortuary but this was only the "dirty area" where the autopsies are done and nothing was being done to the administration areas to improve conditions for the staff. The dissection areas are being upgraded so at present, the staff have to work in very cramped conditions. The change rooms for the staff are makeshift and I had to put on my protective clothes outside the change area in a passage, as there are no change room facilities for females. NPAAC (2004) suggests that shower facilities should be available with clearly demarcated areas for discarding the used clothing clearly displayed. This was not apparent.

At present, the administration offices are very stark and cramped with some staff members sharing offices. There also did not appear to be sufficient equipment for the staff to work with. Some of the bodies had to share trolleys as there were not enough and the staff had to manually lift the bodies as there were no hoists for them to use. NPAAC (2004) suggests that manual lifting be minimised and that body hoists, elevating trolleys or elevating dissection barouches be used. This was not evident in the mortuary visited.

#### 4.2.8.3 The bereaved family

Some of the participants described how hard it was to get a copy of the autopsy findings as some of the bereaved families wanted to know all the details surrounding the death of their loved one and to see if they had suffered in any way. SHAUN had to do a great deal of phoning around to get details of who to contact about the autopsy. When he was able to contact the pathologist concerned, he was however very impressed as the pathologist knew all about the case and was able to give him all the necessary information.

*“He sort of gave us - whether or not that happened - that gave us peace because we knew that he didn't actually suffer. But he was very professional in whatever he did he was really superb, he told me exactly - he said 'if you've got any questions please phone me again', and I was very impressed with that. And then what actually happened when I went to the investigating officer... I went and got some, we actually got the state pathologist report and I have still got it in my office to this day explaining exactly what injuries he had, where, what and why.” (SHAUN).*

CHANTELLE however had this to say;

*“I did see part of the one post mortem (autopsy) report and I read part of it and I stopped and I couldn't go on... it was just so horrific. Umm, one thing I was shocked about is... on the death certificate from what I've heard they normally just put "Motor vehicle accident" or "Natural causes" or whatever it is... they put , "Chest crushed in vehicle accident"... and to read something like that about your child... it was really, really hard.”*

SHAUN mentioned to me that even though they had experienced great difficulties with the staff in the mortuary they were extremely impressed with one staff member who worked there;

*“The way that women treated us - and it is a state mortuary - that's the way that everybody should have been treated. She knew her place, she was compassionate, she was concerned even when I sat down afterwards she helped me because I wasn't writing that well and... She was concerned, you know, that's the type of person that should be in that place”.*

#### 4.2.8.4 Staff members

Initially the mortuary staff were hesitant to talk to me but became very eager to describe the environment in which they work and how very difficult things are for them. They thanked me for being interested in their work and for acknowledging that they too are affected by the death of others. They became very interested in the research and suggested that I return another day to witness what happens in their daily work lives in order to make the data collected on sudden death more complete. I did this and was greeted warmly by the staff. I was told that they were available to help further help if necessary .The staff at the private mortuary were also interested in the research and willing to help.

The participants mentioned to me that working in the mortuary is indeed, extremely difficult. They mentioned that there are lack of resources and psychological assistance;

*"Ja, every day they cutting the bodies due to the lack of man power. Same man is cutting 7 days a week! And he works call again for two weekends or for the next weekend and then again Monday he starts working a whole week again. And it's a traumatising job, you know, he's not given a rest station - 1 week in the mortuary 1 week out - you know. And nobody is debriefing" (NIVEEN and LUSHEN).*

It's up to the individual to decide when to access psychological support, although showing stress may be seen as a sign of weakness. Some of the staff in the mortuary are proud of the fact that they are strong; *"going on with their work, they don't complain, the work is done, the families are attended to on time"* (NIVEEN and LUSHEN). RAJ suggests that the employees should have had access to psychological support from the time that they first started working in the mortuary but this was not the case. Many of the staff never had a choice about working in the mortuary as they were just placed there early in their career. RAJ is of the opinion that staff should work in the mortuary for a maximum of two years and then be replaced. This has not happened as some of the staff members have been there for twenty to thirty years. He says; *"the State wants you to do a piece of work but they don't give you any assistance"*. He also believes that the staff

should be given a special allowance for working in a high stress area like the mortuary but they have never received this (RAJ).

The staff do not have any additional training to work in the mortuary and they know what to do by being shown by the staff before them. Thus the information has been passed down verbally, "*through the generations*" (RAJ). RAJ wanted to send staff on a Forensic Technology course but was told by top management that there is no money. NPAAC (2004) suggest that mortuary staff should be encouraged to undertake mortuary training and receive regular updates.

There are however a number of procedures manuals/protocols available to the staff to guide them regarding a number of procedures in the mortuary e.g. identifying the body, and post mortems. The different staff also have their job descriptions which guide them in what they are suppose to be doing in the mortuary. JACK and SIPHO, at the private hospital mortuary, said that all they do is move the body and that a nursing staff member is always with them to attend to the family as they are not educated to deal with them. NIVEEN and LUSHEN agreed that they did not have any training on how to talk to the families but they have just found what works for them after many years of experience in the mortuary.

All the staff members are supposed to follow universal precautions when involved with the autopsies, but on the visit to the mortuary this was not evident.

A large number of the staff in the dissection room were not wearing a visor or goggles and some did not have gloves on, (they were transcribing the autopsy results but still handled specimens) even though there are signs outside the room warning them to wear the protective equipment. When I asked the pathologist about this, I was shown the sign and told that the police are in charge of the mortuary staff and so it's not up to the medical staff to enforce the staff to follow precautions. This is particularly disturbing when one considers the large number of HIV/AIDS and Tuberculosis clients presenting in KwaZulu-Natal and thus these staff members are putting themselves at risk. During the observation, I was acutely aware of the amount of blood and body fluids splashing around the body and had to move around a great deal to ensure that this did not land on me. Burton (2003) highlights the potential hazards and risks which staff involved in autopsies can be exposed to. These hazards include HIV/AIDS, Tuberculosis and hepatitis. This author recommends that protective clothing includes a cap/hood that completely covers the hair, eye protection, face mask with a filter if the case is suspected to have TB, surgical shirt and trousers, waterproof boots, full length gown, a long waterproof apron and gloves.

The participants mentioned that there is a break in communication between the health professionals and the mortuary staff and that there have been meetings to discuss this with top management. These problems are concerned with the fact that some families are not informed that an autopsy will be performed and thus arrive at the mortuary to fetch the body, only to be asked to return a day or two



after the autopsy. At times the forensic evidence is not kept properly by the health professionals and NIVEEN described an instance where a bullet had been kept in a drawer in the duty room. The health professionals have also on occasion failed to report the case to the police and obtain a case number, thus causing a delay with the autopsy. There are also delays in completing the necessary paperwork from the hospital side and this then also delays the autopsy.

#### 4.2.8.5 Dehumanized body

*The special human qualities appear removed from the body*

During my observations, the dehumanisation of the client was apparent. I entered the dissecting room to be greeted by two naked male bodies. One was on the dissecting table split open from his throat to his genital area and the other male was lying naked on a steel trolley pushed near the wall. Shortly thereafter another naked body was pushed into the small room. She was a middle aged woman, also naked, with her right arm up near her head as her hand had been caught up in the top of the trolley. She was placed near the pathologist but due to the smallness of the room and the fact that there were approximately five people in the room, the bodies waiting to be dissected were very close to the dissecting table and had staff walking around them as they moved around the room. At one point there were two naked bodies sharing the dissecting table – one resting perched on the side of the table lying next to the man who was all cut up. This

was due to the fact that there was only one trolley and the one body had to be moved before the body that had been completed could be removed and taken away. NPAAC (2004) state that it is unacceptable for a body to be left naked on a trolley and that the dignity of the client must be considered at all times by keeping them covered.

The autopsy procedure requires that the body be opened from the head to the genital area and all the organs removed for investigation. Blood was collected from the body with what looked like a soup ladle and the organs were weighed and placed on a "dissecting board" by the pathologist who then sliced through looking for pathology. Bits of tissue and fat would come away from the organs and these are tossed back into the abdominal cavity along with the dissected organs. At times blood and body tissue would collect on the floor and this was periodically washed down the drains. While watching, I was aware of thinking that I was present in a human butchery. The equipment being used were saws, hammers and large knives. At one point another man came in with a knife sharpener and proceeded to sharpen a large knife which he then handed to the pathologist who started chopping through the organs on his dissection table. Incisions were made on the face and the skin was pulled down to reveal the skull. This was then manually sawed open and the dissector used what looked like a chisel and a hammer to open the skull and reveal the brain – this terrible cracking sound filled the room. Once the brain was cut out pliers are used to pull out the brain stem and any other matter still adhering to the skull. Once this has

been examined by the pathologist, all the brain remains are tossed into the abdominal cavity. When I enquired, I was told that as one is not able to make the skull watertight if the brain is returned to the skull there is a great deal of leakage. It is for this reason that the brain is put in the abdomen along with wads of hessian which soak up any body fluids. The bodies are also stitched up with very thick looking string on a very big needle and they (the staff doing the stitching) are able to make this quite watertight. This hessian is also stuffed into the head to make it feel heavy.

After the autopsy was completed on the body it was removed to another large room just outside the dissection room. In order to get there, the naked body was wheeled on a trolley, past the receiving area and into the large room to be surrounded by a number of other people busy stitching up other naked bodies. There was thus absolutely no privacy for the bodies at all.

#### 4.2.8.6 Dehumanized staff

*The special human qualities appear removed from the staff*

During the observation of the autopsies, I could not help but wonder how the dissector was feeling as he cut up the bodies as two of the three bodies were the same sex, race group and approximately the same age as himself. When he proceeded to saw the skull, another member of staff who was busy transcribing the autopsy report looked across at me with a look in his eyes which seemed to

acknowledge that we were present watching a terrible thing being done to a human being.

The participants described how they came to work in the mortuary as an eighteen or nineteen year olds. They were instructed to come to the mortuary and one day later they were told to work with the bodies – *“and when I say the next day, you coming out of an environment where you’ve never seen – you’ve never heard of these things and now you looking at somebody dissecting a body”* (LUSHEN) . NIVEEN described his story;

*“I've been here since I was a child, 18 Years - I shouldn't have been here... Just out of school and you come to work in a place... Now he's been here long time as well - 28 years! We, we hard in this thing now, like basically the death doesn't... The only time it'll really affect me now is if somebody close to me... But at the moment we're hard people, you know, in the way - working with bodies and we can work with the family to ease them, ease their minds, speak to them and you know keep them in the Office and give them a tissue to wipe themselves, you want some water - give them... That's about the most that we can do”.*

The participants acknowledged that some of them are cold and unemotional when they deal with the families and this was due to the fact that they have been working in the mortuary for too long.

RAJ mentioned that some of his staff are like “walking zombies”. He said that you may think that they are normal when looking at them but he said that they are all terribly affected. He mentioned that sometimes it’s difficult to have a good sleep as he dreams about cutting bodies and wakes to find that he is busy tracing out the incisions he would be making on his wife’s body, or he dreams about bodies walking in front of him and he wakes up in a sweat. Although he no longer cuts bodies, his office is placed so that he sees the bodies being brought in, and he can smell the decomposed bodies. NIVEEN agrees and says;

*“Last week I think it was, we worked on a decomposing body, it’s nothing bad but, we got use to the smell, and I went home and I was sitting eating – I was having some [chocolate] and suddenly the smell came, and... But you got to start forcing yourself to eat because I’m not going to get weak now just because of that. But it’s starting to get to me now, even this morning – and it’s not just putting me off from not just eating as well it’s...You loosing your appetite and my sleep is starting to be disturbed...”.*

The participants mentioned that a number of their colleagues have been medically boarded because of psychological disorders or due to alcoholism.

Psychological support is now available to the staff but for many of the participants this is seen as too late to help them. RAJ said that the staff are already badly affected and damaged mentally, as they have been working in the mortuary for many years (20 – 30) and it is too late to start offering help. One

staff member is trained as a de-briefer but the staff have already been affected and don't see the point in being debriefed now. The staff are suppose to be debriefed after a traumatic, horrific experience and RAJ feels that these are daily occurrences in the mortuary so the staff would be spending all their time being debriefed and no one would be doing the work. They have asked for more staff to enable them to carry out debriefing sessions but they are just told that there is no money.

#### 4.2.8.7 Secondary trauma for the family

##### *Adding more to the families trauma*

Some of the families who arrive at the mortuary come from very far away, and they then have to be told that the body is not ready. They may become very angry with the mortuary staff for delaying them and inconveniencing them. LUSHEN said "*but it's not easy for us to explain to them, listen it's not our fault, because now by asking that we're blaming someone else now and then it's going to be with the different departments*". The funerals may be delayed while the families are waiting to get the autopsy done, or while incomplete documentation from hospital side delays the autopsy. A co-researcher said that this often resulted in problems for them as the families then return and ask the health professionals if they cannot help to speed up the process for the families who are waiting to bury their loved one and find some closure. The co-researcher said that this is often a problem of the doctors not completing the necessary

paperwork in good time. A committee has been set up in one of the hospitals to look into this issue and to suggest ways to speed up the process. *"It's particularly difficult if a rural family comes to fetch the body and its not here but at the hospital – they don't understand and don't know about the rules"* (LUSHEN).

LUSHEN explained that some of the bereaved families cause more trauma for themselves by rushing the autopsy;

*"Some of the family members want to push for the body - they want to have the body ready. It's more often religious wise, right, they are probably Indians like Muslims, but after the body is buried that is when they come with questions now... 'What happened here, why did this...?', you know. There are some of us that will explain to them, 'Listen, don't rush the funeral, because later on... you rather waste one day now then go and waste five or six years because you will be wanting to know certain things - you will have questions and you are not going to get answers'. Some of them do listen, but there are others - they want them quickly and that is when our problems start. They want answers from us, they question the pathologist – 'Why is the post mortem report not ready...'- they've got insurance policies they want to sort out, the insurance companies want certain things - they can't get those things. Just because they rushed that funeral".*

SHAUN and CAROL described how they had their son cremated quickly as they could not leave him in the mortuary. Raphael (1984) suggests that the funeral serves a number of functions. It separates the living from the dead and allows an opportunity for the living to say goodbye and it also brings the family support group together to support each other. Raphael (1984) suggests that cremations are too quick and may allow the bereaved to deny the reality of death and the uncertainty of where they are.

Some of the families coming to the mortuary do not know if their loved one is alive or dead and they then have to be told about the death of their loved one by the mortuary staff. NIVEEN explained that

*"You see we get this sudden death... Somebody informs them, they are told, 'Listen, your beloved has now met with an accident', telephonically. Now they are not sure, they come here. When they come to \_\_\_\_\_ mortuary we look through our SAP register, right...And so we just open the book, see 'Yes, confirmed', so and so - the name of the deceased in accident so and so - you know, the whole history - what happened then that's it. So all we say is, 'Now listen, we need the ID document of the deceased and the next of kin - formal identification', they must make funeral arrangements. They are not given a debriefing to say...There's nobody...Some people... O.K. the moment we mention the name then they start crying and start getting hysterical and now we haven't got the facilities here to take them into a special room privately and you know,*



*have them comfortable, a cup of tea or water. O.K. If they are traumatised and they in shock and now they have got to do the documentation, they can sign anything if you ask them to sign they don't even know where to sign or what they are signing”.*

This death telling is done in the waiting room with all the other people who are wanting to see the body of their loved one or those waiting to hear if their loved one is dead. LUSHEN also stressed that some of the bereaved feel very angry towards the police for killing their loved one and thus are very upset to see policemen again in the mortuary. It is for this reason that a number of the mortuary staff who deals with the public do not wear uniform.

The mortuary staff mentioned that they do not have any formal training and some people are more compassionate than others when dealing with the families. SHAUN & CAROL had a great deal of trouble when going to view the body of their son. The staff at the mortuary insisted on having the identity document of their son before he would allow them to see their son. The more they told the staff member that the document had been stolen off their son's body at the scene of the accident, the more he was insisting. As a result they are still extremely angry with the staff member, *“if I see him today I'll take his head off”* (SHAUN). SHAUN said

*“that just added to the stress, it just added to the whole unpleasantness of first of all having my son killed and the circumstances surrounding it and then to go and to be treated like that at the mortuary - that's a place of*

*dignity, those people should be falling hands over heels to help you and that didn't happen".*

Seeing their son on a stainless steel trolley with "muggies" (gnats) in the air made them agree to have him cremated as soon as possible as they found the environment abhorrent. This they now regret as SHAUN would have liked to have spent more time with him. They went to the mortuary with other family members who then tried to get them away from the body of their son as soon as possible. SHAUN and CAROL thus felt very rushed and no one there to tell them they could touch him if they wanted to;

*"He was lying on this stainless steel table...ja, you know I don't think we said goodbye to him properly, I think we should have touched him and held him and whatever, but there were too many people around and we were just.....and I saw one or two muggies (gnats) flying around and I just said well that's it, my son's not staying in this place" (SHAUN).*

NPAAC (2004) suggest that the visitors should be able to view the body through glass initially and then be able to enter the room should they wish to. A member of staff should also be readily available to provide any assistance should it be required, although the privacy of the bereaved families should be respected (NPAAC, 2004).

ZODWA described her experience of going to fetch the body of her sister and being told by the staff at the mortuary that she needed to wash her first. ZODWA

said; *"I was crying so much while I was washing her"*. This was an extremely difficult thing for her to do both psychologically and physically as her sisters body was stiff and heavy, and she only had the assistance of an elderly aunt who accompanied her.

Once they (SHAUN & CAROL) left the mortuary they were asked to sign for their son's belongings, which they did not check. At home they found that their son's watch was not there and the deceased's older brother and a friend went back to the mortuary and returned with the watch. They would not give details as to how they got the watch but SHAUN & CAROL were sure that the mortuary staff would have stolen it had they not gone back, and this upset them as the watch now had huge sentimental value for them.

A participant from the support group described how good their experience was of seeing their daughters body in a mortuary in Ireland;

*"we only saw her after she had died (in Ireland) therefore it was in the mortuary – very impressive and comforting – taken into a room, cosy though cold in temperature. Flowers, candles, ornaments, wall hangings. She was on a bed, under a counterpein and we were allowed to touch her, kiss her and talk to her – three times!"*

She emphasized how comforted her and her husband were by this experience.

