

UNIVERSITY OF SOUTH AFRICA

CRITICAL CARE NURSES' PERCEPTIONS
TOWARDS FAMILY WITNESSED
RESUSCITATION

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CRITICAL CARE NURSES' PERCEPTION TOWARDS FAMILY WITNESSED
RESUCITATION

by

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DECLARATION

I declare that this research project entitled "Critical Care Nurses' Perceptions towards Family Witnessed Resuscitation" is my own work. It is being submitted for the Masters' degree in Critical Care Nursing at the University of South Africa, Pretoria.

It has never been submitted for any other purpose. All references used or quoted have been acknowledged by means of referencing.

SIGNATURE DATE
J DE BEER

This study has been approved for submission by the supervisor of this study, Mrs M.M. Moleki.

SIGNATURE DATE
M.M. MOLEKI

DEDICATION

This study is dedicated to the people of Saudi Arabia.

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The critical care nurses who willingly participated in this study,

The management of the King Faisal Specialist Hospital and Research Centre, Riyadh, Kingdom of Saudi Arabia, thank you for allowing me to conduct my research,

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ABSTRACT

AIM: The aim of the study was to describe the perceptions of critical care nurses concerning family witnessed resuscitation, presenting arguments for or against the practice thereof.

METHODOLOGY: A quantitative, descriptive and exploratory approach was used. For the study, a non- probability convenience sample of 100 critical care nurses from five critical care units were used. A combined open- ended and closed–ended questionnaire was used.

FINDINGS: The majority of critical care nurses in the study disapproved of the idea of family witnessed resuscitation. They believed it to be traumatic for relatives, threatening to the resuscitation process and increasing litigation. Although the dominant feeling was one of disapproval, some critical care nurses felt that family witnessed resuscitation was beneficial to relatives. Recommendations for future practice included incorporation of educational programmes for critical care nurses concerning family witnessed resuscitation and providing training to deal with the stresses of family witnessed resuscitation.

KEY CONCEPTS

Advantages, critical care, critical care nursing, critical care unit, culture, disadvantages, family, perception, resuscitation, witnessed.

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LIST OF ABBREVIATIONS

CPR	-	cardio pulmonary resuscitation
ICU	-	intensive care units
KFSH&RC	-	King Faisal Specialist Hospital and Research Centre
UAE	-	United Arab Emirates
UK	-	United Kingdom
USA	-	United States of America

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Chapter 1

Orientation to the study

1.1 INTRODUCTION

Resuscitation can be visually disturbing and stressful, even to the most experienced clinical staff. Allowing family members to remain with patients during resuscitation efforts is a relatively new concept. Differing views regarding the presence of family members during resuscitation are being debated. Some of the reasons stated for being against it are that family members would have traumatic memories of the event (Axelsson, Zettergren & Axelsson 2005:2). However, not all family members might validate this assumption. According to Robinson, Mackenzie-Ross, Campbell Hewson, Egleston & Prevost (1998:617) the majority of family members would prefer to remain with the patient. Some of the reasons stated for the family to be present during resuscitation are, that:

- Fear and anxiety will be reduced
- The family will have a feeling of being supportive and helpful to staff
- It gives the family closure because they will know that everything possible has been done for their relative

(Bauchner, Waring & Vinci 1991; MacLean, Guzetta, White, Fontaine, Eichorn, Meyers & Desy 2003:208-21).

Denying family the experience may also be perceived as a way through which health workers continue to perpetuate their own myth of control. The established practice is for the relative to be excluded from the clinical area during resuscitation. The common practice is that during the resuscitation in most departments, the patient is

wheeled into a resuscitation room and the family is escorted into the family crisis room while the medical staff works desperately to resuscitate the patient. A social worker or a member of the nursing staff updates the family on the progress of the patient. In case the patient dies, he or she is made as presentable as possible. The tubes are removed; machines switched off and removed from the scene. The room is put in order, and only then is the family invited to say goodbye. The social worker or nursing staff is on standby and is supportive to the family, the resuscitation team in many instances does not even return to meet the family. The opinion presented by this situation is that the family had be done a great service by allowing them to say goodbye to their loved one, only after invasive lines and tubes were removed (Marrone & Fogg 2003:32).

This traditional approach has sparked controversy (Marrone & Fogg 2003:32). Healthcare professionals are divided on whether families should be present or not. Most agree that the issue must be addressed. It is from these ongoing debates that this study intends to describe and explore the perceptions of witnessed resuscitation by the critical care nurses working in intensive care units.

1.2 BACKGROUND AND MOTIVATION

The world today allows easy and free immigration and migration. The population is becoming more and more diverse. This is also true in Saudi Arabia. The country's laws and practices are founded upon the Islamic Faith and the holy Quaran. The Islamic Faith constitutes approximately 95% of the population. There are large groups of Indians, Pakistani, Uranians, South Australian residents and South African

nurses. There are over 40 nationalities in the UAE, thus creating a more diverse workforce in the Middle East with different training backgrounds. One of the conditions for appointment of foreign nurses is that they should be competent in resuscitation namely cardiopulmonary resuscitation (CPR).

Cardio pulmonary resuscitation (CPR) is the emergency situation of attempting to restore vital signs by mechanical, physiological and pharmacological means in case of cardiac arrest (Hudak, Gallo & Morton 1997:304). Family presence during resuscitation remains a dilemma for nurses working in critical care areas. The established norm in the departments of hospitals is that relatives are excluded from the resuscitation efforts and are made to wait in the visitors' room. This practice is based primarily on the idea that resuscitation efforts will be traumatic for relatives and that family presence will interfere with staff performance (Rattrie 2000:32). Although the importance of family support is similar for most people, there are differences on how people experience crisis. According to Leininger (1991:155) care and culture are inextricably intertwined. Knowledge of practices in diverse cultures is essential to guide nursing decisions and actions in providing culturally congruent care. An appreciation of the influence of culture on the perception of family witnessed resuscitation is important if patients and family are to be managed effectively during resuscitation.

One of the first formalised attempts to develop an initiative to incorporate patients' family members during resuscitative efforts had been in 1982, at the Foote Hospital in Jackson, Michigan, in the United States of America (USA) (Tsai 2002:1019). Personnel at Foote Hospital were prompted to examine their policies of excluding

patients' family members during CPR. On two separate occasions family members demanded to be present during the resuscitation. Following these demands, surveys were sent out to the deceased patients' families to determine the families' desire to present during resuscitative efforts. Staff members at Foote Hospital initially resisted implementation of a formal initiative for family presence. However, in 1985, after the survey had been completed, 21 staff members (71/%) indicated their support of the practice (Tsai 2002:1019).

Since the initiative at Foote Hospital, other institutions have developed, studied and implemented formal protocols relating to family witnessing resuscitation. In 1994, the Emergency Nurses' Association in the USA developed an educational booklet to facilitate the implementation of family presence programmes. In 1995, the association produced an official statement regarding the national guidelines for family presence during invasive procedures and cardiopulmonary resuscitation. The association revised and updated the policy statement on family presence in July 2001, with continued support for the option by families to be present during resuscitation and invasive procedures (Tsai 2002:1019).

Finally, in 2002, the update of the Paediatric Advanced Life Support manual supports the option of family presence during resuscitation in the revised guidelines (Tsai 2002:1019). The changes in these events suggest the importance and relevance of these issues to any healthcare professional who may participate in a resuscitation effort. However, opponents to family witnessed resuscitation practice fear litigation and family interference during family witnessed resuscitation (Yanturali, Ersoy, Yuruktumen, Aksay, Suner, Sonmez, Oray, Colak & Cimrin 2005:6).

Setting

Cardiopulmonary resuscitation is a frequent procedure at the King Faisal Specialist and Research Centre (KFSH&RC) due to the nature of the hospital. The KFSH & RC is a 660 bed tertiary referral centre in Riyadh, Kingdom of Saudi Arabia (KSA) serving Saudi Arabia and surrounding countries. (See Annexure 1). Patients often travel distances from surrounding areas and countries in the hope of obtaining medical care. All medical specialities are catered for in the critical care units. Patients with complex cardiac disease, haematological and oncological disorders are treated in the critical care units, neonatological, general and neurosurgical procedures are performed, and an active programme of cardiac, liver, pancreatic, bone marrow, renal procurement and transplantation is maintained in those units. The critical care departments include coronary care, one neonatal intensive care unit (ICU), one paediatric ICU, one cardiothoracic ICU, two medical-surgical ICU'S, one cardiovascular telemetry and one surgical recovery unit. The critical care department also manages an onsite hyperbaric oxygen therapy unit.

