Emergency Nurses Experiences of Family Witnessed Resuscitation in an Irish General Hospital Setting: A Qualitative Study

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‘We shall not cease from exploration and the end of all our exploring will be to arrive where we started and know the place for the first time.’

T.S. Eliot (1888 – 1965)
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ABSTRACT

The purpose of this study was to explore emergency nurses experiences of family witnessed resuscitation.

A qualitative method was utilised in the study. A Husserlian phenomenological approach was chosen as its reductionist approach of ‘bracketing’ was congruent with the study’s purpose. Seven nurses with a minimum of six months clinical experience working in the emergency setting provided their experiences of family witnessed resuscitation during a semi-structured face to face interview.

Themes and subthemes were gathered from the analysis of these interviews with the aid of the Colaizzi framework.

Four themes emerged: (I) barriers to family witnessed resuscitation (II) facilitators to family witnessed resuscitation (III) experiences of family witnessed resuscitation (IV) judging situations and feelings concerning guidelines and policies.

Findings show that nurses believe from their experiences of family witnessed resuscitation that space constraints, inappropriate staff levels, relatives becoming emotional and distracting the resuscitation team act as barriers to the practice. Regardless of these barriers the majority of nurses believe that family presence facilitates the grieving process, aids decision making and gives family comfort in knowing and seeing that all is being done for their loved ones.

It was also found from the study that nurses experiences showed that the practice of family witnessed resuscitation helped staff strengthen relationships and empathise with patient and family. Certain situations were also found as to when family presence was most suitable, they being the patients age, the suddenness of the event, and the condition of the patient as well as the relatives medical knowledge.

The majority of participants were in support of policy development as they believed it would serve as some direction when practicing family presence. From their experiences they believed it would facilitate greater understanding of the practice amongst health care professionals.

Qualitative findings revealed that personal, organisational and social factors influence nurses towards the practice of family witnessed resuscitation. Nursing staff are committed to changing their practice which can be seen in the findings of this study and previously published studies which indicate the need for development of written policies and guidelines on the practice to meet the needs of patients, families, and staff by providing consistent, safe, and caring practices for all involved in the resuscitation process.

Written policies or guidelines for family presence during resuscitation and invasive procedures are recommended and it must be noted that the opinions and experiences of health care professionals should be considered when developing these guidelines.
1. INTRODUCTION

1.1 CONTEXT OF STUDY

Historically family members were always prohibited from being present in the area where their loved one was being resuscitated. In the last few decades this idea has been turned on its head with research and recognised professional bodies now lending support to allowing family members be present during all resuscitative efforts.

As a nurse who has worked in the emergency setting for many years this is a new and exciting concept. Interest within the concept first originated following an incident concerning an elderly gentleman who was brought to the emergency department in cardiac arrest. The man was immediately brought to the resuscitation area where he unfortunately died. For the entire time the patient was in the resuscitation room, his wife of over fifty years was in a separate area due to staff believing it would be of no benefit for her to be present. When the lady came to see her husband she expressed her gratitude to staff for trying to help her husband but conveyed that she would have liked to have been with him in his last few moments of life. Reflecting on this thought, I questioned my right to remove relatives from their loved ones at this ultimate moment in their life journey together. This catalyst led to the area of family witnessed resuscitation being investigated and I was surprised to find that there was very little published Irish research available on this issue.

Of the published research, the majority undertook a quantitative approach which did not consider nurses experiences of the phenomena. The prospect of undertaking the MSc provided the opportunity for this area to be explored by the author.
1.2 HISTORY OF FAMILY WITNESSED RESUSCITATION

Allowing patients family members to be present during resuscitative measures within the emergency setting is a controversial practice. Recent trends towards greater autonomy for patients and their relatives originated in the care of children in the 1980s. Parents and family members became increasingly involved during the treatment of critical illness, induction of anaesthesia and resuscitation, with parallel development also occurring in obstetrics (Resuscitation Council 1996). Traditionally relatives were brought away from resuscitations involving adults, but with increased public awareness of occurrences in the emergency department, this is now being questioned not only by patients and relatives but by health professionals also.

Family witnessed resuscitation (FWR) came to the forefront of nursing in the early eighties following two incidents in the Foote Hospital, Michigan (Doyle et al, 1987). These incidents involved relatives refusing to leave their family member whilst they underwent resuscitation. These experiences were evaluated resulting in positive feedback from both family and staff. Consequently, Foote Hospital developed a programme to involve family members during resuscitation. From this study and others like it, the movement to permit family presence has gradually evolved as a result of the support of professional bodies such as the Emergency Nurses Association (ENA), the American Heart Association (AHA), the European Resuscitation Council (ERC), the Royal College of Nursing (RCN) and the British Association for Accident and Emergency Medicine.

Regardless of this vast body of support, family witnessed resuscitation has not been universally accepted among health care professions and momentum for endorsement
especially within the European context has been at a slower pace than its American counterpart.

1.3 RATIONALE FOR STUDY

As mentioned family witnessed resuscitation has gained considerable support from professional bodies. It has attracted significant interest in publications devoted to healthcare professionals (Mangurten et al 2005; McGahey-Oakland et al 2007; Weslien et al 2005; Rattrie 2000; Moreland 2005). The majority of the journals indicate the benefits of family presence for both family members and patients, and they recommend repeatedly that to meet their needs, programmes and policies should be developed to offer family members the choice of being present during resuscitative measures.

Madden and Condon (2007) conveys that policy development reduces the risk of conflict among the emergency team and the Royal College of Nursing (2002) maintain that every hospital should have a policy concerning family witnessed resuscitation. The hospital in which the study was undertaken has no policy or programme in place as recommended by the Royal College of Nursing. Before a program can be implemented, the author believes the experiences of emergency nurses must be explored so that these experiences can be taken into consideration when developing policies.