#### **4.2.9 Discussion of mortuary findings**

The mortuary environment is very dehumanising for the staff that work there, for the dead client and their bereaved families. McCarroll, Ursano, Wright, et al., (1993) describe the various stressors facing those who work with dead bodies and these include unpleasant smells, the sight of bodies which are burned or mutilated and the sounds which occur during an autopsy such as the saw cutting through bone or a head hitting the table. These authors suggest that the personnel working with dead bodies cope by creating an emotional distance between themselves and the body and try to avoid situations that "humanise" the body. This was evident in the research carried out with the mortuary staff.

In a study carried out by McCarroll, et al., (1993) amongst people who handled dead bodies in Operation Desert Storm, it was discovered that these people had significantly more intrusive and avoidant symptoms than those who did not. McCarroll, et al., (1993) also reported that alcohol abuse was common amongst the personnel handling the dead bodies.

Burgess & Baldwin (1981) and Infante (1982) suggest that being faced with a crisis, such as being involved in a particularly unpleasant autopsy, can result in maladaptive resolution of the individual's coping. The individual becomes or remains vulnerable to similar problematic situations and learns maladaptive, self-defeating or neurotic mechanisms to cope. The level of the individual's functioning is at a lower adaptive level and future stressful events have the

likelihood of developing into a crisis. This maladaptive resolution was illustrated by some of the mortuary staff.

Cahill (1999) suggests in his ethnographic study of mortuary science students, that different occupations require different forms of emotional work and thus trade on different forms of emotional capital. Individuals with different forms of emotional capital tend to select and be selected for different careers. This was very apparent for the author when viewing those mortuary science students who were successful.

Jurkovich, et al., (2000) revealed that bereaved families want to be informed about the autopsy and do not want to be surprised about it happening. The mortuary staff agreed with this and added that well informed bereaved families would make their job easier to do as the mortuary staff would not have to witness the anger and pain of these families when hearing about the autopsy for the first time.

McPhee, Bottles, Lo, et al., (1986) revealed in their study carried out in California, USA, that bereaved families views of autopsy's were not as negative as the health professionals feared. The bereaved families in this study did however point out that their concerns regarding autopsy which included disfiguring their loved one and problems in accessing the results of the autopsy.

### **4.3 Cycle 3**

#### **4.3.1 The setting and participants**

The health professionals from three Level I ED's in KwaZulu-Natal (Hospitals C, D and E) were included in this cycle. The participants involved in this cycle included the co-researchers as well as other interested clinical staff members. See Table 4.4 below for the participants who took part in this cycle.

**Table 4. 4 Participants of Cycle 3**

<b>Hospital C</b>	<b>Hospital D</b>
Two co-researchers and three clinical nursing staff, two of whom were trauma nursing students. A doctor was present at the start of the discussion but he had to leave soon thereafter.	One co-researcher and one other senior clinical nursing staff member.

#### **4.3.2 Data collection**

I followed the steps outlined by Stember (1986) when developing a model. I started by attempting to describe what the model was trying to represent and to identify and describe the concepts active in the domain and then analyzed them in relation to the phenomenon of interest. I also attempted to identify the order of occurrence and to delineate the relationships between the variables. A visual representation of the model was then developed.

I attempted to use the idea of an algorithm as a way of visually presenting the model. This was chosen due to the setting that the model would be used in. In the ED's many of the health professionals are very familiar with algorithms and use them every day in caring for their clients. I thus felt that if the model was designed along the lines of an algorithm, this would be familiar to the staff and perhaps make it easier to understand and follow. An algorithm also allows for a simplified illustration of complex concepts or subject matter which the health professions are able to use in limited time to guide their practice.

Due to the research methodology being used, namely action research, I wanted to ensure collaboration from the co-researchers and other interested health professionals, and thus did not want to meet with them with complete data which they then may feel unable to change. I initially developed a very basic, simplified model based on the data collected from the various participants during the preceding Cycles 1 and 2 and from relevant literature. I attempted to arrange one focus group meeting with all the participants from the three different hospitals but this was impossible due to their various work and personal commitments. I had to settle on meeting with the participants in three separate departments and then planned to pool the data collected. These meetings were difficult to arrange as the departments were interested in doing this during "on duty" time. I met with the participants of two of the ED's in the staff tea lounge and the family bereavement room respectively. After thanking the participants for agreeing to the meeting, I requested permission to tape the discussion and then

went through a description of the proposed model and instruments (family pamphlets and checklists) to be designed (More information on the family pamphlet and checklists is provided in Cycle 4). This proved to be quite a lengthy process as the participants added their suggestions, contributions and experiences. See Annexure F for the questions that guided the discussion.

The crude algorithm which I had developed was used as a starting point to trigger discussions. I had to actively encourage the participants to get involved as they were a little uncomfortable about making comments which conflicted with my ideas. This occurred even though I had a good relationship with the participants and had known the majority of them for a number of years. The participants were always quick to hand the ownership of the research back to me, even though it was stressed to them at all times that they were actively involved in the process and that the change being planned would directly affect them. One of the reasons given for this from the participants was that they were not experienced in research, even though I tried to actively encourage their participation.

One of the co-researchers had concerns that some staff members would want to follow the algorithm precisely. She emphasized that managing death is not something that can only be done in one way as there are, for example, cultural differences which then make one situation differ from another. She also added that there is no rigid sequence, “no A, B, C, D” and that if shown as an algorithm



some people would see this then being the only sequence and the only way to do things. These comments were voiced before the co-researcher had seen the crude outline of the model and after seeing it she said; "*actually it doesn't look that bad*". I discussed her concerns and alterations were made to ensure that the model would not appear prescriptive, but could rather be used as a guide to help the staff when managing sudden/abrupt deaths in their department.

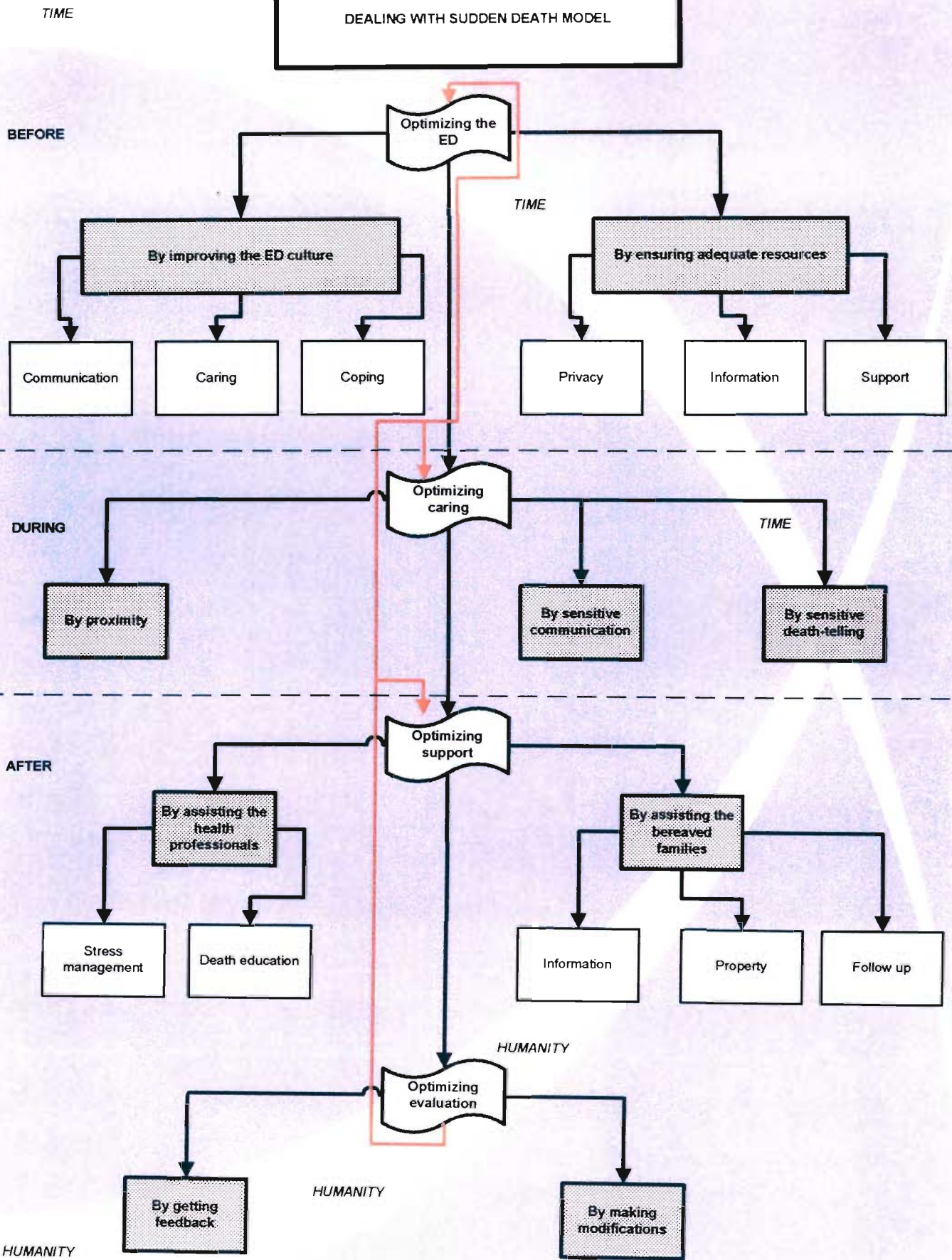
The participants were particularly excited about the family pamphlet as they felt it could be extremely useful and was something that they would be able to make use of straight away. They kept brainstorming new information to add to the pamphlet and saw the use of this pamphlet extending beyond the ED through the entire hospital. The format of the implementation workshop was also discussed as well as ideas as to what information to present that would be useful for the health professionals during this proposed workshop. The duration of the workshop as well as a suitable time to hold the workshop was also discussed.

In the ED of Hospital E, the unit manager abruptly resigned, which posed a possible disaster for the research as this nurse was also a co-researcher and I had planned to implement the model in this department. Luckily, the acting unit manager was also a co-researcher and thus the planning for the implementation was able to go ahead after some delays. After meeting with this acting unit manager, she suggested that incentives (in the form of attendance certificates) be given to the workshop participants and this was done. She also asked that other categories of staff, i.e. enrolled and enrolled nursing auxiliaries be allowed

to attend as these were often the staff members who were left with the bereaved families. I was unable to meet with the staff of this ED to discuss the proposed model or checklists as they were unavailable for a number of weeks. The staff from this department were not available to attend the implementation workshop.

After listening to the tapes of the two focus groups, I combined all the information from the discussions held in the two ED's and added additional literature to refine the model. I then developed the visual representation of the model using Visio 2003 (Microsoft Office). See Figure 4.1 for the developed model.

**DEALING WITH SUDDEN DEATH MODEL**



### **4.3.3 Description of the model**

The aim of this model was to improve the management of sudden/abrupt deaths in the ED's by describing an intervention process based on lived experiences.

This model attempted to describe the essential components in the management of sudden/abrupt deaths which occur in the ED's. This was done in an attempt to provide the health professionals working in this area with empirical guidelines to use in order to ensure the therapeutic management of the dead or dying client, the suddenly bereaved families and fellow colleagues (health professionals).

This process model is diagrammatically illustrated in Figure 1. The processes, which are three stages namely; before, during and after the sudden or abrupt death of a client in the ED, were demarcated on the diagram of the model by using bold dotted lines running horizontally across the page. These three stages were in keeping with the three phases of the conceptual model used in the study namely; The Crisis Theory. The model illustrates directional relationships and these are indicated by a black unidirectional arrow' going from the antecedent (causal) variable to the variable on which it is thought to exert its influence (Chinn, 1986). The feedback loops are illustrated by a unidirectional red arrow.

#### 4.3.3.1 The environment

The environment of the ED is unique as the emergency systems and culture of trauma often creates subtle barriers to good end of life care, as death is viewed as a failure. This makes incorporating palliative care into the ED difficult for a number of reasons. The nature of the traumatic injury, the psychological issues around the bereaved families and the death trajectory are all unique features of a sudden/abrupt death. A sudden death is always a tragic occurrence which is very seldom peaceful or dignified. The care of a dying patient in the ED is not very clear and not much attention is paid to it as this is usually something to offer when all other measures have failed. The public value a death with dignity which is free of machines, equipment and various invasive life saving measures but they also value the high technology of emergency or critical care where dramatic interventions can save the life of the client (Mosenthal & Murphy, 2003).

The ED culture is geared towards caring for the physical rather than the psychological aspects of the client's care (Crowley, 2000) as the ED is an open, busy environment which is noisy and offers little privacy. This author also emphasizes that the ED culture does not assign much importance to communication patterns, mental health and staff values.

#### 4.3.4 Model assumptions

1. The ED is a time-constrained environment which demands that the health professionals working in this arena think and work fast as this can often mean the difference between life and death for their clients.
2. In order to be time-efficient, the health professionals need to plan beforehand and have the necessary strategies or protocols in place so that precious time is not wasted.
3. One's humanity, the particular quality of being human, is greatly influenced by ones beliefs, values, previous life experience and culture. This influences ones personal as well as professional life.
4. The health professionals need to acknowledge that they are human, and this health team should recognize the humanity of each other, their clients (even the dying ones) and their families.

Iserson (1999) agrees that the ED staff have limited time as they need to treat other patients and may often be interrupted to make other decisions, often concerning other clients. The backlog of clients who were neglected during the resuscitation of a critical client need to be attended to and thus the families of clients are often given little attention. In order to work effectively in this time pressured environment the health professionals often make use of algorithms so that precious time is not wasted. Therapeutic management of the dead or dying client and their bereaved family can be extremely time-consuming.

It has been suggested that an individual's behaviour is greatly influenced by one's beliefs and values, and that one's values are affected by personal and professional beliefs and scientific knowledge (Lang, 1976 cited in Crowley, 2000). The influence of the individual's culture should not be overlooked. The health professionals need to acknowledge that they are unable to separate this from themselves when they are at work or, rather that they shouldn't be trying to do this. Whittle (1999) is also of the opinion that unless nurses are able to work through their own issues about death and dying, they will not be able to efficiently help their clients. Who the ED staff are as a human influences their personal as well as their professional life and they should rather embrace this and be aware of the influence and its strengths and weaknesses for them as an individual. The bereaved families also need to have their humanity acknowledged and be made aware that their loved one who is dead or dying was treated with humanity.

#### **4.3.5 Model outcomes**

1. A cohesive team of health professionals who have made the necessary preparations to their environment to cater for the specific needs of those dealing with sudden deaths, and are able to provide optimal care for the dead or dying client, their families and their own colleagues.
2. Optimal care for the dead or dying client and their families during or, immediately after the death of the client, characterized by attempts to

keep families near to the client and use sensitive communication techniques.

3. A cohesive team of health professionals who perceive their own professional skills to be adequate for their jobs and feel supported by their colleagues and management.
4. Bereaved families who receive the necessary assistance immediately prior to leaving the institution and feel supported and cared for.

#### **4.3.6 Model processes and concepts - Stage 1: Before the sudden death**

Definition: This stage is concerned with preparing the ED before a client or clients are admitted in a critical condition.

##### 4.3.6.1 Objective: Optimizing the ED environment for palliative care

There are two processes involved in this objective. The first process is improving the ED culture with communication, caring and coping as the related concepts. The second process is ensuring adequate resources with privacy, information and support as the three concepts related to this process. This means that the two processes of improving the ED culture and ensuring adequate resources for palliative care need to be used optimally in a specific ED to ensure that the health team and the environment are ready to manage sudden/abrupt death.



### *Process one: Improving the ED culture*

The ED culture can be improved by encouraging open channels of communication, a caring philosophy and adaptive coping strategies for the ED team members.

Organisational culture consists of the shared beliefs and values within an organisation and this has a great influence on the success of the organisation (Huber, 2000). The findings from Cycle 2 has illustrated the lack of collaboration and cohesiveness amongst the staff in the ED. The staff appear to be very individualized, following their own ideas and beliefs and giving little attention to others in the team. The ED is an environment of great pressure and complexity and Keenan, et al., (1998) suggest that collaboration between the health professionals would improve effectiveness. Huber (2000) suggests ways to build a culture within an organisation and that one needs to start from where the group is and build forward. Open discussion should be established, shared values and mission of the group identified, strategies determined and then planned action taken. Identifying the health professionals values and beliefs can form the foundation of the ED team's direction, aims and objectives (Manley, 1992 cited in Crowley, 2000).

### Concept one: Communication

Communication between the health professionals in the ED refers to open communication between the different teams namely the nurses, doctors, hospital management, police, transplant coordinators, mortuary staff and the bereaved families, in order to achieve optimal understanding of and support for every individual.

Hojat, Gonnella, Nasca, et al., (2003) emphasized that interdisciplinary collaboration improves clinical outcomes, patient satisfaction and may decrease institutional costs. The communication between the doctors and the nurses needs to be assessed and changes made where necessary to ensure a cohesive health team. This mutual collaboration between doctors and nurses can be influenced by educational factors as well as societal roles and cultural norms. Doctors and nurses need to be supportive of each other and rather see themselves as complementary team members in the ED (Hojat, et al., 2003).

Hospital management need to acknowledge the uniqueness of the ED as this would improve relationships between the hospital management and the health professionals working in the ED (Brysiewicz & Dickson, 1999). Open communication between the ED health professionals and the transplant coordinators is essential in order to ensure prompt identification of possible organ donors. Communication between the mortuary and the hospital staff was also identified as a problem area as failure on the part of the ED health professionals

to inform the families that their loved one would need an autopsy, delays in reporting the case to the police or the documentation not completed timeously resulted in the mortuary staff having to deal with angry families.

#### Concept two: Caring

Caring refers to being attentive to the needs of the client (dead or dying) and their families and anticipating their needs. This involves very small gestures such as providing something to drink, combing their dead son's hair, showing kindness, and offering support. These small gestures indicate to the family that the staff acknowledged their loss, thus they did not feel isolated. They were involved, important and being cared for. Keeping the families updated with information was also seen as caring.