The division of nursing comprises staff from over forty countries, and utilises a patient- centred model of care. During time of employment, all staff working in critical care units have to complete all mandatory competencies necessary to function effectively. Two of these competencies are basic life support and advanced cardiac life support. Only upon completion and certification of these competencies can staff members undertake resuscitative attempts. The staff in critical care units are part of the resuscitative team at KFSH&RC.

Other team members include the:

- resident doctor on call
- pharmacist
- paramedics
- nursing supervisor

Nurses play a vital role in the efforts to resuscitate patients. The nurse often is the one who assesses the patient, initiates CPR and calls the team. The activity usually involves two ICU nurses, one of whom is often the resuscitative team leader, and the second being a fellow team member. Resuscitative efforts are often stressful. Some of the documented concerns by the resuscitative teams surrounding resuscitation include:

- staff stress and discomfort
- impeding work
- inadequate staffing
- chaos
- confusion
- legal issues such as lawsuits
- family complaints (Rattrie 2000:33).

At the KFSH&RC, Riyadh, KSA, there are no current policies allowing witnessed resuscitation. The family is often not included in the resuscitation. If a resuscitative effort fails, the doctor will announce the death. The patients' primary nurse and the physician together with the social worker, if available, will inform the family about the death. As most patients are Arabic speaking, the English language is not used often, members of the healthcare team usually communicated with relatives by making use of an Arabic interpreter to inform relatives of the death of their family member. At the

same time other nurses will prepare the body by removing all resuscitative equipment and straighten the room before the family could view their deceased relative.

1.3 THE RESEARCH PROBLEM

Patients are being resuscitated so that their lives can be saved and that they can return to their families and friends. The wishes of close relatives should be respected. However, resuscitative efforts especially following a traumatic event can be horrifying to an untrained eye. Resuscitation is one of the procedures done frequently at KSH & RC. The majority of the nurses working at this hospital are expatriates. In Saudi Arabia, the family is the primary support system for the patient. The family members stay at the patient's bedside most of the time but should resuscitation be necessary, the family members are requested to wait in the visitors' area. The established practice is for the relatives of critically ill patients to be excluded from the clinical area during resuscitation. This then indicates that family witnessed resuscitation is still not allowed in this hospital.

The traditions and culture of the UAE add to the uniqueness of the region. Emiratis have their own distinctive way of life; their religious practices are also unique. The nurses in the UAE need to adapt to the local cultural practices represented in the healthcare setting and also provide culturally appropriate care to their patients even in emergency situations. Nursing care of patients of the Islamic Faith can be extremely rewarding provided that the nurse is knowledgeable about important aspects of the culture. "Having knowledge of the complex social structure, world view

and cultural context features are critical in promoting a sense of care for these patients” (Luna 1989:22). Religion and family are interrelated and reflect many aspects of health care.

The appropriateness of family witnessed resuscitation for the patient and family has been documented. Several investigators have documented the benefits of family presence during resuscitation (MacLean et al. 2003). The American Heart Association guidelines of 2000 recommend that family members be allowed to witness cardiopulmonary resuscitation (Booth, Woolrich & Kinsella 2004:725). Yet, family presence in the resuscitation room is still controversial and therefore denied. Opponents to family witnessed resuscitation practice fear litigation and family interference during resuscitation (Yanturali et al 2005:6). The issue of family witnessed resuscitation also raises ethical considerations concerning the patients’ confidentiality and the relatives’ rights.

The problem statement of this study stated in an investigative form for this study was:

ARE THE NURSES’ INSTINCTS TO ALLOW OR NOT TO ALLOW FAMILY WITNESSED RESUSCITATION JUSTIFIABLE?

1.4 RESEARCH QUESTIONS

The study intended to answer the following questions:

- What are the ICU nurses’ perceptions towards family witnessed resuscitation?
- What are the factors contributing towards these perceptions?

1.5 PURPOSE AND AIM OF THE STUDY

The purpose of the study was to describe the perceptions of critical care nurses towards family witnessed resuscitation. The aim was to present arguments for, or against the practice. It was hoped that nurses would be in a position to be reflective on what happened in their units, and seek to understand the implications for the patients and their relatives.

1.6 OBJECTIVES OF THE STUDY

This study sought to:

- Describe and explore the perceptions of critical care nurses in ICU in terms of experiences, views, opinions and conceptualisation of family witnessed resuscitation.
- Describe the factors contributing to these perceptions.

1.7 SIGNIFICANCE OF THE STUDY

This study contributed to holistic nursing care within the cultural context which is an essential prerequisite for total patient care. The study should also enhance the nurse's understanding of how family involvement influences the nurses' and clients' wellbeing. The nurses should be aware of their own perceptions and therefore be able to identify their own biases; accept and respect the patients' family choices, and that way, promote reflective practice. This study further ensured that policies with regard to family witnessed resuscitation were established and that the ethical

implications were considered when such policies were established.

1.8 DEFINITION OF TERMS

1.8.1 Advanced nurse practitioner

An advanced nurse practitioner is a nurse that has met both educational and clinical requirements beyond the basic nursing educational requirements for all nurses.

Advanced nurse practitioners have a broad depth of knowledge and expertise in their speciality area and manage complex clinical and system issues (Urden, Stacy & Lough 2002:4).

1.8.2 Critical care nursing

Critical care nursing is a speciality area of nursing that involves caring for patients and families who are undergoing life threatening illnesses or injury. The environment in critical care units is highly technological which needs nurses to have a broad knowledge base, high level of decision making skills and high regard for patients and families who are in vulnerable circumstances (Bucher & Milander 1997:39). It is constant, complex, detailed healthcare provided in various acute life threatening conditions (Mosby's Dictionary 1990:628).

1.8.3 Critical care nurse

Is a clinical nurse specialist who functions at an advanced level of patient care in medical- surgical nursing which includes research and leadership skills within his/her area of clinical speciality. According to the South African Nursing Council (SANC), a critical care nurse is a registered nurse who holds an additional qualification in

Medical-Surgical Nursing: critical care (Government Notice R212 of 1978, as amended).

The critical care nurse practices in any setting in which patient care requirement include complex monitoring and interventions, high intensity nursing interventions or continuous nursing vigilance within the whole range of high acuity care. In the context of the study it refers to a registered nurse either trained or experienced working in ICU.

1.8.4 Culture

Culture is learned, shared and transmitted values, beliefs, norms, and life way practices of a particular group that guide thinking, decisions, and actions in a patterned way (Leininger 1991:23). In the context of the study culture refers to the Arab culture of the people of Saudi Arabia.

1.8.5 Intensive care unit

Florence Nightingale established the first intensive care unit (ICU) during the Crimean War when she placed the sickest patients in close proximity to the nurse (Bucher & Milander 1997:39). An ICU is a specialised section of a hospital designed for the treatment of patients with acute life threatening conditions. These units contain resuscitative monitoring equipment and are staffed by nurses trained and skilled in life threatening health emergencies (Hudak, Gallo & Morton 2004:31-39). It is a unit in which patients requiring close monitoring and intensive care are housed for as long as needed (Mosby's Dictionary 1990:628). In the context of the study; it refers to the critical care units at KFSH & RC.

1.8.6 Nurse Manager

A nurse manager is a registered nurse responsible for the management of a nursing unit in the most cost-effective and adequate way, responsible for quality nursing care (Muller 2002:129). In the context of this study the term refers to the head nurses working at the critical care units at the KFSH & RC.

1.8.7 Perceptions

Perceptions are a way of regarding, understanding, interpreting, experiencing, conceptualising or viewing something (Pearsall, Bailey & Elliot: 1999).

It is the conscious recognition and interpretation of sensory stimuli through unconscious associations, especially, memory that serves as a basis for understanding, learning, knowing or motivation of a particular action or reaction (Mosby's Dictionary 1990:898).

1.8.8 Resuscitation

Resuscitation is the restoration of vital signs by mechanical, physiological and pharmacological means in the event of cardiac arrest or abrupt cessation of cardiac pumping activity (Hudak et al 1997:304). It is the process of sustaining the vital functions of a person in case of respiratory or cardiac failure while reviving him or her while techniques of artificial respiration and cardiac massage are being implemented (Mosby's Dictionary 1990:1249).

1.8.10 United Arab Emirates

The United Arab Emirates (UAE) is an Arab country in the Middle East ruled by Islamic Principles (Longman Dictionary of Contemporary English 1995:1045).

1.8.11 Witnessed resuscitation

Witnessed resuscitation is the “process of active ‘medical’ resuscitation in the presence of family members” (Boyd & White 2000). It is the practice of allowing family in the critical care unit while there is an attempt to save their loved one’s life.

1.9. FOUNDATIONS OF THE STUDY

Assumptions

Assumptions are basic premises or principles that are presumed to be true, without proof of verification (Burns & Grove 2001:46).

Perception of crisis situations and reactions to the situation is culturally determined.

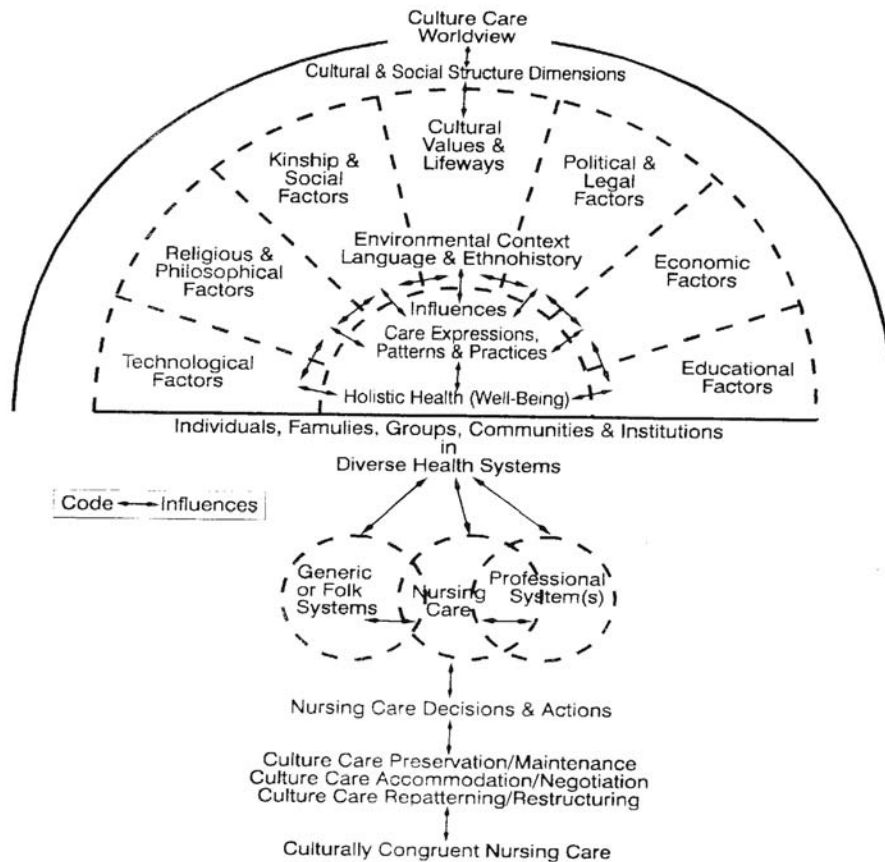
Nurses in foreign employment use their countries norms and attitudes in approaching family witnessed resuscitation. Knowledge of local practices of clients is essential to guide decisions and actions in providing culturally congruent care.

1.10. PARADIGM PERSPECTIVE

This research is based on Leininger’s Nursing theory, Culture Care Diversity and Universality. Leininger’s theory provides a conceptual framework to systematically examine individuals, families, or groups and how their culture influences healthcare practices. In conceptualizing the theory the major tenet was that human care

diversities and universalities existed among and between cultures of the world. Care was seen as the essence of nursing, and the central dominant and unifying focus of nursing. "Culture care would provide a distinctive feature by which to know, interpret, and explain nursing as a discipline and profession" (Leininger 1991:35). The aim of the theory is to provide knowledge on transcultural constructs and practices in order to provide culturally congruent care to people of different or similar cultures, so as to maintain or regain their wellbeing, health, or face death in a culturally appropriate way (Leininger 1991:40).

This theory was used in the study to discover what are the perceptions of critical cares nurses towards witnessed resuscitation. The sunrise model (figure 1.1) was used as a valuable cognitive map in depicting the total view of the different but very closely related dimensions of the theory, to provide an understanding and to develop ways to provide culturally congruent care in diverse cultures. The model shows different factors that need to be studied systematically with the theory. The components of the model should not be seen in isolation, fragmented, or unrelated, instead they are closely interrelated to each other, very much like the total functioning of human beings or the totality of one's cultural world (Leininger 1991:50).



From *Culture Care Diversity and Universality: A Theory for Nursing* by M. Leininger, 1991
 New York: National League for Nursing. Reprinted by permission.

Figure 1.1. Leininger's Sunrise Model

Leininger defines worldview as the way people look out on the world or universe to form a picture or stance about their life or world around them (Leininger 1991:47). Worldview determines how we perceive our world and how we think the world works. It deals with all aspects of reality, the metaphysical, moral and epistemological. It interprets and explains our vision of what is and what ought to be. Thus beliefs regarding illness are influenced from a person's basic worldview. A cultural group derives cultural and social structure dimensions that define their existence from the worldview. Cultural and social structure dimensions are present in every culture and are seen as influencing factors on the patterns, structure, and organization of a

particular culture. However cultural and social structure dimensions are lived and experienced differently from one culture to another. The Sunrise model emphasises that health and care are influenced by elements of the cultural and social structural dimensions, which are addressed within environmental contexts, language expressions, and ethno history. The cultural and social structure dimensions identified by Leininger are:

- Technological factors
- Religious and philosophical factors
- Kinship and social factors
- Cultural values, beliefs and life ways
- Political and legal factors
- Economic factors
- Educational factors (Leininger 1991:43).

These aspects will be discussed as they form the basis for the study.

All the above dimensions are closely related to health and care values and practices (Leininger 1991:43).

Cultural values, beliefs and life ways refer to the learned and transmitted values, beliefs and life practices of a particular group that guide thinking, decisions and actions in patterned ways (Leininger 1991:44). Religious and philosophical factors include the beliefs system that reflect spiritual and worldview. This theory depicts human beings as inseparable from their cultural background, social structure, worldview, and environmental context.

The worldview and social structure dimensions, together with ethno history and language influence cultural care meanings, expressions and patterns in different cultures. It also influences how people view health and illness (Leininger & McFarland 2002:83).

All cultures in the world have some kind of a folk, indigenous, generic, or naturalistic lay care system, and that some people had the exposure to the professional health care systems with professional nurses and other personnel (Leininger 1991: 37).

Generic care (caring) refers “to culturally learned and transmitted lay, indigenous (traditional) or folk (home care) knowledge and skills used to provide assistive, supportive, enabling, facilitative acts (or phenomena) toward or for another individual, group or institution with evident or anticipated needs to ameliorate or improve a human health condition (or wellbeing), disability, life way, or to face death” (Leininger 1991:38).The indigenous health care system is often viewed as more humanistic than the professional health care system. A professional health care system refers to a structured system maintained by individuals engaged in a formal program of study, at educational institutions such as nurses. Folk care involves practices that have special meaning in culture. These practices are used to define illness behaviour, heal and assist people in the home or community (Leininger & McFarland 2002:145).These two major types of health care systems are capable of providing human care that is healthy, satisfying, and congruent with the patient’s culture. The basis of this theory is to provide care practiced within a cultural context, and to form a holistic way of knowing and helping people. Nurses are therefore in a unique position to synthesise aspects from the generic (tradition) and scientific professional care systems.