The caring shown by the staff members depended on the individual as they could decide how much of themselves they wanted to invest in the situation with the families. It was also influenced by their own experiences in professional as well as personal life, especially if they had experienced such a death of their own loved one as they tended to care for the family in the way that they would like to have been cared for. Death views are personal and reflect ones own experiences, religion and culture. The health professionals need to be aware of this and acknowledge how this affects the care of clients and families. The spirituality of death must be remembered (Wells, 1993) however, the health

professionals must be aware of their own religious beliefs and not inflict these on others. Oppewal & Meyboom-de Jong (2001) suggest that the health professionals religious beliefs - or lack thereof - should play a minor role when dealing with the family. They suggest, for example, that the health professionals should not mention God initially, but if the family mentions God's name then the health professional should not hesitate to repeat it. The family needs to be given back the responsibility of their loved one that the hospital assumed when the client was alive, and leave them as much decision making as possible; especially if it's a child that dies (Awoonor-Renner, 1992). A sudden death cheats people out of their assumptive world – what was supposed to be happening. The bereaved feel out of control and their anger, pain, guilt, frustration, helplessness are often misplaced and may be directed to the health professionals (Thayre & Peate, 2003).

In order to improve the ED culture the ED staff need to reach consensus as to what they view as caring when managing sudden/abrupt deaths in the ED. To achieve this, the ED staff need to consider their philosophy of caring. Hetherington (1998) emphasizes meaningful involvement in order to create positive client care and organizational outcomes. The ED is an area where the health professionals are expected to deliver complex physiologic care and this includes performing a number of medical and technological procedures. Nurses who practice in this way often view the family as an obstacle, and when nurses exclude the family and give purely technological care, the results can be

devastating as the families are neglected and their presence is barely acknowledged (Chesla, 1996). Flam (1999) suggests that the health professionals should strive to have a “high touch” approach to managing sudden death in order to complement the already “high tech” care that is being given.

Another decision to be made is whether or not the department staff are in favour of witnessed resuscitation. Historically, the family was prevented from being present as the health professionals felt it would be too traumatic for them to watch and that the family may get in the way and hamper any progress. There is research available on the positive effects that witnessed resuscitation has on the family and that it improves the ability of the bereaved to cope with the grieving process after the loss of their loved one (Meyers, et al., 1998; Rattrie, 2000).

The health professionals also need to clarify issues surrounding organ donation. Some of the ED’s have policies in place whereby the nurses can alert the staff involved in organ donation that there is a potential organ donor. In other departments this is only done by the doctor. These issues need to be discussed within the ED and decided on beforehand, as the retrieval of organs from potential donors needs to be remembered.

The health professionals need to decide on the terminology to use when breaking news of the death of a client. Flam (1999) discovered, in a study carried out in the ED of a Brussels University Hospital that the staff had some

disagreements about the most appropriate terminology to use when telling the family that their loved one had died. These health professionals felt more comfortable using the term "passed away" instead of "died" but this author emphasizes that the families feelings and ability to understand should always be considered when choosing the terminology to use. .

### Concept three: Coping

Coping in this context refers to the health professionals being able to witness the death of the client as well as the suffering of the newly bereaved and emerge from this experience having made use of positive, adaptive coping strategies.

Witnessing the trauma of others on a daily basis places the health professionals working in the ED at risk for developing various stress disorders. This secondary traumatization can be caused by the health professionals starting to question life's meaning and feeling frightened and out of touch with other people. They may also feel helpless to do anything about what happened (Gibson, et al., 2002).

The health professionals need to acknowledge that the work in the ED is difficult and that being exposed to sudden/abrupt deaths in particular makes this environment even more difficult to cope with. It is also important to investigate

how the organisation is coping and the warning signs that an organization is under stress are:

- Loss of staff enthusiasm
- Lack of energy to take on new activities or missing work or a reluctance to be at work
- Individual staff members suffering from burnout (Gibson, et al., 2002).

Knowledge of adaptive and maladaptive coping mechanisms is necessary in order to have better knowledge of ones own coping strategies and those used by ones colleagues. Adaptive coping mechanisms allow the individual to successfully achieve the goals they want to, whereas maladaptive strategies do not (Garland & Bush, 1982). Lazarus (1966, cited in Garland & Bush, 1982) described coping with a potential crisis either by changing the stressful situation (altering ones own feelings and responses to it) or by managing the stress by direction action or avoidance. Coping also depends on the individuals past experiences, personality, relationship with others and the environment (Wright, 1996). The health professionals interviewed in Cycle 2 viewed coping as showing as few signs of emotional distress as possible, which allowed them to remain in control and get the necessary work done.

Personal difficulties that the health professionals may have about facing death may make them ineffective in managing the dead or dying client and the bereaved families (Oliver, et al., 2001). ED nurses have been shown to have high

levels of death anxiety, and be more likely to use “avoiding” coping strategies (Neimeyer, 1994; Payne, et al., 1998). Medical students expect to cure their clients and feel a failure when they don’t whereas nurses nurture a client and deal with their problems as they unfold – be it a cure or death (Merrill, Lorimor, Thornby, et al., 1998). Cantwell & Ramirez (1997) suggested that doctors use “distancing tactics” when dealing with psychological aspects of clients and De Valck, et al., (2001) were of the opinion that doctors are unable to deal with emotions. Papadatou, et al., (1999) suggested the need for support from colleagues to cope with the dying process and death of children. These authors suggested that there is a need for a common philosophy, mission statement and teambuilding within the departments in order to cope as an individual.

#### *Process two: Ensuring adequate resources*

The health professionals can ensure adequate resources by planning for privacy for the families, obtaining and making available the necessary information and support for the families and the health professionals.

#### Concept one: Privacy

The concept privacy has social, physical, informational and psychological dimensions. The social dimension of privacy is concerned with the individual’s ability to control social interaction. Physical dimensions of privacy are the degree



to which one is physically accessible to others. Informational privacy relates to how the individual is able to control the flow of information about themselves. The psychological dimension of privacy is concerned with the individual's ability to control cognitive and affective inputs and outputs to form values and to decide who to share their thoughts or information with (Leino-Kilpi, Valimaki, Dassen, et al., 2001).

Where possible, the health professionals need to attempt to provide for these dimensions of privacy for the families of the client and the client themselves. While the families are waiting to hear about the progress of their critically ill loved one, it is better to give them a private area to sit together in. Attempts should be made to make this room as homely and comfortable as possible, cups for the family to drink from should also be available. If a room is not available, a quiet corner of the department can be identified. Chairs should be made available and all the staff informed so that they know where to send the family. The health professionals need to check there is nothing regarding the appearance of the area in which the family will be sitting which may cause them distress e.g. disturbing pictures on the wall.

Provisions need to be made regarding the safe keeping of the deceased client's property. Preparations can also be made to ensure that suitable bags are available to put the clients clothing in to give to the family to take home. The

health professionals also need to be aware of the safe keeping of forensic evidence, e.g., bullets, and policies need to be in place to guide this.

#### Concept two: Information

Information in this context refers to the collection of the necessary data or facts regarding sudden or abrupt deaths for the health professionals and the dying client and their family.

The necessary information for the families needs to be made available, and this can be done using a pamphlet which can be handed out to the families after a death. Coolican (1994) supports the use of written literature to give to the families as they are usually in a state of crisis and do not absorb the information given to them. More information is provided about this family pamphlet in Cycle 4. The information for the health professionals concerns two areas; namely the preparation of the department for managing sudden/abrupt deaths and an incident evaluation checklist to evaluate how the sudden death was managed. More information is provided about these checklists in Cycle 4. Contact numbers for the police, funeral homes, counselors, religious support people, support groups need to be identified and a list of all these numbers kept in a highly visible and accessible area, for the health professionals to use.

### Concept three: Support

Within this context, support refers to promoting or encouraging another person in an attempt to give that person greater inner strength. The health professionals need to be supported and their needs met in order to maintain the balance of the humane professional (Gibson, et al., 2002). Payne, et al., (1998) emphasized that some of the most difficult situations for nurses was time spent with bereaved families. These authors emphasize the need for easily accessible and confidential support networks in the ED.

Psychological support for the health professionals needs to be considered and made available to all the members of the health team. This support should be offered continuously and not only arranged when it becomes apparent that the staff need it. A suggestion is to have a social worker who comes to the department every week for an hour and talks to the staff available to discuss any problems, stresses etc. Gibson, et al., (2002), caution that support should be offered as soon as possible as they suggest that immediate access to a sympathetic listener can prevent the need for much lengthier help at a later stage.

Attention needs to be given to new staff as they need to be supported and orientated in their role in the ED. The unit managers need to ensure that they are approachable and allow for time when their staff members feel able to talk to them. Informal support is extremely important and this should be encouraged

within the ED as the staff work better when they feel part of a supportive team. Simple ways to improve the quality of the relationships within the workplace can be done by trying to make a time when the staff can get together e.g. teatime, bringing cake after a particularly difficult week can do a great deal for staff morale (Gibson, et al., 2002).

Support for the client and family needs to be considered as well. Plans need to be made to ensure that the health professionals are aware of what support services there are for the bereaved families. The ED can obtain information regarding counselors, social workers, psychologists or religious leaders who the families could be referred to for support. The possibility of support people to sit with families waiting to hear news of their critically ill loved one, needs to be explored as the families do not like sitting alone and appreciate a nurse sitting with them (Wright, 1996). Due to the staffing levels in the ED this is usually not possible as all the staff are needed for the resuscitation of the client.

#### 4.3.6.2 Propositions for Stage 1

1. The better the communication between the health professionals, the health professionals and management, and the health professionals and outside agencies (police, mortuary and organ transplant coordinators) the more cohesive the health professionals are and thus the better the care of the dying clients.

2. When the health professionals reach consensus on how to make caring visible in the ED, caring for the dead or dying client, their family and the health professionals improves.
3. If the health professionals use positive, adaptive coping mechanisms teamwork within the ED and level of support for families of clients who die, improves.
4. The consideration of the importance of privacy and the organization of a private area for the families results in improved family experience of the waiting period and the death-telling.
5. Obtaining the necessary information and making it available for the dead or dying client and the families improves experience of support by families.
6. Ensuring that support structures are in place to assist the client, families and health professionals improves teamwork within the ED as well as the care being offered.

#### **4.3.7 Stage 2: During the sudden death**

Definition: This stage stretches from the time that the client is admitted to the ED in a critical condition, up until immediately after their death. This is usually within a couple of hours.

#### 4.3.7.1 Objective: Optimizing caring for palliative care in the ED

There are three processes namely proximity, sensitive communication and sensitive death-telling, comprising of this stage. This means that in order to ensure that the care offered to the dead or dying client and their bereaved families is optimal, these three processes need to be attended to.

##### *Process one: Proximity*

Proximity in this context refers to the family being kept as physically close as possible to the client. This is supported by Redley, et al., (2003) who discovered that being close to their critically ill loved one was ranked the second most important need of the families in their study. It is also necessary for the health professionals to keep the family nearby as the doctor or the nurse is then able to have immediate access to the family in order to provide essential information or to obtain vital information from the family (Wells, 1993). As soon as the staff are finished with the client, it is important to ensure that the family are given the opportunity to spend time with their loved one as the families in the study by Redley, et al., (2003) said they wanted to see their loved one as soon as possible.

Depending on the policy of the department, families' can also be present during the resuscitation of their loved one. The ED staff needs to remember that this

might be the last time that the families are able to speak to their loved one and they need to allow the families this precious time wherever possible.

*Process two: Sensitive communication*

Sensitive communication within this context refers to the flow of information between the health professionals and the family being as open, empathetic and responsive as possible.

Kim, Kaplowitz & Johnston (2004) found that improving the doctor's empathic communication skills could result in an increase in client satisfaction. Cantwell & Ramirez (1997) suggest that doctors make use of distancing tactics to avoid communication with clients and their families regarding psychological issues. The way that they do this is by focusing on the physical rather than the psychological aspects of care. These authors found that doctors in their study stated lack of time as the most important reason for avoiding questions about psychological problems. Wanting to avoid awkward questions, lack of skill in such issues and self protection were some of the other reasons stated. Ramirez, Graham, Richards, et al., (1995) cited in Cantwell & Ramirez (1997) showed that doctors who felt they were insufficiently trained in communication skills were at higher risk of burnout than those who were sufficiently trained.

Communication between the health professionals is also important and various members of the health team should feel able to approach and communicate with each other. The abrupt shift from providing physical and cognitive skills of resuscitation to the psychological, emotional skills needed for communicating with the families can be very difficult for most health professionals in the ED (Oliver, et al., 2001).

Communication between the family of the client and the health professionals is usually complicated by the fact that they are meeting each other during a time of crisis and this meeting takes place over a short period of time thus they do not get a chance to develop a relationship or rapport with each other (Ewins & Bryant, 1992). Redley, et al., (2003) emphasized that 91% of the family members they researched said that they placed importance on being told about the condition of their loved one before being asked to complete paperwork. The availability of a health professional being able to greet them on arrival and offer support was also of great importance.

Communication between the families and the health professionals should be open and honest at all times. Health professionals must try to keep the families updated on the client's progress. Even if there is nothing to report, they must tell the families this. Merlevede, et al., (2004) agree that families of the critically ill client should be updated frequently on the condition of their loved one and this should be at 15 minute intervals if at all possible. These authors suggest a



number of advantages to this namely the families feel cared for and acknowledged by the staff, the staff have an opportunity to create a trusting relationship with the family and are able to prepare the family for a possible fatal outcome. This communication can be very brief while busy with the client, a “he is still critical” will suffice until the staff have an opportunity to talk to the family.

Avoiding the families was viewed by the bereaved in Cycle 2 as being very hurtful and uncaring. Flam (1999) is of the opinion that the families have a fundamental right to accurate information about their loved one on a regular basis. Marrow (1996) also emphasizes that the family needs to know the information as quickly as possible, even if its bad news. This author suggests that during this time the families are desperate and this can make the minutes drag as time appears to have stopped. Keeping the families informed will help to reduce the element of surprise. If the family are informed about the seriousness of the situation, then a death is not such a surprise and the families would be able to handle it a little better because the news was expected (Wells, 1993).

Communication guidelines for talking to the family are suggested by Greenberg, et al., (1999) and these are the following:

- Greet warmly and don't be rude
- No “talking down” to the family
- Listen to what the family is saying and show interest
- Encourage the family to ask questions but do not lecture them

- Avoid medical jargon as excessive use of medical terminology may increase anxiety. All options should be stated clearly, be understandable to ensure there is no confusion and further clarification should be provided where necessary. Repetition of key concepts is essential (Wells, 1993).

Information should preferably be given by the same person to allow for the development of a relationship between the family and the staff member and also the building up of trust (Coolican, 1994).

The health professionals need to be aware of their non verbal communication. Sit with the family and don't stand over them as this conveys to the family that you are there for them. To remain standing makes one appear aloof and detached. Supportive eye contact should be maintained conveying feelings of caring and sensitivity (Thayre & Peate, 2003). Human touch is an important part of communication particularly when showing sympathy or shared emotions although this needs to be based on the individual health professional or family member – ensure that both are comfortable with what is being done. (Marrow, 1996).

Socorro, et al., (2001) discovered that when the emergency nurses interviewed felt at a loss for words with the suddenly bereaved families, they used non verbal communication such as a look or physical contact. Inappropriate words being used by the staff such as; "I know how you feel" did not improve the situation and that if in doubt the health professionals should rather say nothing. Thayre &

Peate (2003) also caution the health professionals not to be afraid of silences and not to feel the need to fill them with talk as this often leads to saying something inappropriate. These authors suggest that allowing the families this quiet time, allows them time to absorb and process the situation they find themselves in. Being there for the family during this time conveys that the health professionals are there trying to share the burden and this can be very powerful.

### *Process three: Sensitive death-telling*

Within this context, sensitive death-telling refers to telling the families in a very caring, compassionate way that their loved one has died. It is important for the health professionals to understand that the way in which bad news is delivered to the bereaved families can have a life-long impact on them (Jurkovich, et al., 2000). The individual who tells the family about the death will be a permanent part of the family's memories (Oliver, et al., 2001). Death-telling should be done in an area offering privacy so that the other clients are not affected and the families do not have to worry about other people watching them.

There should be more than one staff member present as the families are in crisis and one is never sure how they will react. The staff can also provide support for each other this way. Do not prolong the suspense of giving the bad news by asking unimportant questions, rather get straight to the point and give the family the news. Easily understandable words are essential and the facts need to be

repeated (Wells, 1993). The doctor should always be available to talk to the families at some point, but it doesn't have to be up to the doctor to break the news. This depends on the department's policy. Traditionally, the role of breaking the news was left with the doctors although the way the news is broken, and the interpersonal skills used in this situation greatly outweigh professional role demarcation. It does, however, remain important for the family to talk with the doctor at some point to have all their medical questions answered (Cooke, et al., 1992; Tye, 1993; McQuay, et al., 1995). Jurkovich, et al., (2000) supports this and suggests that as the seniority of the news-giver was not seen as an important aspect for the bereaved families, this task should rather be done by someone who is willing to spend the time with the family provided that they have sufficient information about the deceased.

Details of the resuscitation process should be provided by the people who were involved and time must be allowed to answer any questions that the family/significant others may have. Families have been documented to be specifically worried about whether or not their loved one experienced pain and this aspect should be emphasized to the family (Coolican, 1994; Wheeler, 1996). Reinforce the message to ensure that there is no confusion (Thayre & Peate, 2003).

Finlay & Dallimore (1991) cited in Tye (1993) revealed in their study how parents viewed the handling of the death of their child: 34 of the 120 respondents in the

study said that the news of the death of their child was badly handled or offensive and that the police were rated as being more sympathetic than the doctors and nurses.

After breaking the bad news, have a member of staff with the families for support and to answer any questions. Staff, who were with the client should be involved and all the details around the time of death should be remembered - especially any last words, and these must be passed on to the families as this can be of great comfort to them. When telling the family of the death, use words such as 'dead' or 'died' so that there is no mistake or doubt as to what the family are being told. Watch the language used, and do not say "I know just how you feel" or "its far better now, as he is at peace". Talk about the patient by their name, as this makes it more personal. Be comfortable with silence and be comfortable not saying anything and remember that nothing you are able to say will make the situation better for the loved ones while they are in a crisis.

According to Jurkovich, et al., (2000) the most important aspects of giving bad news are the perceived attitude of the news-giver; clarity of the message; privacy of the conversation and adequate knowledge of the news-giver so that they are able to answer the families questions successfully.

Organ donation needs to be considered. Oliver, et al., (2001) cautions that brain death is often a misunderstood term which can result in long term guilt of the

bereaved. The families need to be very clear what this concept means and that they are in no way contributing to the death of their loved one. Much time needs to be spent by the health professionals ensuring that the family were not responsible for hastening the death of their loved one.

The opportunity to view the body should be offered to the family as soon as possible after death. This should be encouraged, but never forced. The families need to be given privacy and not rushed. (Marrow, 1996). It is important to remember the last words spoken by the client and to tell this to the family. The family should be told that the client would not have been in pain – analgesia would have been given as standard protocol – as they take much comfort in this. The nurse needs to prepare the client to be seen by the bereaved. The nurse should try to make the client as presentable as possible by wiping the face clear of blood, brushing the hair etc if possible. Seeing your loved one with their face covered in blood can be extremely disturbing for the bereaved and it is an image that they will keep with them for always. Brushing the hair of the dead client also creates a lasting impression of caring staff. It is also suggested that the room should not be totally cleaned up or the equipment removed before the family has seen the body. This would make it apparent to the family that everything was done in an attempt to save the clients life.

Prior to viewing the body, the nurses should ensure that the family have been sufficiently informed about the altered appearance of their loved one so that it

does not come as a shock when seeing the body for the first time. The nurse should tell the bereaved family about any tubes, pipes or injuries that they may see in the clients body, and they should be warned that their loved one may feel cold to the touch (depending on how long ago the client died).

If the family view the body of their loved one in the mortuary, the nurse must accompany them to offer support and information as needed. The mortuary staff should be advised of the families visit and thus have the body ready for them. Remember that seeing your loved one in a mortuary is extremely difficult for the families, and the health professionals should try to make the situation as bearable as possible. Often just showing that you care about their loss can be extremely helpful!

#### 4.3.7.2 Propositions for Stage 2

1. The more opportunities to maintain the proximity of the family to the client the better the acceptance of the care and the client outcome (death).
2. The more sensitive the communication between the health professionals and the families the greater the level of support perceived by the families.
3. The more sensitive the death-telling the greater the level of support perceived by the families.

### **4.3.8 Stage 3: After the sudden death**

Definition: The focus of this stage is a short time after the death of the client, from approximately 30 minutes until a few days after the death.

#### 4.3.8.1 Objective: Optimizing support for those involved in palliative care in the ED

There are two processes making up this stage of the model namely; assisting the health professionals and assisting the bereaved families. The former process has two concepts which are stress management and death education. The latter has three concepts namely; information, property and follow up. This means that these two processes of assisting the health professionals and the bereaved families are required in order to ensure that optimal support is possible.

#### *Process one: Assisting the health professionals*

Lack of closure for the health professionals results because they don't know what happens to the family or why the client died (Socorro, et al., 2001). Knowledge of autopsy reports can be of help.



## Concept one: Stress management

Stress management within this context refers to the health professionals being provided with the opportunity to verbalize their thoughts and feelings and to receive some type of support. Witnessing the trauma of others on a regular basis is intense, and all health professionals need to be given the opportunity to validate their own grieving in some way. Often these staff members feel uncared for as they perceive that their co workers and management expected them to just carry on. This can result in a highly skilled practitioner looking for other employment (Levetown, 2004). Health professionals who work in the ED are generally not comfortable with clients dying as this is not the work of the ED, it is rather to save the life of the client. Often the health professionals are then left feeling a deep sense of failure (Wright, 1996).

The health professionals need to feel supported by the other members of the health team. This can be done formally during debriefing sessions or informally over a cup of coffee. The organisational culture in the ED needs to be one where the staff feel supported by the other members of the health team (doctors and nurses) and by management. Remember, staff have their own culture and experience and need to cope or perceive support in different ways. There needs to be a set policy that happens in the department, e.g. every Friday a social worker comes around for an hour to see the staff and to talk informally. The staff are then more likely to feel comfortable enough to approach the social worker individually for help.

Many health professionals debrief by talking to their husbands or a close family member about the day's events. Gibson, et al., (2002) suggests that this may not be the best approach as one would not tell the whole story in order to protect your loved one from hearing the upsetting details. These authors suggest that ones colleagues are best suited to give support as they know exactly what you are being exposed to.

Nurses involved in a management position need to pay particular attention to this. In order for the nurses to approach the nursing manager for help regarding stress or not being able to cope with the situation, the manager needs to be aware of how they are perceived by the staff. Many nurses would never admit to their manager that they were not coping because the manager would then see them as incompetent nurses or may move them to another department. The nurse also needs to be aware of the fact that other members of the health team experience stress, e.g. the doctors. It is thus important for the nurse to remember this when dealing with a difficult situation like telling the family about the death of their loved one. The nurse should not allow the doctor to face this alone, but should be there for support.

There are a number of things that the nurse can do to manage stress and thus prevent the development of stress disorders.

- acknowledge that the work situation does affect you

- take regular leave to allow time to get away from the work situation and to relax
- regular exercise and a healthy, balanced diet
- get enough sleep
- relaxation techniques: time alone to allow yourself “me” time
- talk over the incidences in the day with colleagues, friends or family, particularly if they were difficult or distressing
- speak to a trained counsellor if necessary
- watch for signs of stress in colleagues and offer them support

Remember that in order to care effectively for your clients you need to care for yourself. The health professionals need to be aware and sensitive to personal needs or issues that you may have which increases their vulnerability. Clarify individual, team and organizational roles and responses can help decrease stress (Thayre & Peate, 2003).

#### Concept two: Death education

Death education within this context refers to providing the health professionals with the necessary knowledge and skills regarding the management of the dead or dying client as well as the suddenly bereaved.

Workshops could also be held to educate health professionals about breaking bad news to clients. These workshops have been shown by Farrell, et al., (2001)

to be very beneficial, as the participants reported increased awareness about breaking bad news issues and the identification of strategies which could promote effective clinical practice. These participants were of the opinion that one of the most beneficial aspects of the workshop was the sharing of personal and collective experiences. By getting the nurses together at workshops to increase their knowledge about how to deal with death could help reduce their stress levels as well. These workshops allow people to talk about experiences they had which were particularly distressing and let others learn from their experiences.

In the work environment, it may be helpful for the nurse to draw up protocols to be used when dealing with death. These can be tailor made to suit the environment where the nurse is working; be it a clinic, hospital or in the client's home. These protocols can then be used to guide the nurse in providing holistic care for the dying client, their families and their nursing colleagues.

### *Process two: Assisting the bereaved families*

#### Concept one: Information

Information in this context refers to the collection of the necessary data or facts regarding sudden or abrupt deaths for the suddenly bereaved.

Jurkovich, et al., (2000) carried out a study amongst bereaved families in Seattle, Washington, looking at the giving of bad news. The findings suggested that the families felt that the health professionals were worst at giving them information about the likelihood of an autopsy. Due to legal requirements, most clients dying a sudden/abrupt death are required to undergo an autopsy. My findings from Cycle 2 suggest that visiting the mortuary and issues surrounding the autopsy can expose the bereaved families to secondary trauma. It is for this reason that the health professionals need to ensure that adequate information is given to the bereaved families regarding the autopsy. Oppewal & Meyboom-de Jong (2001) discovered in their research regarding family members experiences of autopsy, that the families were often not given enough explanation as to what was involved in an autopsy. These authors suggest that the best way of explaining an autopsy is to compare it to an operation, and the health professionals need to be aware that the families may be concerned about what their loved ones body will look like after the autopsy.

Oppewal & Meyboom-de Jong (2001) also point out that the health professionals giving the autopsy results need to emphasise the fact that the client did not suffer as this can be of great comfort to the bereaved families. Oppewal & Meyboom-de Jong (2001) discovered that several family members were reassured by the autopsy results and that receiving clarification about the cause of death was important for these family members. Documentation from the hospital should be sent to the mortuary without delay, so as not to postpone the autopsy. The

families also needed information about how to contact the health professionals involved in helping their loved one as later questions could then be easily asked. The families often experienced great difficulty in getting in contact with the health professionals in order to ask their questions.

#### Concept two: Property

Property in this context refers to any tangible possession that was owned by dead client that is what the client then had on their person when they arrived in the ED.

Great distress can be experienced by lack of thought regarding the handling of property (Marrow, 1996). Handing over the property should be done with great care. The families can read much into the way the health professionals handle the clothes as this was perhaps the way they handled their loved one – just stuffed into a garbage bag! The nurse needs to take time to pack the clothing neatly and to hand it over with care to the bereaved families. Valuables need to be handed over as per institutional policy and the nurse needs to take great care with this as handing over valuables to the incorrect member of the family can create problems. Remember that the clothes and valuables are extremely important to the family as these are often seen as a part of their loved one. The clothing and property of the patient should be given to the relatives during the

immediate care of the client as leaving the hospital with the possessions of the deceased makes the bereaved confront the reality of the situation.

Remember to prepare the families about what the clothes will look like e.g. blood, wet, cut up. If clothing is to be retained by the police, the family need to be informed. For some families, washing their loved ones soiled clothing for the last time is something they can do in a situation where they are feeling very helpless (Marrow, 1996). Oliver, et al., (2001) mention that the families want every item from their loved one and thus the health professionals need to ensure where possible, that all clothing and personal effects are kept and returned to the families

### Concept three: Follow up

Within this context, follow up refers to the way in which the health professionals are able to remain in contact with the bereaved families for a short period after the death of their loved one. Follow up services for the families are important.

Merlevede, et al., (2004) described how the bereaved families in their study showed a great need to understand the exact cause of death of their loved one, and that most families left the ED with unanswered questions which then needed answering later on. Information on who to contact in order to answer these questions would be of great assistance to these families. The family pamphlet

developed contained a space where the health professionals could add the name of a contact person. A list of counselors, psychologists and support groups could be useful. The families should also have the names and contact details of the health professionals who dealt with their loved one and be told that they can phone for more details or to ask questions in the future. A follow up call to check how the families are doing has been mentioned to be beneficial. McClelland (1993) also suggests that a card or letter can be sent to the families approximately one month after the death. An information booklet will help in providing this information.

A bereavement coordinator has been suggested (McClelland, 1993) who is then able to follow up the bereaved families and ensure that all is in place to assist them as well as being able to liaise with bereavement organizations. This person is also responsible for staff development and assisting the staff in being able to manage deaths in the department.

A booklet for the family outlining the following; how to register the death and obtain a death certificate; the bereavement process; and contact numbers of support groups and counselors, could be extremely beneficial to the newly bereaved (Wright, 1996). The families also need to be informed by the nurses or doctor if an autopsy is to be performed on their loved one, as it is not appropriate for them to receive this information once they are trying to bury their loved one. Contacting the bereaved relatives after the incident can also provide the relatives



with further help and information, This could be done telephonically or by letter (Ewins & Bryant, 1992). Do not send the family home alone and, if possible, telephoning their home to ensure their safe arrival is a caring and compassionate way of concluding your role (Thayre & Peate, 2003).

#### 4.3.8.2 Objective: Optimizing evaluation of palliative care in the ED

There are two processes making up this stage of the model namely, getting feedback and making modifications. In order to achieve optimal evaluation of the palliative care being offered in the ED, feedback needs to be obtained and the necessary modifications made.

##### *Process one: Getting feedback*

Feedback in this context refers to the health professionals receiving information regarding the way in which they manage sudden/abrupt death in order to make the necessary changes to improve their performance in any way.

Due to the methodology used, opportunities for the staff to reflect on their practice and to then make the necessary changes were needed. By obtaining feedback from the health professionals in the department or hospital and the families, the model and instruments developed could be evaluated. Regular

evaluation is necessary to check if the model and instruments are relevant and to keep the additional information i.e. contact numbers up to date.

#### *Process two: Making modifications*

Modifications within this context refers to the act of making small alterations or adjustments to the Three Stage Death Model to ensure it remains relevant and useful to clinical practice. Making changes to the model increases the ownership, as this allows for the model to be adapted to a specific unit or team. This also allows for new technology or ideas to be incorporated.

#### 4.3.8.3 Propositions for Stage 3

1. Providing stress management for the health professionals allows them to feel supported and improves teamwork.
2. Death education for the health professionals allows them to feel more confident in their management of sudden deaths and thus improves the death-telling and support of families.
3. Information made freely available to the bereaved families allows them to feel more supported by the health professionals and better equipped to deal with the death of their loved one.
4. The better the handling of the property the greater the level of support perceived by the bereaved families.

5. The better the follow up the better supported the bereaved families will feel.
6. The more feedback obtained regarding the model, the more optimal the evaluation will be.
7. The more modifications made to the model, the more care will improve.

#### **4.3.9 Feedback loops**

It is vitally important that the information obtained through the evaluation of the model has a way to influence and shape the model at each different stage. The feedback loops fulfill this function. The information obtained from feedback from the health professionals as well as the bereaved families can be evaluated and used to make changes to the model to ensure that sudden death is being managed in the most therapeutic possible way in the ED.

### **4.4 Cycle 4**

#### **4.4.1 The setting and participants**

Three Level I ED's in KwaZulu-Natal (Hospitals C, D and E) were included in this cycle. I had planned to implement the model in two ED's but the co-researchers from the third hospital were very enthusiastic and willing to continue as part of the research and thus they were included.

The co-researchers from three Level I ED's in KwaZulu-Natal (Hospitals C, D and E) and other clinical and managerial staff (including the doctors) were involved in this cycle. As the research progressed, and due to the prolonged engagement necessary in action research, there were changes in the co-researchers. Table 4.5 describes the co-researchers involved in each of the cycles.

**Table 4.5 Profile of the co-researchers**

Hosp.	Cycle 1	Cycle 2	Cycle 3	Cycle 4
<b>C</b>	Unit manager plus two clinical staff (registered nurses)	Unit manager and one clinical staff member (registered nurse)	Unit manager and one clinical staff member (registered nurse)	Unit manager and one clinical staff member (registered nurse)
<b>D</b>	Unit manager plus one clinical staff (registered nurses)	Unit manager resigned and the clinical staff co-researcher took over as the unit manager	Unit manager	Unit manager
<b>E</b>	Unit manager	Unit manager and two clinical staff members (registered nurses).	Unit manager resigned and the one co-researcher	

#### **4.4.2 Data collection**

The data in this cycle was collected from the implementation workshop as well as from the focus groups held in each of the three ED's, six weeks after the implementation workshop.

##### 4.4.2.1 The implementation workshop

Workshops involving the health professionals (both clinical and management staff) were planned for each of the three ED's. The objective of the workshop was to explain the model being implemented and to discuss any potential obstacles and concerns. The participants from Cycle 3 had also suggested that additional information about death and dying should also be included in this workshop to improve the death education of the staff attending. The co-researchers suggested that one workshop involving all the departments should be arranged as this would allow the opportunity for the different departments to meet each other and pool their thoughts and ideas. This proved to be very difficult to organize as I had to find a time and venue which would be suitable for all three institutions.

I eventually managed to arrange a venue at the university where I was employed. This was central for the three institutions and also then ensured that all the staff would be meeting on neutral ground. Invitations were sent to the various institutions in order for the staff to arrange with their hospital management to

have the time off work to attend. The time chosen was around lunch time as one of the co-researchers had to attend an important meeting later in the afternoon. Six participants (all registered nurses) from two of the three ED's were present at the workshop. The one ED (Hospital E) had planned to send staff but decided at the last minute that they would be unable to attend due to a department inspection.

I started the workshop with introductions and then asked the participants to complete some worksheets which forced them to reflect on their own ideas of death and dying. There was much discussion and debate surrounding these questions and a number of the participants felt comfortable enough to share intimate experiences of losing their own loved ones. This was purely voluntary.

Time was then spent discussing the proposed model and the instruments which had been developed. I emphasized the fact that the model should not be seen as complete and all staff using the model should feel free to suggest any changes they felt could improve it. There was much debate surrounding the use of colour in the model. Time was also spent discussing the family pamphlets and the checklists which had been developed. See Annexure N, O and P for the family pamphlet (in English and Zulu), the Preparation Checklist and the Incident Evaluation Checklist. A lively discussion followed concerning the appearance of the family pamphlet as some of the participants wanted it to have a picture on the front.

I attempted to make the workshop environment informal and encouraged active participation from the participants at all times. Lunch was provided which then allowed for more time for the participants to talk to each other and there was much sharing of ideas and experiences. The participants did mention that it was unfortunate that the staff from Hospital E were not able to attend as the participants felt that they would have been able to contribute a great deal to the discussions.

#### 4.4.2.2 Evaluation of the workshop

The participants of the workshop were asked to complete a workshop evaluation form at the end of the workshop. The participants were asked if this model would help in managing sudden death and they said that it definitely would. One participant said that the model; "*would help the department to develop their own guidelines*". The participants liked the fact that the model was simple and easy to use as well as containing all the necessary information. The participants particularly liked the family pamphlet and thought that the other checklists would help guide the staff and make the staff more prepared to deal with sudden death in the ED. A participant said that the model and instruments would make the staff's job easier to do by ensuring that all the necessary information is in place.

After the workshop I visited Hospital C and D to deliver the family pamphlets, checklists and property bags. When handing this over to Hospital C the co-

researcher told me that she had been waiting for these goods before putting them all together in a box so that all the necessary tools would be quickly available to the staff. She had already completed the "Preparation Checklist" and started to put in place things that were missing. In Hospital D the co-researcher told me that I would be very happy with the changes already made in the department. She had already compiled a list of funeral homes for the staff to have available. She had a file ready to put all the information in and had already told the staff about the workshop. Both of these co-researchers thanked me for the valuable information and both had enjoyed the workshop and found it to be very beneficial. They were also very happy with copies of the family pamphlet in English and Zulu.