Leininger identified three major modalities to guide actions and decisions to provide culturally congruent care for the general health and wellbeing of the patients or to help them face death or disability (Leininger 1991:40). The three modes are:

- cultural care preservation and/or maintenance
- cultural care accommodation and/or negotiation
- cultural care repatterning or restructuring

Cultural care preservation and/or maintenance refers to those” assistive, supporting, facilitative, or enabling professional actions and decisions that help people of a particular culture to retain and/or preserve relevant care values so that they can maintain their wellbeing, recover from illness, or face handicaps and/or death”

(Leininger 1991:48). This can be accomplished by having knowledge about the rituals, customs, and cultural practices of a particular cultural group. Cultural accommodation or negotiation refers to assisting, supporting and facilitating the patient to adapt and negotiate with others for a beneficial and satisfying health outcome (Leininger 1991:48). Patients of the Islamic Faith value total family participation. The family is the foundation of the Islamic Society. The peace and security offered by a family unit is greatly valued and essential for healing. For a child of the Islamic Faith who is sick in the hospital, the mother is obligated to stay with him/ or her. In this response the nurse would need to plan to accommodate the mother and child in order to provide the most beneficial and satisfying care. Cultural care repatterning or reconstructing is defined as the “assistive, supportive or enabling actions and decisions that help patients change their life ways for new or different patterns that are culturally satisfying” (Leininger 1991:48).

1.11. STUDY LAYOUT

CHAPTER 1 contains the introduction, background information, objectives, the purpose and significance of the study.

CHAPTER 2 provides a review of the literature that already existed on the topic.

CHAPTER 3 outlines the methodology as well as the ethical considerations used in the study.

CHAPTER 4 describes the findings of the research.

CHAPTER 5 contains the limitations, recommendations and conclusions of the study.

1.12. CONCLUSIONS

Resuscitation of a patient in an ICU is a traumatic and stressful situation because all parties involved are stressed due to the possibility of losing a life. The presence of families during resuscitation is believed by some authors to interfere with the procedure and it is seen as being traumatic, but to others it could also mean closure to the family. The aim of this research was not to solve any complex problems encountered with witnessing resuscitation, but to present the perception of critical care nurses towards the new trend.

Chapter 2

Literature review

2.1 INTRODUCTION

The aim of the literature review was to obtain information concerning the topic. According to Brink (1996:76) the literature review is a process that involves finding, reading, understanding and forming conclusions about the published research and theory about a particular topic. Furthermore, the literature review would enable the researcher to:

- determine what is already known about the topic;
- assist in refining certain parts of the study;
- form a basis for comparison;
- inform or support the study (Brink 1996:76).

The discussion in this chapter has been guided by the research question;

“What are the perceptions of critical care nurses towards family witnessed resuscitation in ICU?”

2.2 WITNESSED RESUSCITATION IN CRITICAL CARE UNIT

Critical care units are highly specialised units that house critically ill patients who require close monitoring. Staff working in these units is usually highly competent trained personnel who are able to deal with challenging situations. Resuscitation of

patients is one of the many challenging situations critical care nurses are often faced with.

Traditionally, during a resuscitative effort of a patient, family members are moved from the resuscitative area to a waiting area, as nurses and doctors work desperately to resuscitate the patient. The reason for this approach was fear of family members becoming too distraught during these efforts (Marrone & Fogg 2003:32). Different views and perspectives have been documented on family witnessed resuscitation.

Following is a discussion on the arguments for and against family witnessed resuscitation as perceived by nurses in the clinical areas.

2.3. FAMILY WITNESSED RESUSCITATION

2.3.1. Arguments for the presence of family during resuscitation

There has been a limited number of studies in relation to family witnessed resuscitation (Rattrie 2000:32). One of the first attempts to incorporate the presence of patients' family members during resuscitation was in 1982 at Foote Hospital in Jackson, Michigan, USA. On two separate incidences family members demanded to be present in the resuscitation room. This led to personnel examining their policy of excluding patients' family members during resuscitation. Initially, staff at Foote hospital resisted the implementation of a formal policy for family presence,

but in 1985 following a survey on the inclusion of families during resuscitation was completed, 21 staff members (71%) indicated their support for the presence of family members during resuscitation.

A similar survey conducted by Rattrie (2000:32) revealed that 72% of family members wished that they had been present. Relatives believed that their presence during resuscitation would have helped them with their grieving process (Rattrie 2000:32).

Robinson et al. (Cole 2000:8) reported on the perception of staff on 25 patients' relatives who had been present during the resuscitation. The reports were that:

- staff viewed the patient as a valued family member;
- all relatives felt that it had been beneficial to be present;
- no relatives commented on any technical procedures.

These reports indicated that there was little evidence to support the exclusion of relatives who wished to be present during the resuscitation (Cole 2000:8).

Children are the most vulnerable group in emergency situations. Children's' vulnerability and inability to care for themselves cannot be over emphasised during invasive procedures and resuscitation. McGahey (2002:29) highlighted he parents' desire to be present during invasive procedures performed on their children. A total of 400 parents completed the survey. Five scenarios were presented which included various degrees of invasive procedures, with resuscitation being the ultimate procedure. Of these respondents, 83.4% wished to be present in the likelihood of their child dying. Parents were adamant about not allowing physicians

to make decisions about their presence during resuscitation. The survey prompted paediatric healthcare providers to recognise the importance of parental desire for them to be included into their practice policies (McGahey 2002: 29).

This study reiterated that resuscitation of children has unique characteristics and should strive to be family- centred: the focus should be on the inclusion and empowerment of the family as an integral part of the child. Health professional providing care to children must not only strive to facilitate family- centred care but should also incorporate parental desire to be with their children during a crisis (McGahey 2002:30). However, not all research indicates positive staff attitudes.

2.3.2. Arguments against family witnessed resuscitation

Following is a discussion on the nurses' view on family witnessed resuscitation.

2.3.2.1 Sensory disturbance

Trauma resuscitation can be visually disturbing, even to the most experienced clinical staff. The smell of a patient' fluids, blood and other secretions can result in unpleasant, upsetting smells during the resuscitation. Similarly, patients who are crying due to pain or anxiety would cause auditory disturbance to the relatives (Cole 2000:15). McGahey (2002:36) disputes Cole's view, for she proposes that the patient is an extension of the family. She supports her argument that by respecting the relatives' wishes to be present during resuscitation allows them to know everything possible has been done and this decreases anxiety. Finally, the media familiarises the public with the resuscitation process, grounding them in reality

2.3.2.2 Confidentiality

Traditionally, a patient's permission is required before medical information is disclosed to outside parties. Breaching this confidentiality can have several repercussions, beginning with damage to the fiduciary nurse- patient relationship. If the patient is unconscious, it is difficult to gain his or her consent for witnessed resuscitation. Consequently, the patient's confidentiality may be broken if the patients' wishes are not known (Rosenczweig 1998:7).

Conversely, O'Brien (2004:32) describes the experience of a resuscitated patient as deriving comfort from the presence of family and friends, "having an expectation that they would in fact be there".

2.3.2.3 Fear of litigation

Cole (2000:15) commented on emergency nurses' fear of litigation. Nurses feared that an observed action or remark may be offensive to the relatives leading to complaints and litigation thereafter. Errors may occur during resuscitation. The presence of a relative may increase the resuscitation team's self-consciousness due to the potential litigation and public awareness that may result when a mistake is witnessed (Rosenczweig 1998:7).

Moreland (2004) also recognises family members as possible sources of increased liability.

2.3.2.4 Relatives' emotional response

Nurses feared that relatives would panic, become uncontrollable and disrupt the resuscitative efforts. Cole (2000:5) reported that relatives who witnessed the resuscitation had decreased levels of anxiety, terrible imagery, depression and grief in contrast to with those who did not witness resuscitation. No family member was

asked to leave the resuscitation room (Robinson et al. 1998:67). Another concern regarding relatives' emotional response is their potential impact on the resuscitation team. Relatives could impede the performance of staff in several ways. Their presence may influence the decision to prolong a futile resuscitation effort. More dramatically is the potential for hysterical relatives to intervene physically during resuscitation (Rosenczweig 1998:7).

2.3.2.5 Religion and culture

Another concern facing witnessed resuscitation is the issue of religion and culture. Martinelli (1993:6) describes religion as "a person's attempt to understand his or her relationship with the world". Culture is described as "developing awareness of one's own existence, sensations, thoughts and environment" (Martinelli 1993:6). Values and beliefs are derived from religion and have an influence on healthcare practice. Culturally competent care is especially significant for critical care nurses who work in high acuity, high stress environments (Flowers 2004:48). Critical care nurses are seen as patients' advocates (Muller 2002:130) and are required to support decisions made by the patients or their relatives.