These co-researchers were also concerned about the fact that the family pamphlet did not have a picture on the front of it. I asked them to think about what picture should be on the front taking care to remember that the picture should not be associated with any religion, funeral home, hospital etc. This proved to be quite difficult. I had also obtained a number of English pamphlets from The Compassionate Friends and gave a selection of these to the departments. The topics of these pamphlets covered violent death (murder), death from a road traffic collision, children understanding death, suggestions for health professionals dealing with deaths and an outline of the principles of The Compassionate Friends. I asked the health professionals to look at the pamphlets and decide which would be useful for them to hand out to their clients.



The idea suggested was that the health professionals would then place a suitable pamphlet in with the deceased's clothing so that when unpacking them later on the bereaved families would find the pamphlet and know where they could access support should they wish to.

A separate focus group discussion was held two weeks after the implementation workshop with Hospital E. I met with four staff members (3 registered nurses and 1 student nurse) in a private office. Due to time constraints I only discussed the model and the accompanying instruments; exploring their beliefs concerning death was not done. When I started discussing the model and the instruments the co-researcher said; *"this is very interesting...we really need this now as we're having big problems"*.

#### *Family pamphlet*

The family pamphlet was designed from the data collected (from the health professionals, bereaved families and the mortuary staff) and from relevant literature. See Annexure N. The broad outline was verified by the co-researchers and changes were made during Cycle 3. Due to the sensitive nature of these pamphlets I asked educational and mental health specialists to examine the pamphlet to ensure it was sensitive and appropriate. A bereaved family member involved in the research was asked to look at it and she said that I had captured all the important points and seemed to know exactly what bereaved families were

going through. This pamphlet was then also translated into Zulu. The section on the post-mortem was difficult to write about for the families due to my observations which revealed the dehumanization of the body in the mortuary. I wanted to provide brief details about what happens in an autopsy in an attempt to reassure the families that their loved ones body would be treated with dignity and respect but the mortuary findings did not suggest this. As a result this section in the family pamphlet was very brief. I did add a warning to the family to try and prepare them for the mortuary so that the cold, institutional approach did not come as such a shock. In Cycle 4 the workshop participants spent time reading through the pamphlet and the co-researchers present said they were happy with their finished product.

### *Checklists*

These were designed from the data collected from Cycle 2 and from literature. See Annexure O and P. The health professionals involved in the research mentioned on a number of occasions that the way they deal with the sudden death situation is up to the individual. There were no policies or protocols to guide this practice and I was repeatedly asked to rectify this. Due to the time constraints, the participants said that they would then not have to waste time thinking about and planning what to do, they would rather have guidelines to follow. This would also possibly stop much of the current practice which is based on trial and error. Some of the staff wanted to use this while they were dealing

with the sudden death in order to guide their practice, and others would use this afterwards as a way of evaluating. The use of these checklists could be decided by the individual departments.

#### 4.4.2.3 The evaluation of the implementation

Regular contact was kept with the implementation team (co-researchers) in order to monitor the progress of the implementation of the model over six weeks, and to be aware of any problems or difficulties experienced. Arrangements were then made to hold focus groups in the different ED's to hear about their experiences of implementation and to hear about any changes being suggested to the model or the instruments. I arranged a time to meet with the staff (whichever ED staff (doctors and nurses) were interested) in the individual departments. The focus group was held in their staff tea lounge or a private office. The participants were reminded of the issues of confidentiality and the right to withdraw from the focus group at any time. I asked the staff the following questions:

1. What has changed in the way you and your department deal with sudden deaths?
2. When considering the model and the instruments, what could you use?
3. What could you not use?

I did not use a tape recorder to record the session as in the previous cycles I had experienced how the sight of the tape recorder made the participants hesitant to

talk. Instead I just made notes while the participants were talking. In Hospital D, I interviewed the co-researcher and one of the doctors on duty. In Hospital C, I held a group with two of the co-researchers. Hospital E was unavailable.

#### **4.4.3 Findings of the evaluation**

No sudden deaths had occurred in any of the hospitals within the six weeks, although Hospital D said that they had used the model to manage three natural, expected deaths and had found it to be extremely useful. The co-researcher in this department had used the Critical Evaluation Checklist a day after the death and had gone through it with the staff member involved in the death. She said that this had been a beneficial experience for them both.

##### 4.4.3.1 Changes to managing sudden deaths

The participants said that being involved in the research and helping to develop the model and instruments (family pamphlet and checklists) had changed their practice. One of the participants said that having the model to use when managing a death provided her with closure. She could evaluate her practice and know that she had done what she was supposed to do. She said that it also gave meaning to the actions she was carrying out.

One of the participants said that being involved in the research had made her very aware of the importance of preparing the families to visit the mortuary and she would now provide them with information so that the environment would not come as a shock to them. Another participant said that she was now acutely aware of the small gestures and how important these were to the bereaved families. She explained how in the past she was always very aware of making the environment around the deceased presentable but now she paid particular attention to combing the hair of the deceased. The participants agreed that they had never thought about the importance of these small gestures before but now they would use this in their practice.

The co-researchers had already made changes in their departments in that there were files and boxes available containing all the information necessary to deal with death in the department. The co-researcher in Hospital C had already initiated visits for her staff to a mortuary and had asked various mortuaries to provide her with pamphlets which were then available to the families in the ED.

The co-researcher in Hospital D said that the research had highlighted the fact that she needed to arrange for counseling in the department. She said that after being involved in the research she was now aware that the suddenly bereaved families needed more counseling than the little the staff was currently able to offer. She is busy trying to arrange for this as well as to establish counseling for the staff members.

The doctor interviewed said that the model appeared very comprehensive and could be really useful as one could never know enough about death. She agreed that she may look at the model to help her when managing a sudden death in the department. She had already seen the family pamphlets and thought they were useful.

#### 4.4.3.2 Changes to the model and instruments

No changes were suggested to the model or the instruments, although the co-researchers said that they would continue to use the model and evaluate it to see if they discovered any changes that needed to be made in the future.

Hospital C had gone so far as to encourage people to read the family pamphlets and asked them for feedback. One of the participants described how she was busy telling a staff member about the family pamphlet when a client who was having his dressing changed asked if he could look at it. She then gave him the pamphlet to read and asked for his comments. He said that he thought it was a really good pamphlet which contained important information.

One of the unit managers in this hospital also asked to see the pamphlet. Her daughter had died suddenly three years ago and this staff member started crying while she was reading it. She told the co-researcher that she wished she had

been able to read the pamphlet three years ago as it contained vital information which she had battled to obtain at the time. She said that she had not known what documentation etc to complete and this pamphlet would have been a great help. She told the co-researcher that it was a very good pamphlet and she would make use of the information in her professional role in the hospital.

The co-researcher at Hospital C also told me that they had already asked their hospital if they could have packets made with the hospital logo to use when handing the property of the deceased to the families as well as developing a family pamphlet for natural, expected deaths. This co-researcher felt that much of the information already obtained for the sudden deaths could just be modified and would then be useful to the rest of the hospital.

The participants thanked me for the research although I reminded them that it was, in fact, their research. I asked them if they were not able to recognize their own contributions to the model and instruments and they all acknowledged that they were able to recognize this. The co-researchers also emphasized that they needed to use the model when managing a sudden death and they would then be in more of a position to evaluate and suggest changes.

#### **4.5 Conclusion**

The four cycles carried out were described in detail. Cycle 1 was concerned with establishing if there was a need for the research and if staff would be interested in participating. Cycle 2 explored the experiences of dealing with sudden/abrupt deaths from the perspectives of the nurses, doctors, mortuary staff and the bereaved families. Cycle 3 involved the development of the model and during Cycle 4 this model was implemented. The Dealing with Sudden Death Model is an intervention model to help guide the practice of the health professionals dealing with sudden/abrupt deaths in the ED.



## **CHAPTER 5:**

# **CONCLUSION**

*"Then the Almitra spoke, saying, We would ask now of Death.*

*And he said:*

*You would know the secret of death. But how shall you find it unless you seek it in the heart of life? The owl whose night-bound eyes are blind unto the day cannot unveil the mystery of light. If you would indeed behold the spirit of death, open your heart wide unto the body of life. For life and death are one, even as the river and the sea are one".*

**KAHLIL GIBRAN**

## **5.1 Introduction**

I undertook a four year action research project with health professionals working in three Level I ED's in order to foster a change in practice by involving the clients (dead or dying clients and their families) and health professionals with a view to improving the management of sudden or abrupt deaths in the ED. I approached the health professionals working in the Level I ED's of KwaZulu-Natal in order to establish if there was any support for the idea of a model to aid in the management of sudden death. There was an enthusiastic response from the health professionals who thus became very committed to the research and initiation of change in the way in which they managed sudden death in their departments. I attempted to remain true to the mutually collaborative action research approach adopted (Holter & Schwartz-Barcott, 1993), and ensured that the health professionals were encouraged to be actively involved in shaping this research.

I created an action research team comprising of registered nurses, both clinical and managerial, who had volunteered to become co-researchers in the research. Some of these researchers remained involved over the four years of the project and helped to ensure that the change being initiated was relevant and appropriate for the clinical area of concern. Thus the action research team comprised of nurses from three of the departments, although due to work and personal commitments they never all met together. Action research is a cyclic process, which involves planning, acting and reviewing or reflecting, with each

cycle resulting in better action and better research (Dick, 2002). This methodology is particularly relevant to the study of nursing issues as the knowledge gained is “grounded” in the actual practice and is validated and revised through its practical application. It can also be used to bridge the gap between theory, practice and research (Holter & Schwartz-Barcott, 1993). The research methodology required prolonged engagement with the participants and the research setting. This resulted in the fact that I would sometimes be stopped by staff who wanted to tell me about their own stories of death and bereavement or to pledge their support for the project.

When involving the other participants of the study namely, the bereaved families and the mortuary staff, I was thanked on numerous occasions for being interested in this field. The bereaved families thanked me for being interested in their deceased loved one, and for the fact that someone as interested in exploring what the experience was like for them and what could have helped them. Making contact with these bereaved families was extremely difficult because of the restrictions placed on the sampling methods to be used to identify these families. This was due to the extremely sensitive nature of the research. The interviews with the bereaved families were also extremely difficult for me in terms of having to listen to their stories and witness their suffering. The mortuary staff were very surprised that someone was interested in their experiences. Both of these groups were enthusiastic about the research and ready to help wherever they were able to.

The development of the Dealing with Sudden Death Model was an exciting cycle, for the co-researchers and myself. It was seen as the culmination of a number of years work and for the co-researchers this was when they were able to see concrete results of their efforts and the development of tools which they had been wanting four years ago.

### **5.1.1 Spin off spirals**

McNiff (1988) describes the ability for an action research study to deal with a number of problems at the same time by allowing the development of spin off spirals. In reality one problem may be symptomatic of many underlying problems and thus these spin off cycles allow the researcher to explore other issues without losing sight of the main focus of the research. During the exploration of sudden death and its therapeutic management in the ED, I became aware of the importance of the autopsy and the mortuary setting. I was able to pursue this to some extent by interviewing mortuary staff and by carrying out observations at a mortuary. The problems uncovered were that the mortuary experience for the bereaved families could result in secondary trauma for these families. Issues between the health professions and the mortuary staff were explored and attempts made to rectify the problems which caused delays with the autopsies. The mortuary staff were very enthusiastic that their story should be heard and I was able to do that.

I acted as a facilitator for change by guiding and providing information to the participants which then allowed them to self-reflect and identify problems, their cause and possible solutions. This self-reflection was essential to enable the change process to go ahead and hopefully continue without me. The resulting new and common understanding of the identified problems and causes, which is referred to as local theory, and the resulting model to guide the management of the clients is hoped to ensure that change is implemented in the ED.

### **5.2 Outcomes of the study in terms of change.**

The aim of the study was to use action research to change the management of client's dying suddenly in the ED. At the start of the research I asked the participants how they manage sudden/abrupt death' in their departments and a wide variety of descriptions were given. A large number of the participants said they didn't know what to do and often they would rather avoid the situation and leave it to another staff member. When discussing managing death in the ED with them they said it was too time consuming and this limited what care they were able to provide.

By the end of the research a number of the participants would come up to me to initiate discussions regarding death and dying. There appeared to be a greater acceptance of the reality of death. The participants seem to be more open to discuss death and to talk about what they had or could do to help the dying

client, family or colleagues. I was told very proudly by some of the co-researchers about how they had followed the model and that it worked, or how they had made a “death information pack” containing all the information needed to manage sudden/abrupt deaths in the ED. The participants seemed very enthusiastic and excited about the fact that they had the concrete guides to follow to aid them where they had previously been muddled and lacking direction. The participants also said that the research had changed what they thought was important when managing sudden/abrupt deaths as they were now very aware of how important small gestures like combing the deceased’s hair, were to the bereaved families. The research had also highlighted their departments or their own weaknesses for example counseling availability or informing families about the mortuary experience.

### **5.3 Outcomes of the study in terms of the production of knowledge**

Holter & Schwartz-Barcott (1993) state that knowledge derived from action research is grounded in the actual practice situations. These authors go further to say that if the ultimate purpose in developing nursing knowledge is to improve nursing practice, then obtaining knowledge which has been validated and revised through practical application is of vital importance. Action research is thus ideally suited to provide for the development of knowledge in a practice orientated discipline like nursing.

In this study, a model was developed to guide the therapeutic management of sudden/abrupt deaths in the ED's. Along with this was the development of the family pamphlet, the Preparation Checklist and the Incident Evaluation Checklist. The model and checklists were developed from the data obtained from the health professionals, bereaved families and the mortuary staff. The co-researchers were nursing staff currently working in the ED's who then ensured that the model and the checklists were appropriate for the actual clinical situation. Following the evaluation of the implementation (Cycle 4) no changes were deemed necessary to the model or instruments, and the co-researchers had asked other staff and clients for their comments. This feedback was positive.

Higgins & Moore (2000) differentiate between four levels of theoretical thinking in nursing, namely; meta-theory, grand theory, middle-range theory and micro-range theory. Meta-theory is the most abstract and universal level of theoretical thinking, and is the theory of inquiry. Grand theories are "formal, highly abstract theoretical systems that frame our disciplinary knowledge within the principles of nursing, and their concepts and propositions transcend specific events and patient populations" (Higgins & Moore, 2000:180). Grand theories are said to describe and explain large segments of the human experience (Marriner-Tomey & Alligood, 2002). Middle-range theory is similar to grand theories in that it explains the empirical world of nursing but it is more specific and less formal. Micro-range theory is the least formal level of theoretical thinking and restrictive in terms of time and scope or application (Higgins & Moore, 2000).

Chinn & Kramer (1999) described how the need for practice linked theory resulted in the development of middle-range theories in nursing. Meleis (1987, cited in Chinn & Kramer, 1999) highlighted the need for nurses to move away from broad scope theories to develop a substantive theory which provided specific guidance for nurses in regard to specific practice concepts. Middle-range theories are described by Chinn & Kramer (1999:255) as "substantive theory that tends to cluster around a concept (usually clinical) of interest to nursing". A middle-range theory has a narrower focus and is more concrete than a grand theory in its level of abstraction. It is more precise and focuses on answering a specific nursing practice question. It contains information indicating the situation or the health condition, the patient population or age, the location or the area of practice and the actions of the nurse or the necessary interventions. (Marriner-Tomey & Alligood, 2002). Chinn & Kramer (1998) suggest that clinical nurses need middle-range theories to guide practice. Marriner-Tomey & Alligood (2002) suggest that middle-range theories have been developed from themes in qualitative research.

This Dealing with Sudden Death Model is a middle-range theory that is very action oriented, as my co-researchers were practitioners who needed and wanted something concrete that they could understand and successfully implement in the clinical situation.



## **5.4 Evaluation of a middle-range theory**

Five broad analysis criteria described by Marriner-Tomey & Alligood (2002) are used to review the Dealing with Sudden Death Model.

### **5.4.1 Clarity**

This involves the examination of the major concepts, sub concepts and their definitions in order to evaluate how clear the theory is. The words used in the Dealing with Sudden Death Model were carefully and specifically defined and these were related to the framework from which they were derived, namely sudden or abrupt deaths, and based on the qualitative data from which they emerged. The theory developed logically and the assumptions are consistent with the theory's goals. Three stages of managing sudden/abrupt deaths are clearly described as are the roles to be carried out by the health professionals (Marriner-Tomey & Alligood, 2002).

The theory also needs to be orientated to outcomes that are important for the clients and the theory should not just describe what nurses do (Nolan & Grant, 1992). The Dealing with Sudden Death Model has attempted to take into account the views of the health professionals as well as the users (dead or dying clients and their family). The conceptual linkages of the theory have also been provided in a diagrammed model.

#### **5.4.2 Simplicity**

This answers the question “how simple is this theory?” Dealing with Sudden Death Model is sufficiently comprehensive to include the vast amount of information available regarding sudden/abrupt deaths but this is provided in a way that appears very simple and easy to follow (Marriner-Tomey & Alligood, 2002).

#### **5.4.3 Generality**

To determine the generality of the theory one needs to consider the scope of the concepts and the goals within the theory. The more limited the concepts and goals, the less general the theory (Marriner-Tomey & Alligood, 2002). The Dealing with Sudden Death Model could be applied to many different situations (other than ED'S) where health professionals are expected to manage sudden or abrupt deaths of their clients, particularly Critical Care Units or Operating Rooms. The co-researcher were also of the opinion that this model can be successfully used to manage a natural, expected death as well.

#### **5.4.4 Empirical precision**

This aspect of evaluation is concerned with the testability and ultimate use of the theory (Marriner-Tomey & Alligood, 2002). The Dealing with Sudden Death Model is based on reality and the relationship between the theory and the

empirical data is available to other researchers to validate and verify. This model has not been tested, but its propositions are clear and can be tested. Specific instruments might need to be developed to measure some of the variables; e.g. support of families.