Flowers (2004:9) noted with concern that, during resuscitative attempts on patients, family members are often excluded, even though the Arab culture has a strong sense of family. Illness and wellness form an important part of the Arab culture. The author is of the opinion that the goal of the critical care nurse is to provide the best possible care to the patient. Lack of cultural awareness and the inability to provide culturally competent care can lead to conflict, increases levels of anxiety and stresses amongst both nurses and a patients' relatives (Flowers 2004 :49). In Riyadh, the language and culture pose a constraint as many of the nurses may not

necessarily speak the Arab language and understand the culture. Cultural beliefs of the family and patient concerning death should be considered. When the family is not given the freedom of choice to remain with their dying loved one, the importance of death as a unique human event is devalued. The importance of death as a mystery or passage is ignored. In doing this, nurses enforce their own myth of control. This approach had been carried out for years, and nurses expected family members to follow their rules. According to the values and beliefs of the patients and families they should be given more autonomy in decision about witnessing their relatives' resuscitation (Byrd 2001:5).

2.4. NURSES PERCEPTIONS ON FAMILY WITNESSED RESUSCITATION

Rattrie (2000:30) stated a need for a specific educational qualification for the family support nurse. This need stressed the importance of the specialist support nurse in implementing witnessed resuscitation and the ethical implications that might be involved in resuscitation. In the study carried out by Mclean et al. (2003:30) the policies, preferences and practices of critical care and emergency nurses on witnessed resuscitation was identified. The results revealed that the majority of nurses perceived family presence as:

- increasing their understanding of the patients' condition;
- facilitating family decisions about resuscitation;
- providing emotional support for both patient and family;
- facilitating closure;
- providing an understanding for families to know that everything possible was done to save the life of their loved one (MacLean et al 2003:26).

However, nurses are of the opinion that each situation needs to be assessed differently. The significance of having policies guiding family witnessed resuscitation, prepare and educate families for what they might experience is stressed (MacLean et al. 2003:26). Nurses expressed the importance of having a staff member designated to support and guide the family.

The results of this study were congruent with the study conducted by Grice, Picton and Deakin (2003:4) on the attitudes of staff to family witnessed resuscitation in adult intensive care units in the United Kingdom. The results indicated a positive attitude by nurses toward family witnessed resuscitation; majority of personnel had experienced family witnessed resuscitation and felt that it was beneficial to relatives. Almost all intensive care staff felt that the views of both relatives and patients should be addressed prior to admission (Grice et al. 2003:820). A similar research conducted by Booth, Woolrich, Kinsella (2004) in the United Kingdom (UK) found that family witnessed resuscitation in emergency departments were common only when children were being resuscitated, not adults. They also documented that further research was applicable in other areas, such as intensive care units (Booth et al. 2004:725).

In the same vein some of the nurses in this study expressed their concerns on the option of family witnessed resuscitation. They raised concerns about the following:

- privacy of the patient;
- staff stress and discomfort in relation to extra work burden and

- inadequate staffing;
- family behaviour due to lack of education and understanding as well as emotional reactions;
- environmental issues such as chaos, confusion and limited space; family complaints and litigation (McClean et al. 2003:26).

The negative perception of these nurses is similar to the results of the study conducted by Goodenough (2001:12) which aimed to explore the attitudes and practices of family witnessed resuscitation by staff in a Level 1 emergency department in KwaZulu-Natal, South Africa. A qualitative approach was used to explore the attitudes and practices of participants. A total of six participants were used in one hospital from the public sector and one from the private sector. The findings documented were that staff disliked family witnessed resuscitation, as it was seen as a harmful experience, and a threat to the process of resuscitation as well as to the staff (Goodenough 2001:56).

In Moreland's study (2004) health care providers expressed fears that family members will increase stress of medical staff, disrupt procedures and increase legal liability. Meyers, Eichorn, Guzetta, Clark, Klein and Calvin (2000: 32) evaluated the stress levels of 96 healthcare workers involved in resuscitative efforts with family presence, of which 84% were unaffected by family presence. Boyd and White (2000) documented similar results on the perceived stress levels of healthcare workers and found no significant differences. Hanson and Strawser (1992) documented no instances of family interference in a nine-year review of Foote Hospitals' resuscitation programme.

2.5. CONCLUSION

The reviewed literature indicates that although, there are different perceptions and degrees of resuscitation, blanket perceptions and policies that exclude relatives from resuscitation are a knee jerk reaction taken because the worst possible scenario has been envisioned. It is true that not all resuscitations are a forum of chaos. Nurses need to introspect their perception on family witnessed resuscitation in order for them to be at ease with it. The nurse has an enormous task regarding integrating family witnessed resuscitation into their organisations. They have a privileged opportunity to be the last people to see the patient being alive. Being present during these final moments should be perceived as a privilege to be shared with the family as this will probably bring the greatest comfort to the relatives. The literature reviewed indicates that there is a definite trend towards acceptance of family witnessed resuscitation as a good practice, primarily due to the positive benefits for the relatives. It is important for critical care nurses to review their perception towards this move and the implications for practice. Nursing staff need more education to provide attending relatives with relevant information on procedures and patients' response, as well as being able to provide constant support. New policies and procedures will need to outline clinical procedures and staff attitudes.

The research methodology will be discussed in the next chapter.

Chapter 3

Research methodology

3.1 INTRODUCTION

A description of the research methodology is given in this chapter. The rationale for the study design and methods is described. The section also contains the data collection methods, data preparation and data analysis plan are discussed. Problems encountered with the data collection instruments are also discussed.

3.2. RESEARCH DESIGN

The research design is a set of logical steps taken by the researcher to answer the research question. It forms the recipe for the study and determines the methods used to collect and analyse data and to interpret results (Brink 1996:100).

The design is seen as the structural framework for the study (Burns & Grove 2001:23). It is also seen as the overall plan for gathering data in a research study (Brink 1996:214). The choice of the design depends on the expertise of the researcher, the purpose of the researcher and the research problem (Brink 1996: 59).

The study design helps the researcher in planning and implementing the study so as to achieve the intended goal (Burns & Grove 2001:23). In this study a quantitative, exploratory, descriptive survey design was adopted.

Following is the detailed explanation of the terms in the design;

Quantitative research

Quantitative research is a formal, objective, rigorous, systematic process for generating information about the world (Burns & Grove 2001:23). It is the investigation of phenomena that can be precisely measured and quantified involving a rigorous and controlled design (Polit & Beck 2004:729). This was a quantitative study with the development of a questionnaire. According to Brink (1996:13) a quantitative approach also facilitates logistic deductive reasoning. This approach was chosen because it allowed the researcher to start with something about which little is known and to further explore the topic. Furthermore, because of its systematic fashion the researcher was able to progress logically through a series of steps. A quantitative design was chosen because the data was presented numerically in the use of frequency tables and percentages.

Descriptive research

Descriptive research seeks to describe phenomena in real life situations (Burns & Grove 2001: 24). Descriptive designs provide description of the variables in order to answer the research questions (Brink 1996: 109). The purpose of descriptive research is to observe and describe aspects of a situation as it naturally occurs (Polit & Hungler 1997:195-196). This design was chosen because new meanings might be discovered, that will describe that which already exists and forms the basis for future research. The researcher would be able to describe the relationships between variables. Problems with the current practice of resuscitation might be identified.

Exploratory research

Exploratory research is conducted to explore the dimensions of phenomena or that which develops or refines hypothesis about relationships between phenomena (Polit & Beck 2004:718). It involves examining the data descriptively to familiarise oneself with it (Burns & Groves 2001:463). This study was exploratory in the sense that it intended to explore the experiences relating to problems associated with family witnessed resuscitation by critical care nurses, identifying the relationships amongst variables and differences amongst the critical care nurses.

3.3 POPULATION STUDIED

The population can be described as all the elements or subjects that meet the criteria for inclusion in the study (Burns & Groves 2001:474). It comprises the entire group of persons or objects that the researcher is interested in studying (Brink 1996:132).

The population consisted of 400 critical care nurses working in the critical care areas in KFSH & RC. Some nurses were intensive care trained, others were intensive care experienced working both on night and day duty.