#### **5.4.5 Derivable consequences**

This criterium is concerned with reviewing how important the theory is. The Dealing with Sudden Death Model provides important and practical guidelines for the health professionals when dealing with sudden or abrupt deaths. These guidelines can be used to attempt to provide the therapeutic management of the dead or dying client, their family and the health professions colleagues. I do believe that this model can make a significant contribution to the nursing knowledge base.

#### **5.5 Limitations to the study**

The limitations to this research study are related to the chosen research design and the topic being researched. These limitations are inherent in action research as well as research conducted around a sensitive issue such as sudden/abrupt death.

### **5.5.1 Informed consent**

Meyer (1993) questions the extent to which participants in an action research study can actually give informed consent due to the fact that the proposed research only becomes clear as the process continues. In the present study there were many changes made to the original tentative research proposal, which then required that I had to resubmit the research proposal for additional ethical clearance. I also attempted to remain open to any signs of discomfort due to these changes, as shown by any of the participants. This initial tentative planning of the action research project also meant that I did not start the project with a clear plan, but rather that I had to develop methods and strategies whilst in the field.

### **5.5.2 Collaboration**

Collaboration between myself and the practitioner (co-researchers) is an essential feature of action research, although Meyer (1993) questions whether this is truly possible as there is a potentially threatening relationship between the researcher and the practitioner. This author suggests that the researcher has a position of power over the practitioner which then places the practitioner in a vulnerable position. I was keenly aware of this imbalance of power as I was seen by the practitioners as an "academic expert" who had a great deal more knowledge concerning research. I attempted to minimize this wherever possible by pointing out to the practitioners that I did not have the necessary knowledge

and experience of the "everyday" life of the ED, and had limited experience of managing sudden/abrupt deaths in the ED. Hart & Bond (1996) suggest that there is a problem when a researcher attempts to initiate the process of re-education for the purpose of achieving ones own goal, and also to empower the participants in the same process. Conducting research primarily for the purposes of a higher degree has the characteristics of the experimental type of action research because in terms of the educational base it has a strong scientific base and its researcher focused project is research led and had clearly defined researcher role. It is thus primarily the researcher who controls the project (Hart & Bond, 1996).

Collaboration was made more difficult due to the fact that there were a number of resignations and new staff appointments during the research period. This was however, particularly difficult when the ED unit manager of Hospital E abruptly resigned just prior to the model being implemented. The action research team never met and collaborated together and all the meetings with the co-researchers were done separately and the findings then pooled by myself.

I attempted to use the mutually collaborative approach to action research in this study. This approach, described by Holter & Schwartz-Barcott (1993) strives to achieve a more equal involvement between the researcher and the practitioners. On reflection however, I can only claim to have *encouraged* a mutually collaborative approach as I identified all the research questions and the

interventions in the study, which may have detracted from the level of collaboration from the practitioners. Kelly & Simpson (2000) suggest that there is a difference between the ideals of collaboration in action research and the reality, and that for change to occur in an organization there must be some amount of leadership. This was evident in Hospital E once the unit manager (a co-researcher) resigned, the change process was retarded. Cohen & Manion (1989, cited in Kelly & Simpson, 2000) are of the opinion that although collaboration is important for the researcher to aim towards, in reality, various levels of collaboration are likely to be encountered. The limitations of the mutual collaboration approach are that the change implemented is associated with the individuals involved in the change process and the intervention tends to be short-lived if these individuals leave or a large number of new people enter the system.

### **5.5.3 Confidentiality and anonymity**

The issue of confidentiality and anonymity is also a concern as I was involved in three Level I ED's for approximately four years. The practitioners in these departments were thus very aware of who was involved in the research and thus it may be possible, once the research is written up, to identify the individual participants. Meyer (1993) voiced the same concerns and questioned the morality of making a participant vulnerable to the unknown in such a public way and then calling it research. Williamson & Prosser (2002) emphasize that the issue of confidentiality and anonymity need particular attention when the action

researcher is from inside the organization and the research results have potential consequences for their careers, although this was not an issue for the study.

#### **5.5.4 Other limitations**

I was unable to transfer the findings from this research study because of the small sample used. There was also a problem in accessing bereaved families to participant in the research and I was thus forced to access the majority of these participants through a support group. Recall bias is an inherent limitation in this study as the participants were asked to recall information that had occurred months or years before (Burns & Grove, 2000). A limited amount of time - six weeks - lapsed before I evaluated the implementation of the model in the ED's. Due to this short period of time the ED's had not been able to utilize the model as no sudden deaths had occurred, although they had used the model for expected deaths.

### **5.6 Recommendations**

#### **5.6.1 Service**

The values and mission of the health team working in the individual ED needs to be explored to promote cohesion and collaboration between the different health professionals. Support services for the health professionals needs to be attended to, and this should be initiated in the departments as a permanent feature. This

should not just include nurses but doctors as well, which could then aid collaboration and teambuilding in the ED.

A bereavement coordinator (McClelland, 1993) could be introduced to follow up the bereaved families and ensure that the ED is prepared to deal with sudden, abrupt deaths. This person would also be responsible for staff development and assisting the staff in being able to manage deaths in the department, although there would however be cost considerations. The bereaved families also suggested that attempts be made to set up a contact network of people (with bereavement experience) who would be willing to be called out to sit with the families of the critically ill, as having the extra staff to allow one nurse to fulfill this function is often just not possible.

There appears to be a lack of support groups for the bereaved in the Durban Metropolitan area and its surroundings. The only support group available, which is not affiliated to any religion or culture, is the Compassionate Friends which is for grieving parents, siblings and grandparents. They receive numerous queries regarding the availability of other support groups, and they have identified a specific need for a support group for bereaved children. There is a Christian group for bereaved spouses, although due to its religious ties, it is not suitable for all cultures. Another issue raised was that the bereaved Africans appear to grieve differently and ways need to be explored in order to cater for their needs in a culturally appropriate and sensitive way.



### **5.6.2 Education**

Death education for health professionals still remains a priority as well as stress management and coping strategies. This information needs to be added to the curriculum of the various categories of health professionals. Attention needs to be given to the exploration of the individual's beliefs of death and dying and also for health professionals to understand that death is an aspect of the work we do and that death should not just be seen as a failure.

Communication patterns between the health professionals should also be discussed and attention paid to the differences inherent in the different roles played by the health professionals. Collaboration between the different health professionals should be encouraged and perhaps the integration of nurses and doctors when they are still students would allow for socialization and understanding of the different roles and views. Medical and nursing schools need to include some inter-professional education in their curriculum in order to promote shared experiences, and a better understanding of the complementary roles of doctors and nurses within the health team.

### **5.6.3 Research**

Due to the prolonged nature of action research it is advisable to have a fairly large number of co-researchers as they are lost as the staff move around. ED's are an area where there is quite a movement of staff due to the stress of the job

and the lure of well paid jobs overseas due to these professionals valuable training and experience. The scope of this research study did not allow for the evaluation of the developed model and thus this needs to be carried out. The co researchers were of the opinion that this model is not and should not be limited to the ED. They felt that this could be used throughout the hospital, particularly in the Critical Care Units, and this could be explored. There are many research opportunities available concerning the mortuary - particularly related to the experiences of the mortuary staff - and the experiences of the bereaved families.

### **5.7 Conclusion**

Sudden or abrupt deaths occurring in the ED's can present a possible crisis for the bereaved families as well as the health professionals witnessing the death of the client and the suffering of the newly bereaved. The management of these deaths directly influences the outcomes for the bereaved families and the health professionals. "Trial and error" management by the health professionals is very dangerous as the staff are muddled, wondering what they should be doing and having no time to fully plan their care.

Optimizing the ED so that it has the necessary tools to manage sudden death, optimizing caring and support will ensure that the dead or dying client, the bereaved families and the health professionals are managed in the most therapeutic way possible. Optimizing the evaluation will ensure that the change

process initiated continues to improve and remain relevant to the needs of those dealing with sudden death in the ED.

Death is a very sensitive subject for many individuals to talk about as we all have our own beliefs based on our experience, religion and culture. As a health professional we are called to assist those who are dying and those who are bereaved, and it should be considered a privilege to attempt to make this situation as good as it can be for all concerned.

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## **ANNEXURE A**

### **The guide for focus groups in Cycle 1**

- Introduction of researcher and participants
- Procedure to be followed during the group
- Presentation of the research
- Questions to the participants:
  - What do you think about the proposed development of a model to deal with abrupt death trajectories in the ED?
  - Do you think that this proposed research would change clinical practice for the better?
  - Do you have other issues/problems in the ED which you would like to be addressed?
  - How would you go about addressing the issues/problems you highlighted above?
  - Would you be interested in becoming involved in carrying out research in your department?

## **ANNEXURE B**

### **The interview guide for the families in Cycle 2**

#### Biographical data

- Tell me your relationship to the person who died, how long ago the death occurred and where, and how the person died.

#### Structure

- Tell me about your experience of losing your loved in the ED
- What facilities were available in the ED which helped you during this experience?

#### Process

- What was good about the way in which you were dealt with?
- What was bad about the way in which you were dealt with?
- What helped you in this situation?
- What did not help you in this situation?

#### Outcome:

- Do you have any suggestions to improve care you received in the ED?

## **ANNEXURE C**

### **The interview guide for the health professionals in Cycle 2**

#### Biographical data

- How many years have you worked in the emergency field and do you have any additional emergency qualifications?

#### Structure

- Tell me about a recent experience you had where you lost a patient to an abrupt death in your ED.
- What facilities available in your ED have you used to help aid the experience for the family of the client and the health professionals?

#### Process

- What are the strengths and limitations with the present way you handle abrupt deaths in the department?
- What psychological support was made available to the family members and yourself?

#### Outcome

- Do you have any suggestions to improve the current way of dealing with these deaths in the ED's?

## ANNEXURE D

### The interview guide for the managers in Cycle 2

#### Biographical data

- How many years have you worked in the emergency field and do you have any additional emergency qualifications?
- How long have you worked as a manager in this department or others?

#### Structure

- What facilities are available in your ED to help aid the experience for the family of the client and the health professionals?

#### Process

- What are the strengths and limitations with the present way your department handle abrupt deaths?
- What psychological support is available for family members and health professionals?

#### Outcome

- Do you have any suggestions to improve the current situation in the ED's?



## **ANNEXURE E**

### **The interview guide for the mortuary staff in Cycle 2**

#### Biographical data

- How many years have you worked in the mortuary and do you have any additional qualifications?

#### Structure

- Tell me about a recent experience you had where you lost a patient to an abrupt death in your ED.
- What facilities available in your ED have you used to help aid the experience for the family of the client and the health professionals?

#### Process

- What are the strengths and limitations with the present way you handle abrupt deaths in the department?
- What psychological support was made available to the family members and yourself?

#### Outcome

- Do you have any suggestions to improve the current way of dealing with these deaths in the ED's?

## ANNEXURE F

### **The guide for focus groups in Cycle 3**

- Introduction of researcher and participants
- Procedure to be followed during the group
- Presentation of the model
- Questions to the participants:
  - Do you find the model easy to understand?
  - Does this model provide you with sufficient guidelines on how to deal effectively with abrupt deaths in your ED's?
  - Do you think this model will be practical and easy to use?
  - Do you think this model could change the present way of dealing with abrupt deaths in your units for the better?
  - Do you have any suggestions or recommendations to improve this model?



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**RESEARCH ETHICS COMMITTEE**

Student: MS Petra Brysiewicz

Research Title: The development of an intervention model for managing abrupt death trajectories in KwaZulu-Natal level-1 emergency departments

A. The proposal meets the professional code of ethics of the Researcher:

YES  NO

B. The proposal also meets the following ethical requirements:

	YES	NO
1. Provision has been made to obtain informed consent of the participants.	<input checked="" type="checkbox"/>	<input type="checkbox"/>
2. Potential psychological and physical risks have been considered and minimised.	<input checked="" type="checkbox"/>	<input type="checkbox"/>
3. Provision has been made to avoid undue intrusion with regard to participants and community.	<input checked="" type="checkbox"/>	<input type="checkbox"/>
4. Rights of participants will be safe-guarded in relation to:	<input checked="" type="checkbox"/>	<input type="checkbox"/>
4.1 Measures for the protection of anonymity and the maintenance of confidentiality.	<input checked="" type="checkbox"/>	<input type="checkbox"/>
4.2 Access to research information and findings.	<input checked="" type="checkbox"/>	<input type="checkbox"/>
4.3 Termination of involvement without compromise.	<input checked="" type="checkbox"/>	<input type="checkbox"/>
4.4 Misleading promises regarding benefits of the research.	<input checked="" type="checkbox"/>	<input type="checkbox"/>

Signature of Student: [Signature] Date: 5/6/2002

Signature of Supervisor: [Signature] Date: 10/6/2002

Signature of Head of School: [Signature] Date: 10/6/2002

Signature of Chairperson of the Committee: [Signature] Date: 30/7/2002  
 (PROFESSOR M MORRIS)

# ANNEXURE University of KwaZulu-Natal

The Universities of Durban-Westville and Natal merged to become the University of KwaZulu-Natal on 1 January 2004

## RESEARCH ETHICS COMMITTEE

Student: PETRA BRYSEWILZ

Research Title: The development of an intervention model for managing abrupt death trajectories in KwaZulu-Natal Level 1 Emergency Departments - amendments to the research project.

A. The proposal meets the professional code of ethics of the Researcher:

YES  NO

B. The proposal also meets the following ethical requirements:

	YES	NO
1. Provision has been made to obtain informed consent of the participants.	✓	
2. Potential psychological and physical risks have been considered and minimised.	✓	
3. Provision has been made to avoid undue intrusion with regard to participants and community.	✓	
4. Rights of participants will be safe-guarded in relation to:		
4.1 Measures for the protection of anonymity and the maintenance of confidentiality.	✓	
4.2 Access to research information and findings.	✓	
4.3 Termination of involvement without compromise.	✓	
4.4 Misleading promises regarding benefits of the research.	✓	

Signature of Student: [Signature] Date: 16/3/04

Signature of Supervisor: [Signature] Date: 23/3/04

Signature of Head of School: [Signature] Date: 23/3/04

Signature of Chairperson of the Committee: [Signature] Date: 23 ME'04  
(Professor F Frescura)

ANNEXURE I



# St Augustine's Hospital

107 Chelmsford Road, Durban • PO Box 30105 Mayville, 4058  
Tel +27 (0)31 268-5000 • Fax +27 (0)31 201-4606  
Web address: [www.netcare.co.za](http://www.netcare.co.za)  
P.R. No. 5802562

27<sup>th</sup> August 2002

Ms Petra Brysiewicz  
School of Nursing  
Faculty of Community & Development Disciplines  
DURBAN  
4041

Dear Petra

## **RE PERMISSION TO CONDUCT RESEARCH IN TRAUMA UNIT**

We have no objection to you conducting a study on developing a model to aid the trauma staff to deal effectively with death of the patient in the unit.

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

Yours sincerely

A handwritten signature in black ink, appearing to read 'Ms B Huddle'.

**MS B HUDDLE**  
Nursing Manager



Netcare Hospitals

**ANNEXURE J**

**Entabeni Hospital**  
148 South Ridge Road  
Durban 4001  
P O Box 2230  
Durban 4000

Telephone 031 204-1300  
Facsimile 031 261-6435  
Docex DX 287 DURBAN

Ms Petra Brysiewicz  
University of Natal  
School of Nursing  
Faculty of Community and Development Disciplines  
Durban  
4041

11 September, 2002

Dear Ms Brysiewicz

Permission is hereby granted for you to conduct research in the ER 24 Unit at Entabeni Hospital.

I look forward to seeing the outcome of your research.

Yours sincerely



**Mrs A Williamson**  
**Nursing Manager**



**ANNEXURE K**

**KING EDWARD VIII HOSPITAL**

**(Recipient of the Premier's & PWC Good Governance Awards 2001)**



Postal Address: Private Bag , Dalbridge , 4014. • Telephone: 031 3603853 • Fax: 031 2061457 •

Enquiries: Mr. A.J Seekola  
Reference: KE 2/7/1 (49/2002)  
Research Programming  
9 September 2002

**Ms Petra Brysiewicz**

School Of Nursing

Faculty of Community & Development Disciplines

NRM Medical School

DURBAN

4000

**Application for research at King Edward VIII Hospital**

*Protocol : The development of an intervention model fro managing abrupt death trajectories in KZN Level 1 Emergency  
Departments*

Your application received on the 22 August 2002 is approved.

Please ensure that King Edward VIII Hospital receives full acknowledgement in the study on all publications and reports and also kindly present a copy of the publication or report on completion.

Please sign an Indemnity Form at Room 8, Admin Block before commencement.

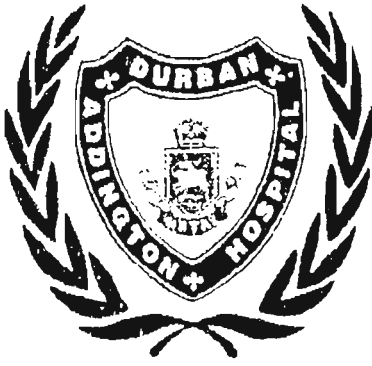
The Management of King Edward VIII Hospital reserves the right to terminate the permission for the study should circumstances so dictate.

Yours Sincerely

Dr ZN Kharva

Acting Hospital Manager.

ANNEXURE L



**Office of the Medical Superintendent**

Addington Hospital  
P.O. Box 977  
**DURBAN**  
4000

Tel: 031-327-2970/2568

Fax: 031-368-3300

E-Mail: [hdmp@dohho.kzntl.gov.za](mailto:hdmp@dohho.kzntl.gov.za)

Your reference:

Our reference:

AD/9/2/3/R

Enquiries: Dr D.K. Naidoo  
Extension: 327 2568/2970

13 January 2003

Ms P. Brysiewicz  
School of Nursing  
Faculty of Community and Development Disciplines  
University of Natal  
DURBAN  
4001

Fax No.: (031) 2601543

Dear Ms Brysiewicz

PERMISSION TO CONDUCT RESEARCH: THE DEVELOPMENT OF AN INTERVENTION MODEL FOR  
MANAGING ABRUPT DEATH TRAJECTORIES IN KWAZULU-NATAL LEVEL 1 EMERGENCY  
DEPARTMENTS

Your research in the above regard refers.