3.4 SETTING

Intensive care areas of KFSH&RC were used. This facility is a 660 bed tertiary centre catering for the needs of the people of Saudi Arabia and its neighbouring

countries. The researcher has been employed at this hospital during the research survey. Ninety seven percent of the nurses were non- Islamic expatriates, yet most of the patients were of Islamic Faith.

3.5. SAMPLE AND SAMPLING PROCEDURES

Sampling is the process of making a selection of the study participants (Burns & Grove 2001:478). According to Burns & Grove (2001) a sample is a subset of the population that is selected for a particular investigation; it is a representation of the population.

A non-probability convenience sample was used for this study. Convenience sampling is also referred to as accidental or availability sampling and involves choosing readily available people or objects for the study (Brink 1996:135). A limitation of convenience sampling provides little opportunity to control biases. Available subjects may be atypical of the population of interest with regard to critical variables (Polit & Beck 2004:294). This sample was chosen because it was convenient and economical in the sense that the researcher was employed there. The non- probability sampling uses the judgement of the researcher to select those subjects who know most about the phenomenon and who are able to articulate and explain nuances to the researcher (Brink 1996:135).

The following ICUs were used to collect the sample:

- Paediatric ICU
- Cardiothoracic ICU
- Medical - surgical ICU-east wing

- Medical - surgical ICU-west wing
- Neonatal ICU

In this study, the researcher overcame the limitations by using a sample of critical care nurses working in critical care units at KFSH & RC.

A sample size of 100 critical care nurses from the five critical care units was selected conveniently, depending on availability.

3.6. CRITERIA FOR INCLUSION

The criteria used to select the sample was that:

- Respondents should be critical care nurses, trained or experienced;
- Respondents should be working in a critical care unit.

3.7. DATA COLLECTION INSTRUMENTS

The data collection instrument used in this study was a questionnaire. A questionnaire with open-ended and closed-ended questions was designed by the researcher, with the assistance of the statistician and study supervisor. The questionnaire was designed after an in-depth literature review. Questionnaires are used because they are cost effective, required less time to administer and offered complete anonymity. A guarantee of anonymity was crucial in this study because questions were of a personal and sensitive nature. It also facilitated the absence of

interviewer bias. A large number of people could thus be reached in a short space of time. A disadvantage of this method is a low response rate if questionnaires are posted. To prevent this problem the questionnaires were hand delivered and collected by the researcher.

Open-ended questions required the respondents to provide their own answers while closed- ended questions required the respondents to select answers from a list of possible answers provided. Open-ended and closed- ended questions have both weaknesses and strengths. Good closed-ended questions are difficult to construct, but easy to administer, analyze and are more efficient. The analyses of open-ended items are more difficult and time consuming (Polit & Hungler 1997: 455).

The questionnaire for this study was divided into two sections, namely:

Section A: Biographic data of the respondents;

Section B: Perceptions of critical care nurses towards witnessed resuscitation.

3.8. DATA COLLECTION METHODS

3.8.1. Measures for ensuring reliability and validity of the instrument

The tool was tested for validity and reliability.

Reliability

Reliability can be defined as “the degree of consistency or dependability with which the instrument measures attitudes it is supposed to measure” (Polit & Hungler

1997:297). The reliability of a quantitative measure is a criterion for assigning its quality (Brink 1996:171).The researcher ensured reliability of the instrument by:

- Asking questions that people were likely to understand
- Asking about issues relevant to the subject.

Validity

Validity can be defined as "the degree to which an instrument measures what it is intended to measure" (Brink 1996:168).

Before the data was collected the tool was pre-tested. It was given to three critical care experts to assess for content and face validity. The three experts were not included in the final study. The instrument was corrected according to their recommendations before it was administered.

The researcher proposed to ensure validity of the instrument by:

- Avoiding selection biases
- The same measuring instruments were given to all the participants,

Several criteria were considered in the constitution of the instrument to standardise the evaluation:

- The questions were as simple as possible
- Sufficient time was allowed to complete the questionnaires
- Instructions were as clear as possible regarding the completion of the questionnaire.

3.8.2. Data collection procedure

Appointments were made with the respective head nurses of each unit. He or she

was given twenty questionnaires to hand out to respondents. A total of hundred questionnaires were handed out. A letter was attached to the questionnaire explaining the purpose of the study, also stating that permission was granted from the management of the institution used, and with contact details of the researcher. The completed questionnaires were collected from each head nurse of the respective units. Although on collection of the completed questionnaires it was found that some were not filled in, the overall return rate was good. A total of 100 questionnaires were distributed, a total of 70 was completed thereby giving a return rate of 70%.

3.9. DATA ANALYSIS

Data analysis refers to systematic organization and synthesis of research data (Polit & Hungler 1997:455). Microsoft Excel was used to analyse the data. The data was presented in frequency tables and percentages.

3.10. ETHICAL CONSIDERATIONS

Informed Consent

Informed consent can be defined as “an ethical principle that requires researchers to obtain voluntary participation from subjects, after informing them of possible risks and benefits” (Polit & Hungler 1997:704). No minors were involved in the study.

Confidentiality

Participants were assured that the information was accessible to the researcher only

and this information was used solely for the purpose of this research.

Anonymity

Anonymity was assured by informing the respondents that names were not revealed and questionnaires were not linked to names.

Persuasion

The respondents were not forced to participate, it was done out of their own free will.

Sponsorship

There was no sponsorship, the decision to undertake the research was the choice of the researcher.

Benefits

There were no potential physical, psychological, social and legal risks to the participants.

It was explained to the participants that there was no direct benefits to them and that they would not receive course credit for participation in this research. However the information they contributed may enhance the improvement of healthcare provision.

Permission of the study

In order to be able to proceed with the study, permission was obtained from the research council at KFSH & RC. Covering letters requesting permission as well as permission granted are included in the research report.

Chapter 4

Data analysis and description of findings

4.1 INTRODUCTION

A total of 70 (70%) out of 100 responded to the questionnaires. All the respondents were critical care nurses from KFSH & RC. The data was analysed by Microsoft Excel and was presented in frequency tables and percentages.

4.2 ANALYSIS OF THE RESULTS

Section A: Biographic information

Section B: Attitudes to family witnessed resuscitation

SECTION A: BIOGRAPHIC INFORMATION

Biographic information refers to personal information namely: age, gender, educational qualifications and country of training.

Following is a discussion of the biographic data

4.2.1 Age and gender of the respondents

There were N= 19 (27.1%) males and N= 51 (72.9%) females. The age ranged from 30 - 59 years, as indicated in the tables below.

Table 4.1: Age of respondents (N=70)

Age	n	%
Less than 30 yrs	22	31,4%
30-39 yrs	24	34,3%
40-49 yrs	19	27,1%
50 and above	5	27.1%
Total	70	100%

Most of the respondents N=24 (34.3%) were aged between 30-39 years; respondents in the age category of less than 30 years was N=22 (31.4%); N=19 (27.1%) in the age category between 40-49 years and the much older respondents being N=5 (7.2%) in the age category between 50-59 years.

This age trend is normal in most ICUs.

Table 4.2: Gender of respondents (N=70)

	n	%
Male	19	27,1%
Female	51	72,9%
Total	70	100%

N=19 (27.1%) were males and N=51 (72.9%) were females. This is a normal gender pattern in the nursing community.

4.2.2 Education

Table 4.3: Educational status (N=70)

	n	%
Masters degree	1	01,4%
Bachelor degree	42	60,0%
Diploma	27	38,6%
Total	70	100%

Respondents with the highest educational level, N=1 (1.4%) possessed a Masters degree in Nursing Science, N=42 (60%) had a Bachelors degree in Nursing Science

and N=27(38, 6%), a basic diploma in Nursing Science.

4.2.3. Country of training

Respondents were from 13 different countries with diverse religious and cultural beliefs.

Table 4.4: Country where respondents trained

Country	n	%
Philippines	12	17%
India	10	14%
Canada	9	13%
South Africa	7	10%
Jordan	6	9%
United States of America	6	9%
Malaysia	5	7%
England	4	6%
Lebanon	3	4%
Australia	3	4%
Czech Republic	2	3%
Kingdom of Saudi Arabia	2	3%
New Zealand	1	1%
Total	70	100%

The highest number of respondents were from the Philippines N=12 (17%), followed by India with N=10 (14 %), Canada N=9 (13%) and South Africa N=7(10%) New Zealand had the least of N=1(1%).

4.2.4. Experience as a registered nurse

Table 4.5: Years of experience of respondents

	N	%
3 yrs or less	8	11,4%
4-5 yrs	8	11,4%
6-10 yrs	21	30,0%
11-15 yrs	13	18,6%
16-20 yrs	6	08,6%
Greater than 20 yrs	14	20,0%
Total	70%	100%

N=21 (30%) of the respondents had 6-10 years of nursing experience; N=14 (20%) had more than 20 years of nursing experience; N=6 (8.6%) of the respondents having the least number of years nursing experience. In the study conducted by Cole (2000), more experienced staff opted for the presence of family witnessed resuscitation; they felt more competent in their resuscitative efforts than less experienced staff members who feared carrying out a resuscitative effort for the first time will lead to litigation.

4.2.5. Nursing positions

Most of the respondents N=67 (97.2%) were staff nurses, i.e. registered nurses are the given the title of staff nurses in the KSA. Both managers and advanced nurse practitioners, N=1 (1.4%) were respondents. staff nurses form the bulk of the workforce in the ICUs at KFSH & RC.

4.2.6. Type of patients cared for

There were N=36 (51.4%) adults and N=13 (18.6 %) children that were cared for by the respondents. A total of N=21 (30%) respondents cared for both adults and children.

4.3 SECTION B: PERCEPTIONS TOWARDS FAMILY WITNESSED RESUSCITATION

4.3.1 Previous experience with CPR

Only N=11 (15, 7%) respondents had been involved with family witnessed

resuscitation. Respondents with previous experience believed it had more positive effects than negative effects for families.

4.3.2 Preferences for family witnessed resuscitation

Response to a direct question like: In your unit would you prefer presence of family during CPR? elicited N=63 (90 %) negative response where respondents stated that they would not allow the presence of family during resuscitation. These findings are similar to those by Moreland (2004:58), who documented that staff fears that family witnessed resuscitation will increase stress levels, be disruptive and increase litigation. The N=7 (10%) of respondents who preferred the presence of family witnessed resuscitation, believed that it facilitates the grieving process and enhances closure and healing. These results were similar to those of MacLean et al. (2003) who documented similar benefits for FWR.

4.3.3 Policy preference

Table 4.6: Family witnessed resuscitation options

	n	%
Prefer a written policy allowing the option of family presence to CPR	18	25,7%
Prefer a written policy prohibiting the option of family presence to CPR	28	40,0%
Prefer no written policy but want the unit to allow the option of family presence to CPR	24	34,3%
Total	70	100%

N=18 (25.7%) of respondents preferred a written policy allowing family witnessed resuscitation, N=28 (40%) respondents preferred a written policy prohibiting family witnessed resuscitation and N=24 (34.3%) preferred no written policy but felt that

family presence should be allowed during CPR. Rattrie (2003) documented that 71% of the respondents supported the implementation of policies with regards to family witnessed resuscitation in the study carried out in Foote Hospital, USA. MacLean et al. (2003) also documented similar findings, stating that nurses stressed concern in providing equal access to, and the need to have policies guiding family witnessed resuscitation.

4.3.4 Permission

There were more respondents N=43 (61.2%) that felt that no permission should be obtained from patients allowing family witnessed resuscitation as opposed to N=27 (38.8%) respondents who felt that permission was vital and that the privacy and confidentiality of patients should be respected. Grice et al. (2003) documented that the views of both the family and patient should be assessed prior to admission regarding family witnessed resuscitation.

4.3.5 Emotional stress for medical and nursing staff

The majority, N=59 (84.2%) of the respondents indicated that family witnessed resuscitation will increase the stress levels of both medical staff and nurses. Goodenough (2001) found that family witnessed resuscitation was a threat to staff and harmful to implement. Meyers et al. (2000), and Boyd and White (2000) had opposing findings. The authors reported on stress levels of healthcare workers and found no significant changes.

4.3.6 Presence of relatives

N=63 (90%) of respondents felt that the presence of relatives during resuscitation will interfere with the resuscitative efforts. Similar findings were documented by Cole (2000) who reported that nurses feared relatives would panic, become uncontrollable and disrupt the resuscitative efforts. Only N=7 (10%) of the Respondents agreed that the presence of relatives were not threatening to the resuscitative efforts.

4.3.7 Trauma to relatives

There was an overwhelming response, N=62 (88.2%), stating that family witnessed resuscitation will be traumatic to relatives while in a similar study, Cole (2000) expressed concerns surrounding the emotional response of families fearing that they would become uncontrollable during the resuscitative efforts. However Robinson et al. (1998) had a different point of view and reported that families who witnessed resuscitation had lesser levels of anxiety and grief whereas those who had not been present.

4.3.8 Benefits for relatives

However, N=24 (33.8%) respondents felt that family witnessed resuscitation was beneficial to patients while N= 46 (66.2%) respondents felt that witnessing resuscitation had no benefits for patients at all. Benefits included facilitating the grieving process and knowing “everything possible was done” (McGahey 2002:29). MacLean et al. (2003) documented numerous benefits for family witnessed resuscitation, with the facilitation of closure and healing being some of the many benefits documented.

Table 4.7 The most common benefits for relatives

	n	%
Facilitates the grieving process	30	43,5%
Satisfaction knowing that everything possible was done	40	56,5%
Total	70	100%

Most respondents, N=40 (56.5%) felt that “knowing everything possible was done” (McGahey 2002:29), for their loved ones was the most beneficial to the relatives. N=30 (43.5%) respondents felt that family presence is most beneficial because it facilitates the grieving process.

4.3.9 Litigation

The nurses expressed various concerns concerning allowing relatives witness resuscitation. A total of N=43 (62.1%) respondents were concerned that family witnessed resuscitation would increase legal liability in comparison to N=27 (37.9%) who were not concerned. Similar findings were documented by Moreland (2004) who states that healthcare workers feared that family witnessed resuscitation would increase legal liability.

4.3.10 Support of relatives

Many respondents N=59 (83.8%) believed that relatives should be supported by staff during family witnessed resuscitation. MacLean et al. (2003) states that ‘preparing, educating and updating family for what they “might experience” is significant’ (MacLean et al. 2003:208-21).

4.3.11 Staff performance

In relation to staff performance, N=35 (50%) respondents felt that family witnessed resuscitation inhibits staff performance, while an equal number of respondents N=35 (50%) felt that the presence of relatives will not alter staff performance. Hanson and Strawser (1992:49) have confirmed that family witnessed resuscitation does not interfere with performance and that family witnessed resuscitation was rather beneficial relatives.

4.3.12 Duration of resuscitation

Table 4.8: Will the presence of relatives prolong the resuscitation, making the decision to stop more difficult?

	n	%
Yes	55	78,3%
No	15	21,7%
Total	70	100%

N=55 (78.3%) respondents stated that family presence during resuscitation makes the decision to stop he effort more difficult.

4.3.13 Personal preference

Table 4.9: Would you prefer to be present during the resuscitation of your loved one?

	n	%
Yes	25	36,2%
No	45	63,8%
Total	70	100%

The majority of respondents N=45 (63.8%) answered no to this question. It is important to indicate that those respondents who did not support family witnessed resuscitation were the same respondents who did not want to be present during the

resuscitation of their own loved ones, and that those who wanted to be present supported the new trend of family witnessed resuscitation.

A summary of the findings, as well as the limitations, recommendations and conclusions of the study will be discussed in the next chapter.

Chapter 5

Summary of findings, recommendations and conclusions

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

5.1 INTRODUCTION

The aim of the study was to investigate the perceptions of critical care nurses towards family witnessed resuscitation. The discussion of the findings will be based on themes based on answers by respondents as discussed in chapter 4.

5.2 COUNTRY OF TRAINING

The respondents that opted for family witnessed resuscitation N=7 (10%), were mostly from western countries. These countries included the United States of America, United Kingdom, Canada, Australia and New Zealand. Most of the respondents from Eastern and Middle Eastern countries preferred no family presence. Respondents from Jordan N=7(10%), Lebanon N=3 (4%) and the Kingdom of Saudi Arabia N=2 (3%) who all shared the Arab culture were against the idea of family witnessed resuscitation. Family witnessed resuscitation is a new trend especially amongst the non-western countries. Two respondents, one from India and the other from Malaysia, opted for the presence of family members during resuscitation. These respondents' willingness for the family members to be present during resuscitation is congruent with the norms and values of the Asian population.