Please be advise that Dr Geyer, Head, A&E Unit has given approval.

You are wished everything of the best in your research.

(for) HOSPITAL MANAGER

DKN/rb

c.c. Ms Anthony  
Dr Geyer





**ANNEXURE M**

**CYCLE 2**

**INTERVIEW: BETH**

**26/11/02**

**HOSPITAL D**

CAN YOU JUST GIVE ME ANOTHER NAME THAT I CAN USE WHEN I AM IDENTIFYING YOU THAT NO-ONE IS ABLE TO TRACE?

Oh, my

WHATEVER YOU LIKE.

Beth.

WHATEVER YOU LIKE. BETH, OKAY. TODAY'S DATE IS 26/11/02. YOU ARE A UNIT MANAGER. ALRIGHT. THE FIRST THING I WANT TO KNOW IS HOW MANY YEARS HAVE YOU BEEN WORKING IN THE EMERGENCY NURSING FIELD?

This is my 13<sup>th</sup> year.

ARE THERE ANY EMERGENCY QUALIFICATIONS THAT YOU HAVE GOT?.

Trauma update ATLS, APLS course. I haven't done the short courses.

YOU HAVEN'T A DIPLOMA? OKAY. AND HOW LONG HAVE YOU BEEN WORKING AS A MANAGER OF THE UNIT?

This is my 6<sup>th</sup> year, going into my 7<sup>th</sup> year.

TIME FLIES.

I know.

## ANNEXURE M

ALRIGHT, BEFORE WE CARRY ON, AS YOU KNOW MY RESEARCH IS ALL ABOUT "DEATH AND DYING" AND THE EXPERIENCE OF DEALING WITH FAMILIES WHO HAVE LOST A LOVED ONE IN THE UNIT AND STUFF. SO IF YOU COULD JUST EXPLAIN TO ME, UM, MAYBE YOUR MOST RECENT EXPERIENCE OF A DEATH IN THE UNIT. JUST TELL ME THE STORY OF WHAT HAPPENED.

The one that stands out of an actual death – it was about 6 weeks ago, it was a friend of mine. Does that count?

IT DEPENDS IF YOU FEEL UNCOMFORTABLE TALKING ABOUT IT.

No, I feel quite comfortable talking about it.

CARRY ON.

It was a gunshot wound while on duty. I have known him for quite a few years, um, it was a working relationship. He was one of the police guys that works for one of the department's that we have adopted. Um, I was the first person they phoned after he had been shot. I knew that he was pretty critical. Um, we got him here about 2 hours later, and when he came in he had .... Of 50 ... he was talking to us – not much – but he was conversing and he went straight to theatre. He was in theatre for about 3 ... 8.30. He died at about 2.30 while on the table. It was quite a while, um, we were getting continual updates from DAVID (he was in the theatre all the time). I knew that his condition was. I think I knew the outcome right from the word go, because of the nature of the injury and that they were telling us by phone. Um, his colleagues starting arriving at about nine o'clock. He was already in theatre and they arrived about 9/9.30, so we started straight away with them. Started counselling them, exactly what was going on. Um, his wife arrived here at about 11. Um, she was accompanied by a police social worker. She was very, very calm and I basically just brought her through and introduced myself to her. I had heard of her just by chatting to LARRY, but I hadn't met her

## ANNEXURE M

before. I had some idea of the background – that there were children. It was a happy marriage – a very stable marriage. Um, she was quite knowledgeable as to what was going on. Um, I basically sat around her and explained to her from the word go and found out first what she knew, and we explained what had happened from the time he arrived here, what had happened in the theatre, and made her comfortable and tried just – you know – just chatting to her and be as honest as possible. Um, he died 2.30. I think it was his father telling his colleagues that he had passed away. Because they were in the unit the whole time. They were sitting around here in the office – tried to keep jovial, as long as there was any hope. I think that was more difficult, than dealing with ANN, because she was so strong. The guys were very, very emotional. Um, that impacted on me, because they were my friends. Um, not really friends, but I work closely with them. Um, it was quite difficult, I found I battled with that one – it was quite difficult. I saw her on Friday night at a work function and discussed the events with her, in view of what we discussed about follow-up stuff. I have spoken to her twice since the funeral. Once at the funeral and I have made a phone call about 4 weeks after his death. I spoke to her yesterday, I mean Friday, just “how do you feel” – you know – and funnily enough the one thing she said that stuck out was how honest we were and how she appreciated that and you know “this is what is going on” and so, ja, you know, that is probably the most recent death.

IT WAS DIFFICULT FOR YOU, BECAUSE ...

It was difficult for me because I identified with them. Um, I don't know if you know about the units we have adopted? Um, it started about 7 or 8 years ago when JENNY was still here. A police officer was shot, um, it was fatal – he came in here with his partner and he was basically dumped here. He died in the trauma unit. When DR A and I were working and all we noticed was this young policeman just sitting in the passage with no support – nothing. That was more traumatic than the death. And we decided there and then that we needed to offer more than just the nursing care. So we identified three or four high risk areas in the police department, because we are the receiving hospital for those police injuries. We started working with them. So if

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something goes wrong they know they can come to the HOSPITAL D – DAVID's here, BETH's here and MARY's here, um, if there are any problems they know they can phone us and we will organise helicopters, ambulance and something to get them here. So it is like security for them. It has been fantastic and when something goes wrong we are able to assist them as best as possible. The downside is that it takes a tremendous toll on the nursing staff, because they are no longer just a policeman, they are now MICHAEL, or BARRY, or LINCON – so they know. That is how it works. They have got to the point where they can pop in if they have had a lousy day, or they are fed up and they can have a cup of coffee. So, it is a lot more personal. That was very difficult for me. Seeing the guys. When I left I felt I had let him down. I hadn't been able to fulfil my part of the bargain. I knew that we had done everything possible for him. But I still felt I had let him down. I discussed this with quite a few of them – when I talked to them it's like "wow, you did everything, how do we thank you". So that has been quite hard to deal with.

AND THE REST OF THE NURSING STAFF? DID THEY ....?

At the time they know them, but it is more a policeman from the reaction unit. On that day the staff were fantastic. I actually can't tell you what happened in the unit. I can't tell you who many patients. They just basically took over the running of the unit to leave me with the guys to do counselling and stuff like that. Um, subsequently, we have had two team building efforts with them. Two team building days with them, as a result of this. It started as a way to thank the unit for helping in a time of need. So, now the girls say that's EARL, so we haven't had a shoot-in yet since then, or an injury since then, but I am sure it will happen in a much larger way now.

JA, IS THERE ANY OTHER EXPERIENCE YOU WANT TO TELL ME ABOUT?

(LAUGHS) ....

SOMETIMES IT IS NICE TO TALK ABOUT EXPERIENCES.

## ANNEXURE M

Which one? There's like 30 billion ..

MAYBE THE NEXT ONE THAT JUMPS IN YOUR HEAD. MAYBE NOT SOMEONE YOU KNEW SO WELL.

Well, the last few friends who died were friends of mine, so it is quite a difficult one. I think, um, there are two that really, really stand out, but they were a long time ago.

HMM.

Um, not that they were difficult to deal with, but they made a huge impact. One was a young girl, at least 7 or 6 years of age. She was a little girl. She was about 8. She was at school, I think, SCHOOL A. She stood up in class and said she had a headache and dropped down stone dead. She was an only child. Um, her parents were separated and it was quite a nasty divorce from what I can understand. They flew her in and basically she was dead on arrival. She was about 7 or 8. Um, the mom arrived and she was "but she went to school with a headache", and Dr A was still here and we had to tell this mum that her child was dead. You know, the denial was just unbelievable. Um, I told the mother and she cried when I told her, and, you remember that old room we had at the back, we used to use for offices? We took her to go through there. She died in the morning at about 10, and her mom basically stayed with her the whole day. We laid her out in that little room and I just sat with the mom the whole day while she talked to her child. And, um, she sang her songs and she spoke about all the dreams for her. Eventually a minister came – it was a woman – a priest – a lady. I think a Catholic or Anglican. She had that dog collar on and she, and, um we asked the mom if she would like to bath her one last time – and myself and the minister and the mom, we bathed her and washed her hair and we put her in this little dress, um, and the mom laid a little flower on her chest and that made a huge impact on me. Just watching the mom's anguish. It was unbelievable. She had lost everything now. I remember her mom was

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cradling her, you know, how you do it like this? And she would say to her "your hands are getting cold" and take her hands between her thighs, under her arms to try and keep this child warm. That was – shoo – very difficult. Um, that was one that stands out. Nothing that I did. I was just so raw – the grief was so raw. Um, there is nothing you can do to make that better. There is nothing you can do and the second one was round about Christmas time. Um, also in the old unit when a guy and his girlfriend were involved in a car accident and he was killed. He died in the trauma – his girlfriend – it was a mixed couple – he was white and she was an Indian girl. And, um, they were on a motorbike. She had facial injuries and he had massive head injuries. And, um, we eventually tracked the parents down. They were shopping at the Pavilion for Christmas presents and I think that was quite emotive. The whole Christmas thing. It was like two days before Christmas and um, when they came down here all they wanted to know is if he was alive. We said that unfortunately he passed away. What happened was that the parents had just recently found out about his relationship. They were quite a conservative family and they kicked him out the house. So the last thing for them was this anger. This "kick-him-out-the-house" and that got to me. Ag man, because they can never undo that. Those are probably the two that stick out most. Um, but otherwise I am pretty comfortable with that. I don't have a problem. I think LARRY's was difficult because it is personal. Um, but otherwise no.

OKAY. WHAT FACILITIES DO YOU HAVE HERE IN THE DEPARTMENT TO AID THE EXPERIENCE FOR THE FAMILY? WHAT FACILITIES, OR WHAT HELP DO YOU OFFER THE FAMILY?

Okay, um, should I just talk you through it? Okay, when they arrive – um, if the family don't arrive with the patient, generally it is left to me to start counselling with the family. Um, each one is an individual. It is not like when they arrive – go to the toilet, make coffee. Um, generally I try to get as much information from the paramedics as to what happened at the accident. Um, where the car is – who is in charge – the tow trucks and that. And get as much information from the staff and doctors. (LAUGHS). That one in particular (LAUGHING) ... (INTERRUPTION) As much information as

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possible. With the medical – what's been done. Um, I always make sure I am presentable. Brush my hair, put lipstick on, wash my face. I must look okay. No hair sticking up and that. Um, I introduce myself. Um, I take them through to our grieving room, which we are currently redoing. It was quite clinical. We have painted it and put new pictures up and have carpeted it and changed the lighting. We have ordered couches and that. Um, and making it more conducive to a family atmosphere. We try to make sure it is as private as possible and establish some sort of order, like who is the head of the family, and generally start with "How much do you know? What do you know?", and fill them in as much as possible. I don't believe in beating about the bush. I try to be as honest as possible because I think you can deal with anything as long as you know what you are dealing with. I have learned from experience. Once I saw that a doctor who was like: "Hello, I am Doctor So-and-so, your son was here and we did a CVP – we went through and intubated him and put in a catheter, and ..... but unfortunately he died". By that time the family have already worked through everything that had been done and then of course he died. I rather say "I am terrible sorry, this is what we are dealing with", and then go into all that. If they are critical I will tell them. The condition is critical I am not sure if he is going to make it. Um, so give them some idea to what we are dealing with. Um, I always ask if there is anything you don't understand. As I know from personal experience when you are sitting there, no matter how qualified, there is like a black cloud. You don't know what is going on. I try tell them where the car is – they worry about personal belongings. Where is the car? Um, try find out if the children must be picked up from school – can we arrange it for you? Um, basic stuff. Make sure they know where the loo's are – where the phones are – can we get you something to drink - stuff like that. Um, but I generally take DORIS with me and introduce DORIS, so we can make sure there is tea, coffee, lunches, whatever they need as well. Um, depending on the nature of the injury and we play it strictly by ear. I get CAROL involved, as well, our Clinical Counsellor – gets involved as well – to start early counselling with the family. If it comes to be a situation we I am actually going to be courser block with the actual care of the patient, we get CAROL involved quite early if one sees that the patient is not going to survive. If it is a traumatic thing like a car accident or a gun shot, when there has been

## ANNEXURE M

quite a lot of trauma to the family, we get CAROL involved quite early, even if I am counselling as well.

WHAT QUALIFICATIONS DOES SHE HAVE?

She is a Social Worker. She has been fantastic I must say. Um, then what we also do is, like recently, if we realise that there is no outcome and I might go towards a donor. (*INTERRUPTION*). If there is a possibility that it might go towards a donor I'll get a donor transplant organisations involved. Sometimes it is nice for me to hand over to someone else so I can go to the loo or have a cup of tea. Sometimes it is nice to have someone else to be there with you. Um, that is basically how we deal with it here.

UM, AND SO YOU ARE WITH THE FAMILY. AND OTHER FACILITIES YOU OFFER? YOU MENTIONED SOMETHING ABOUT A FOLLOW-UP?

We do the follow-up and if we need to refer them to psychologists or social workers and for myself, if they are in hospital, like a critical injury, um, I make sure I try and see them every day while they are here. If there is a death we like to try and phone about two or three weeks afterwards: "How are you doing? Is there anything you are not sure – are there any questions you want to ask?" Nine out of ten cases we do it like that, unless it is a rural patient – we battle to get hold of them. We follow up with a phone call. Um, we have quite a few patients phoning back, or families, and they say that they just want to ask a few questions about the post-mortem results: "What does this/that mean?" and we do offer that. They have got our phone numbers and names and we make sure they understand – 24 hours a day if they need to phone and ask: "What was that white flight tube. What is it?" – they are more than welcome to phone the department. I must say that it is seldom that they do phone. I like them to know that if this is a problem they can phone.

AND DO YOU USUALLY FIND WHEN YOU DO YOUR FOLLOW-UP CALL?



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Quite positive generally. They are quite willing to talk about it. Questions like did he suffer? Was he in pain? - I think that the biggest thing – concern for the patient. Um, now and again like: “Do you know what happened?” Offer to repeat information we gave them right at the beginning. Actually, generally quite positive: “Thank you so much for everything you did. We really appreciate the call.” So you know, very positive I'd say. I have never had anyone say like: “I don't want to talk to you – or you are insensitive” – or anything like that.

OKAY, AND WHAT DO YOU THINK ARE THE STRENGTHS AND THE LIMITATIONS OF THE WAY THAT YOU DEAL WITH THE FAMILIES HERE?

Um, I will start with the limitations. I think our limitations are if it is after hours. I think my staff sometimes battle with it, because I think it often lands on my shoulders as manager. I am super-immune (not clear) .... So they can often cope quite well without me. So BETHH can go and do it and let them go do it. Um, the girls don't get enough exposure as they should. Um, so after hours we don't have social workers here. So we need a referral like come back next week if you need to speak to someone. Um, limitations – our room – until recently it wasn't comfortably furnished, but that is being taken care of now. Also, meals – we have got meals. Um, just to try make it more comfortable for them. We have addressed them. I suppose this is our strength – we have identified the problems and we have sorted them out. Our strength is that we have got very caring staff here who are quite comfortable with death – even the nursing staff to a certain degree – with the actual dying of a patient. Um, very supportive doctors. We do have a social worker who is on site during the day. I think I am less stressed because I am comfortable with it. I can deal with it. Um, I don't have any problem discussing death with them. Um, we have somewhere private where they can sit. Um, I think that is about it.

WHAT ABOUT FACILITIES FOR THE STAFF?

Well, post-resuscitation?

## ANNEXURE M

### DURING – POST.

During it – DAVID – are really good about the staff. After every single death we try have some form of a debrief – um, pretty informal, while we are doing the packs. We find that it is better for the girls on a one-on-one situation – to deal with it at the time: “Are you guys alright? Do you need to talk about it?” “You did everything possible – let’s go through over it again”. We normally do that when we have a charge. When we are having a cup of coffee afterwards. Um, we do have a social worker and if it gets a bit hairy, and if we have a critical situation we do have a psychologist on standby and he will come out and counsel us, as well. We have used him in the past and it has been very beneficial. The social worker or the counselling consultant we use on an adhoc basis, like, JANE and I – we have scheduled a whole lot for her now, because we are going into the Christmas period with the drownings and that. It is almost to get the girls ready for what is going to happen. We will go over certain topics with her like we will do little workshops with her through the course of the year. Like death of a child – crime death. Um, just to try and prepare the staff and give them some space to deal with it. “What is okay. What is not okay. What you can and cannot say”. Um, I think the staff know they can phone me any time and they have. They are quite happy to phone me at 3 o’clock in the morning if they need to talk, or at 8 o’clock at night when they get home. I find the staff generally phone me when I am at home and not at work. Um, they are all experienced. They same think like we need to talk about yesterday again and sit down as a group. One thing I have tried to make the staff understand is that this office is a safe office and anything they say here is safe. They can say anything – they can cry – get their anger and frustrations – whatever happens in here is confidential. It will not be discussed anywhere else – just in this office. Um, so I try to make sure that they are aware of this as well. They do know that. If they are in here, whatever they say when this door is closed, this is where they can say with they like, it doesn’t matter this is a safe office.

AND IF YOU HAVE HAD A CRITICAL INCIDENT AND THE PSYCHOLOGIST COMES TO YOU, HOW DOES THAT FOLLOW?

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Basically we just run it by management, when we have had a critical incident. Luckily, we haven't had it too often. Um, he will come and we will have a group debrief about 12 hours after the incident and everyone is involved and we will do proper stress debrief: "What did you see – what do you feel – what did you smell – how are you feeling". Um, what's okay. Ja.