Family forms a basic support structure in this population. When one of the family members is ill, the family members alternate by sitting next to the patients' bedside. The other possible contributory factor could be that the respondents understand the Islamic Faith. According to the Islamic Faith the corpse should not be touched by a female person once the patient has died (own experience).

5.3 PREVIOUS EXPERIENCE WITH FAMILY WITNESSED RESUSCITATION

Most of the respondents N=59 (84.3%) had no previous experience with family witnessed resuscitation. Although having no previous experience with witnessed resuscitation, the general feeling amongst the respondents towards family witnessed resuscitation was one of dislike. Respondents expressed fear of trauma to relatives. All the respondents, N= 11 (15.7%), with no previous experience felt that allowing family witnessed resuscitation was beneficial to families. Most of these respondents believed that family presence helped with the grieving. Rattrie (2000) also reported that family witnessed resuscitation facilitates closure and healing.

5.4 PREFERENCES FOR FAMILY WITNESSED RESUSCITATION

The majority N=60 (90%) of the respondents were against family witnessed resuscitation and only N=7 (10%) of the respondents opted for this procedure. It was evident that family witnessed resuscitation was a new concept amongst the critical care nurses at KFSH & RC. Respondents expressed dislike for the presence of relatives being present during the resuscitation process. Respondents believed that family witnessed resuscitation was too traumatic and stressful for relatives. MacLean

et al. (2003) documented nurses raised concerns about inappropriate family behaviour during resuscitation due to the lack of education and understanding which results in a stressful and traumatic experience for the family. Conversely, Meyers et al. (2000) who evaluated the stress levels of participants found no significant changes. Only N=2 (3%) of the respondents preferred to be present during the resuscitation of a loved one.

5.5 POLICY PREFERENCE

N= 18 (25.7%) respondents felt that there was a need for policies allowing the presence of family witnessed resuscitation. During the course of the study, there were no written policies allowing the presence of family witnessed resuscitation at KFSH & RC. N=24 (34.3%) preferred no written policy but felt family witnessed resuscitation should be allowed. Most of the respondents, who felt that family witnessed resuscitation should be allowed with no written policies, were respondents that nursed adults only. Only N=1 (2%) respondents who nursed both children and adults agreed with the presence of family witnessed resuscitation, with no policies in place. Booth et al. (2004) found that family witnessed resuscitation in emergency departments were common practice only when children were being resuscitated. Tsai (2002) reported that in 2001 the Emergency Nurses' association in the United States of America produced updated national guidelines for family witnessed resuscitation with continued support for family witnessed resuscitation after a survey was completed on families of recently deceased patients determining their desire to be present with their loved one during family witnessed resuscitation. McGahey (2002) highlighted the parents' desire to be present during family witnessed

resuscitation. it was documented that healthcare providers must strive to facilitate family - centred care as the resuscitation of children have unique characteristics.

5.6 ADVANTAGES OF FAMILY WITNESSED RESUSCITATION AS PERCEIVED RESPONDENTS

Respondents that agreed for the option of family presence felt that the primary benefit for family members were that it facilitates the grieving process. One respondent stated that “it is comforting for the family to know that everything was done for the relative”. Another respondent stated that family witnessed resuscitation facilitates closure. Similarly, Rattrie (2002:32) documented that relatives believed that their presence during family witnessed resuscitation helped their grieving process. MacLean et al. (2003:26) reported that family witnessed resuscitation provides an understanding for families to know that everything possible had been done for their loved ones. In the study by Grice et al. (2003) the attitudes of staff to family witnessed resuscitation in the UK were positive.

5.7 DISADVANTAGES OF FAMILY WITNESSED RESUSCITATION AS PERCEIVED BY RESPONDENTS

The overriding feeling towards family witnessed resuscitation in this study has been one of dislike. Respondents felt that allowing the presence of family during resuscitation will be too stressful for both relatives and staff involved. One respondent stated that “family members would be traumatized themselves by observing such a procedure and such consequences can never be beneficial to the

relatives". Another respondent stated that "family members would be too distraught to understand what was happening and would be dissatisfied with the resuscitative efforts". Respondents also expressed that family witnessed resuscitation could lead to chaos and confusion as the work space is sometimes limited. All of the respondents, N=63 (90%), who agreed with family witnessed resuscitation agreed that family presence would increase litigation. Respondents felt that the presence of relatives will prolong the resuscitation process although one respondent stated that "it depends on the doctor present to terminate the resuscitative efforts when necessary ". Thus the feeling of dislike is quite evident amongst the critical care staff at KFSH & RC. The findings in this study are similar to the study by Yanturali et al. (2005:5) who feared family witnessed resuscitation would lead to family interference and litigation. Goodenough (2001) found that staff disliked the presence of family during resuscitation as it was seen as a harmful experience. Moreland (2004) expressed concerns that family members would increase the stress levels of medical staff and disrupt procedures. Conversely, Hansen and Strawser (1992) documented no instances of family interferences. Similarly, Boyd and White (2000:51) found no significant changes regarding the stress levels of healthcare workers.

5.8 CRITICAL CARE STAFF PRACTICES

During this study, the practices of the respondents towards family witnessed resuscitation were explored.

As there were no current policies at KFSH & RC respondents stated that their practices towards family witnessed resuscitation involved asking the relatives to wait

outside the resuscitation room. Relatives were then informed when a staff member could be available to communicate information on the patients' condition.

Due to the shortages of nursing personnel, family members were always informed after the resuscitative procedure. It was quite clear from the respondents that commented on their practices, that there was consistency amongst staff practices when dealing with family witnessed resuscitation.

5.9 LIMITATION OF THE STUDY

The researcher identified the following as the limitations to this study:

5.9.1 Generalisability

Generalisability is the criterion used in a quantitative study to determine the extent to which the findings can be applied to other settings or groups (Polit & Beck 2004:40). Although the study consisted of 70 respondents that completed the questionnaires, only N=2 (3%) of the respondents were from the Kingdom of Saudi Arabia, therefore the study cannot be generalized to the critical care nurses of Saudi Arabia

5.9.2 Questionnaire

Respondents were on duty when questionnaires were handed out, and due to work constraints the questionnaires could have been completed in a hurried fashion with some respondents providing answers which they think the researcher would be in favour of. The typing and printing of the questionnaires were costly, and the collection process of the completed questionnaires was time consuming.

Only questionnaires completed by critical nurses were used. It would have been interesting to elicit the perceptions of the family members regarding their presence during resuscitation.

5.10 RECOMMENDATIONS FOR FUTURE PRACTICE

It was discovered during this study that there is a need for the critical care staff at KFSH & RC, to be informed about family witnessed resuscitation. This new trend needs to be incorporated into the educational programme for critical care nurses at this hospital.

Staff has to be informed about the concept of family witnessed resuscitation, the advantages as well as the disadvantages thereof.

Training to cope with the stressful situation of a family witnessed resuscitation needs to be implemented. Resources need to be available to make family witnessed resuscitation successful. Resources include more staff and larger working spaces. The formulation of policies according to the specific units and the needs of the family should be implemented to provide guidance.

5.11. RECOMMENDATIONS FOR FUTURE RESEARCH

Further research with regards to family witnessed resuscitation needs to be done at King Faisal Specialist Hospital and Research Centre.

The nursing population at the King Faisal Specialist Hospital and Research Centre is made up of diverse cultures and religious beliefs, therefore the needs of the patients and family members should be explored.

As family witnessed resuscitation is a new concept in nursing, more with regards to this practice needs to be researched and established.

5.12 CONCLUSION

From the respondents' responses and comments it was evident that family witnessed resuscitation was a relatively new concept for staff. Although witnessed resuscitation is currently a new trend in nursing, more education on this topic will lead to nurses becoming more familiar with this practice, well trained and motivated thereby providing considerable benefit for family members and staff during this difficult situation.

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ANNEXURE 1

ANNEXURE 2

ANNEXURE 3

ANNEXURE 4

ANNEXURE 5

ANNEXURE 6