### WHERE DO YOU DO THAT?

In the unit here. Unfortunately we can't leave here to do it anywhere else. We just sit quietly in the theatre. The staff are quite comfortable. We haven't had one for about two years now. But it worked quite well – obviously, except if there is some resistance on the staff to talk. Generally, I will try and talk first, because it is okay for me to talk. I suppose anyone can talk. You do get quite emotional sometimes. Um, I think I have tried to make it clear to the girls that anytime it is okay to feel ... you like to be fine at work. It is when you are at home when you hear the news, or read the papers – this is often when it strikes home. Is this what really happened? But then with a violent death or a traumatic death, you are so busy trying to work on a patient, you don't actually compute what actually happened, or what is going. When I speak to the staff I find it is not so much what's happened here, it is the family and the kids that are left behind that are most upsetting for them, then what actually happened.

### SO YOU SAY THAT THEY OFTEN PHONE YOU AT NIGHT. WHAT SORT OF THINGS DO THEY PHONE YOU ABOUT?

The need to talk, um, about what happened. Did they do the right thing, um, things they didn't want to discuss in front of anyone else. They might feel they can't cope anymore – there has been one too many, um, and the last girl who phoned said: "I just can't do it anymore". In this situation I just went out and I said that I was on my way and came out and sat with her for about two hours. I said that it was alright, that is what I am here for – let's talk about it and just positive reinforcement all the time. That they are okay – that they are doing a

## ANNEXURE M

good job and tonight you feel like this and, with her in particular, she got to the point where she didn't want her children to leave her. She didn't want them to go with her husband in the car. She didn't want them out of her sight ... she didn't want to send them to school. It is okay to feel like that – it's normal – let's look at the big picture. We've had quite a few deaths. Let's try put things into perspective.

THEN WHAT DO YOU ADVISE FOR HER?

Basically, take a bit of time, um, she was overdue leave. Granted her some leave. To try look after herself. Take some time for yourself everyday, um, discuss it and talk to me. If you can't talk to me, talk to someone else – to her hubby. We have to I-care – the well-being programme as well.

OKAY

Talk to them (*INTERRUPTION*) – suggest take some time off.

DO YOU DO THAT OFTEN WITH STAFF? LET THEM TAKE TIME OFF?

Yes, because of the nature of our work here I encourage them to take time – two weeks every three months. Um, generally there is no rules about leave, um, try do this four weeks in advance so we know and can make the plan. But if the girls need leave we generally try and accommodate them – so if they need leave and it is their only time off. That's fine. You come in and then you can go. There are no hard and fast rules. The girls work hard. They really do, um, so if I can accommodate them I let them take some leave.

OKAY. IS THERE ANYTHING ELSE YOU THINK I NEED TO KNOW ABOUT HOW DO DEAL WITH THE DEATH AND DYING HERE, OR THE STAFF?

I think my staff here can give themselves some credit for the good job they are doing. Um, I know it is pretty tiring. It is quite thankless. Ja, we try and

## ANNEXURE M

work on positive reinforcement all the time. They are doing a good job. Um, we just recently done a performance précis, it has just come up quite a bit that they need more exposure to counselling and death. So what we started doing every time there is a death, one of them will come with me now, just to get exposure to it.

ARE THEY FINE?

They are not fine. They have there own issues about death and that, um, but I like to think that we do try and answer their questions – make it easier for them – make sure that all the policies are well understood and that they know what do to and how to do it.

ANYTHING ELSE THAT YOU WOULD LIKE TO CHANGE? ANY SUGGESTIONS OR RECOMMENDATIONS YOU HAVE ABOUT HOW TO DEAL WITH DEATH AND DYING?

Um, one of the things I have actually recommended to our management – first, if we could do some sort of pamphlet, as it is fine talking to the families afterwards, um, at the time of death and the day afterwards, um, they – nothing prepares you for death, especially the traumatic death. They aren't quite sure what to do with the clothes, or what about post-mortems, um, bank cards that must be closed and accounts and stuff like that. So, I would like to give them some sort of handout that, you know, when you get home about that what you need for a post-mortem, how to manage a cremation, um, what to do about bank accounts – what to do about the identity book – what to do about home affairs and stuff like that. Um, just so the families don't leave here empty-handed. There is nothing worse then to say goodbye to them and you see the lost souls going up the ramp there and you know what they are going to find at home where there are still clothes or toys. Just what's facing them. I don't think they have any idea what's facing them. Maybe some compassionate friends – or Life Line – or anything. Some sort of resource where they can go chat about things. So, that always concerns me. We can fulfil their needs immediately, but what about afterwards. You know, when

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they wake up at two in the morning, and they realise that hubby is not coming home. What are you going to do. We try to say that it is okay to cry. It is okay to experience that. Just recently two friends of mine were killed and the other day I was talking to his sister – last Tuesday, and she had been to a funeral. She was his older sister – so he was the younger brother. She said to me that when she was there, um, it sort of opened up all these wounds and she was just feeling so sad for herself for the loss of her baby brother and his wife and the children, and the impact it made on their family and she just couldn't stop crying. I said it is okay to cry. No-one tells you that it is alright to cry. This was four weeks after her brother's death and she just wanted someone to say to her "Are you okay? How are you doing? It is alright to talk about it", because I think it must take over everything. You think, eat and all you think about is what has happened to you, and it is okay for the first week, because everyone's saying, "Are you alright?". And then everyone goes back to school or back to work and you are left with this – your brother's never coming back. And she doesn't know it is alright to talk about it, to talk about Phillip and to cry about Phillip and that sort of thing. That always worries me, that you know it is alright to cry and it is alright to grieve and to feel awful and to be angry and to be, you know, to be really, really angry with God and with whatever. That this guilt associated with being angry with God, I just think we need to tell the patients or families, the survivors, that it is okay to feel that. Even me, with LARRY, I was so angry that I, or we, couldn't save him. Um, actually I felt I had left the team down. I had left the guys down. And yet I knew that we had done everything possible – I even got a helicopter for him. Um, there is nothing more I could have done. And I know that if even DR B was sitting next to me and was shot, we couldn't have saved him - there was nothing I could have done. His injuries were not salvageable, you know. But at the time – maybe for a while – to come to this, so it must be very difficult for the families to deal with stuff like that.

OKAY, SO BESIDES THE BOOKLET, THERE IS NOTHING ELSE THAT YOU CAN THINK OF THAT YOU NEED TO CHANGE – THE ROOM, WHICH YOU HAVE ALREADY DONE?

## **ANNEXURE M**

Ja, we are doing that alright, ja. The booklet, follow-up phone calls. I think we just need to ensure that every question is answered before the patient leaves hospital and that we tried. They don't know what their expectations are. It is like hindsight, you don't know what to expect. But I need them to know that before they leave here that, um, (a) everything was done and (b) if any questions aren't answered, and if we can't answer them now, they must feel free to phone us at any time. I can't think of anything just offhand.

ANYTHING ELSE YOU WANT TO TELL ME, OR DO YOU THINK I HAVE EXHAUSTED YOU?

No, you haven't exhausted me. I will probably think of 30 things in two minutes time. Anything I need to know?

NO, THAT WAS ALL FOR ONE DAY.

## ANNEXURE N

If you are reading this you have suffered the loss of a loved one. This pamphlet was designed in an attempt to help you and your family in some way through this very difficult time. The pamphlet contains some information about what you need to organise now that your loved one has died as well as some information which is hoped will be of help to you in the near future.

### Post-mortem (autopsy)

A post-mortem is required by law if your loved one died a sudden, unexplained death or died due to unnatural causes, such as a motor vehicle collision. A post-mortem is a careful examination of the internal organs and tissues of the body with the hope that this will give a better understanding of the cause of death. If you want to understand better how or why your loved one died you can contact the police mortuary where the post-mortem will be carried out. Ask for the contact details of the pathologist who performed the post-mortem to discuss the findings. Once the post-mortem is complete you can arrange for the funeral home of your choice to fetch the body of your loved one and go ahead with the funeral or memorial service.

*If for religious reasons you need to have the post-mortem completed as quickly as possible, please make the hospital staff aware of this.*

Please remember that the police mortuary is part of the justice system and not the health system. The environment and the approach of the staff should be seen in this context.

### Legal requirements

There are a number of legal requirements which you will have to deal with during this difficult time. To either bury or cremate your loved one you have to:

- Get their identity document and any funeral policies they have.
- Get the identity document of the next-of-kin arranging the funeral or cremation.
- Get the name and contact details of the attending doctor.
- If you will be cremating your loved one, additional forms need to be filled in by the doctor.
- Obtain a form from the state mortuary to release the body after

the post-mortem to give to the funeral home and get a post-mortem number.

- Obtain a death certificate from the Department of Home Affairs which they will issue after having received documentation from the mortuary.

The next-of-kin needs to go to the Department of Home Affairs with the deceased's identity document, as well as their own. They also need to have the post-mortem number. The next-of-kin will then be issued with a death certificate which is required by the funeral homes. Check with the mortuary when you should go to Home Affairs as this is usually a few days after the death.

### How to contact the hospital

The name of a staff member whom you can contact at the hospital should you have any questions about your loved one while they were in the hospital is:

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Please do not hesitate to contact them with your queries, however small.



## **ANNEXURE N**

### **Funeral homes**

If you don't know the names and contact details of funeral homes ask the hospital staff to provide you with the information. These funeral homes can then assist you with the necessary funeral arrangements.

### **What to expect with your emotions**

At times you will find it very difficult to believe that your loved one has died. You may feel very angry and depressed and want to cry all the time. You may feel very isolated and alone or have feelings of helplessness. After the death of a loved one it is important to remember not to compare your grief and feelings with that of others. Every person responds differently. Don't think that there is something wrong if you don't react in the way that you or others think you should. If after about a year you are feeling no better please contact a counselor or friend.

### **Looking after yourself**

During this difficult time try to remember to eat a well balanced diet and try to get enough rest. If you have trouble sleeping make sure you get moderate exercise or try other measures to help you sleep. After the death of a loved one it is important to find someone to talk to, especially your family and friends. Ask the

hospital staff for details of counselors or psychologists whom you might approach for help. If you attend church remember to ask for support from your minister. Here are some people that might help:

### **The Compassionate Friends**

**031 – 4631890 or 0827747053**

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### **Researched and compiled by:**

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Any comments to Petra (Ph: 031-2601281)

## **DEALING WITH SUDDEN BEREAVEMENT**

**A guide for families who's  
loved one dies an unexpected  
death**

## ANNEXURE N

Uma ufunda lokhu ulahlekelwe umuntu omthandayo. Lelipheshana linemininingwane okumele ukuthi uzenze manje uma usushonelwe kanye nemininingwane esikholelwa ukuthi izoba usizo ngekusasa lakho.

### Ukuhlolwa Kwesidumbu

Ukuhlolwa kwesidumbu kumele kwenziwe ngokomthetho uma ushonelwe isihlobo sakho ngokuzuma, ukufa okungachazeki noma ukufa ngengozi, njengokufa engozini yemoto. Ukuhlolwa kwesidumbu kuwuncwaningo ngaphakathi komzimba ukubheka imbangela yokushona.

Uma ufuna ukuqonda ngokufa nangembangela yokushona kwezihlobo zethu, ungaxhumana namaphoyisa asemakhazeni lapho ukuhlolwa kwesidumbu kade kwenzelwa khona. Cela imininingwane ka-dokotela okade enza ucwaningo lwesidumbu ukuze nixoxe ngemiphumela ayitholile. Uma ucwaningo lwesidumbu selwenziwe, usungenza amalungiselelo nabangcwabi abakhethwe nguwe ukuzolanda isidumbu.

usungenza nenkonzo yesikhumbuzo. *Uma kuyisizathu sezenkolo, kuyadingakala ukuthi ucwaningo lwesidumbu lwenziwe ngokushesha. Uyacelwa ukuthi ubazise abasebenzi basesibhedlela ngalokhu.*

Uyacelwa ukuba ukhumbule ukuthi amakhaza asemaphoyiseni ayingxenywe yomthetho, hhayi ingxenywe yezempilo. Indawo nendlela yokusebenza kwakhona ihlukile kokwezempilo.

### Okomthetho Okudingekalayo

Ziningi izincwadi zomthetho ezidingakala uzigcwalise kulesosikhathi sobunzima. Ukungcwaba noma ukushiswa kwesidumbu sesihlobo sakho kuzodingeka:

- . Uthole umazisi kanye nomasigcwabisane abanawo.
- . Thola umazisi wesihlobo okuyisona esenza amalungiselelo omgcwabo/ ukushiswa kwesidumbu.
- . Thola igama kanye nemininingwane kadokotela.
- . Uma isidumbu sesihlobo sakho sizoshiswa kumele udokotela agcwalise eminye imininingwane

- . Thola ama-forms emakhazeni kahulumeni azokhulula isidumbu emva kokuba sesihloliwe usithumele kubangcwabi, bese uthola inombolo yokuhlolwa kwesidumbu.
- . Thola isitifiketi sokufa emnyangweni wezasekhaya, isitifiketi uzosithola uma uphethe izincwadi zasemakhazeni.

Isihlobo kumele siye emnyangweni wezasekhaya siphethe umazisi waso kanye nomazisi woshonile. Kubalulekile ukuthi bathathe inombolo yokuhlolwa kwesidumbu. Isihlobo noma izihlobo zoshonile bazothola isitifiketi sokufa esidingekalayo kumasingcwabisane. Bonisana nabasemakhazeni ukuthi inini lapho kumele uye emnyangweni wezasekhaya ngoba kumele usithole isitifiketi ezinsukwini ezimbalwa emva kokushona.

### Ungaxhumana Kanjani Nesibhedlela

Igama nomsebenzi wasesibhedlela ongathintana naye uma unemibuzo mayelana nesihlobo sakho esisesibhedlela:

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Ungabi nokungabaza ngokubathinta ngemibuzo onayo, noma ngabe mincane.

## ANNEXURE N

### Abangcwabi

Uma ungawazi amagama kanye nzinombolo zabangcwabi, ugabuza kubasebenzi besibhedlela lyomininingwane. Labangwabi bangakusiza mayelana nezinhlalelo zomgcwabo.

### Ikuphi okulindele ngemizwa yakho

Kwezinye izikhathi uzothola kunzima ukukholwa ukuthi ushonelwe isihlobo sakho. Ungazizwa udiniwe futhi nomoya wakho uphansi sengathi ungakhala ngazozonke izikhathi. Ungazizwa unomzwangedwa futhi uwedwa noma uzizwe sengathi awunasizo lwalutho. Emva kokushona kwesihlobo sakho kbalulekile ukhumbule ukuthi ugaqhathanisi usizi kanye nemizwa yakho nabanye abantu. Wonke umuntu unemizwa yakhe ehluke. Ungacabangi ukuthi kunesimo esingahambi kahle kuwena uma ungenzi njengedlela wena noma abanye abacabanga ukuthi kufanele wenze ngayo.

Uma kuze kuphele unyaka ungazizwa unokukhululeka emoyeni wakho, kumele uxhumane ne-counselor noma umngane wakho.

### Ukuzinakekela wena

Esikhathini sobunzima ukhumbule

ukudla okunempilo futhi uthole ukuphumula okwanele. Uma ungakutholi ukulala okuhle, qikelela ukuthi uyawuvocavoca umzimba wakho noma uzame ezinye izindlela ezizokusiza ukuba ube nobuthongo. Emva kokushonelwa isihlobo sakho kubalulekile ukuba ube nomuntu oxoxisana naye ikakhulukazi emndenini wakho noma abangane. Ungabuza ezisebenzi zasesibhedlela mayelana neminingwane yabasizi (counselors) noma ama-psychologists ongaya kuwona ufune usizo. Uma ungumuntu oyayo esontweni ukhumbule ukucela ukuxhaswa kumphathi webandla. Nampa abanye abantu abangakunika usizo:

**The Compassionate Friends**  
**031-4631890 or 0827747053**

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Icwaningwe futhi yahlanganiswa ngo:  
P. Brysiewicz & L.R. Uys (2004) University  
Of KwaZulu-Natal  
Ihlanganyelwe ngokubambisana nonesi  
ezibhedlela ezahlukene e-Thekwini (Durban)

KwaZulu-Natal

Uma kukhona othanda ukukusho  
ungaxhumana no Petra  
kulenombolo (Ph: 031-260 12 81)

**UKUMELANA NESIMO  
ESIBUHLUNGU**

**Incwajana yemindeni eshonelwe  
izihlobo zayo ngokuzuma**

## ANNEXURE O

### PREPARATION CHECKLIST FOR MANAGING SUDDEN DEATH IN THE EMERGENCY DEPARTMENT

UPDATE		DATE:	DATE:	DATE:	DATE:
		TICK OFF	TICK OFF	TICK OFF	TICK OFF
Monthly	Shared values and mission of the ED amongst the staff				
Monthly	Good communication between interdisciplinary groups in the ED				
Monthly	Regular support for staff in department				
Monthly	Individual support available for staff				
Monthly	Private room or area for families identified				
Monthly	Safe area to keep deceased's property				
Monthly	Contact numbers of:				
	• Police				
	• Organ transplant coordinators				
	• Support services for families				
	• Clergy				
	• Funeral homes				
Two weekly	Cups for families to drink from				
Two weekly	Tissues available for families				
Monthly	Counselor or support person available for families while they are in the ED				
Two weekly	Bag for deceased's clothing				
Two weekly	Pamphlet for bereaved families				
Monthly	Cards of condolence to send to bereaved families				

## ANNEXURE P

### INCIDENT EVALUATION CHECKLIST FOR MANAGING SUDDEN DEATH IN THE EMERGENCY DEPARTMENT

ACTION CARRIED OUT	TICK		DID THIS WORK?
	Yes	No	
Family contacted timeously			
Staff involved introduced to family			
Family put in private area near client			
Kept family updated			
Allowed family to be with client where possible			
Police informed			
Client considered as a possible organ donor?			
Good flow of communication between the groups (doctors, nurses, police etc)			
Family sensitively informed regarding the death of their loved one			
Body wiped and made look presentable.			
Allowed family to view body in private area (with support)			
Family allowed as much time as possible			
Family given direction regarding interacting with the dead client e.g. talking to them			
Documentation complete			
Handed over all client's personal effects with dignity			
Family informed that post-mortem is required			
Family prepared about what to expect at police mortuary			
Family given brochure			
Family given referral for support groups			
Names of attending staff given to families			
Considered feelings of all colleagues involved			
Feedback given to staff re cause of death			