Whilst reading through the literature it became apparent that gaps were present. It was noted that the majority of views expressed were from a North American perspective. This can mislead the reader due to alternate cultural and ethical views that may be present in a European context especially within an Irish perspective. Reading the literature it appears that
no study has explored Irish emergency nurses experiences concerning family witnessed resuscitation utilising a qualitative approach.

1.4 AIM OF THE STUDY

The aim of this study is to explore emergency nurses experiences of family witnessed resuscitation who are working within an Irish general hospital setting to inform the development of guidelines and policies in relation to family witnessed resuscitation.

1.5 OBJECTIVES OF THE STUDY

The objectives of the study were as follows:

1. Explore emergency nurses experiences of family witnessed resuscitation
2. Gain an insight into the current nursing practices concerning family witnessed resuscitation
3. Utilise information developed to inform the development of guidelines and policies concerning family witnessed resuscitation
1.6 DEFINITION OF RELEVANT TERMS

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family</td>
<td>Relatives or significant others with whom a patient shares an established relationship (Emergency Nurses Association, 2005)</td>
</tr>
<tr>
<td>Family Witnessed Resuscitation (FWR)</td>
<td>The attendance of family member(s) in a location that affords visual or physical contact with the patient during cardiopulmonary resuscitation or an invasive procedure (Eichhorn et al 2001)</td>
</tr>
<tr>
<td>Family Presence (FP)</td>
<td>The process of active medical resuscitation in the presence of family member(s) (Emergency Nurses Association, 2005)</td>
</tr>
<tr>
<td>Cardiopulmonary Resuscitation (CPR)</td>
<td>Artificial breathing and cardiac chest compression initiated to sustain life (Mutchner, 2007)</td>
</tr>
<tr>
<td>Invasive Procedure</td>
<td>Any intervention that involves manipulation of the body or penetration of the body’s natural barriers to the external environment (e.g. endotracheal intubation, placement of a central catheter, lumbar puncture, insertion of a chest tube, orthopaedic reduction) (Emergency Nurses Association, 2005)</td>
</tr>
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1.7 CONCLUSION

The intention of this introduction was to familiarise the reader with the concept of family witnessed resuscitation, giving an overview of the subject with focus on an Irish perspective. The aims and objectives in addition to the justification for undertaking the study have been clearly outlined. The study will be separated into chapters with each section focusing on the literature review, the methodology and approaches utilised to obtain the data, the presentation and discussion of findings and finally the recommendations that have resulted from completing the study.
CHAPTER 2
2. LITERATURE REVIEW

2.1 INTRODUCTION

The intended goal of the literature review was to provide the author with a foundation to complete the intended study. Reading through the literature the study was put into the context of what is known concerning family witnessed resuscitation. Comparisons could be drawn from previous research as well as questions posed when gaps within the studies became apparent. Parahoo (2006) state that a literature review involves the critical reading of the relevant literature to discover how it may be useful to the current research. With this in mind the author read and critiqued journals relevant to the topic to provide a rationale for undertaking the proposed study (Appendix I).

The literature review will inform the various stages of the proposed study and put into context what is already known (Burns and Grove 2003). It stimulated the authors thinking and provided a wealth of ideas and perspectives.

2.2 SEARCH STRATEGY

Databases utilised to provide sources of information were the Cumulative Index to Nursing and Allied Health Literature (CINAHL), Blackwell Synergy, PubMed, Science Direct and The Cochrane Library of Systematic Reviews. A manual search of relevant journals was also undertaken within the Waterford Institute of Technology, Wadding Library. Unpublished theses undertaken by Irish health professionals were included in the search string so that an
Irish perspective of family witnessed resuscitation could be included within the research. During the literature review the author included informative and conceptual literature published by professional organisations such as the Royal College of Nursing and the Emergency Nurses Association in order for relevant and current best practice to be included within the study. The Cochrane Library of Systematic Reviews unfortunately did not uncover any relevant articles regarding family witnessed resuscitation.

2.3 SEARCH TERMS

The following search terms were used when accessing the mentioned databases:

- Family presence
- Resuscitation
- Witnessed
- Relatives
- Sudden death
- Staff experience

2.4 TIMEFRAME

To source the most current and comprehensive material the timeframe utilised for the search was from 1998 onwards. On retrieval of this material it became apparent that primary sources pre-dated the proposed timeframe. Dates were therefore amended to the beginning of 1980 so that seminal literature could be included within the study.
2.5 LITERATURE REVIEW

2.5.1 Effects of family witnessed resuscitation on families and relatives

It is apparent in the literature that nurses have vast and widening opinions regarding family witnessed resuscitation and its effects on family members and relatives. In their study Badir and Sepit (2007) examined the experiences and opinions of Turkish nurses regarding family witnessed resuscitation. Employing a descriptive postal survey questionnaire containing forty three questions, they explored the opinions of critical care nursing staff from ten different hospitals. They achieved a response rate of 68% (n= 278). To give strength to the questionnaire selected, it was pilot tested on thirty nurses prior to the main study. The results of the study showed the majority of respondents believed it was not necessary to invite the family to be present nor that they should be involved in the decision making (83.1% [n= 231] and 75.9% [n= 211] respectively). Reasons for these opinions were that nurses believed that it would be too stressful for families to be present (87.8%, n= 244), have long term psychological effects on family members (88.5%, n= 246) and certain decisions during the resuscitative period may upset the relatives (74.1%, n= 206).

Limitations found within the study conducted by Badir and Sepit (2007) include the fact that the study was undertaken within Turkey, which questions its transferability. The quantitative methodology did not allow for perceptions, experiences and opinions to be explored and the method of data collection being postal questionnaires questions the reliability and validity of the piece.
The opinions found by Badir and Sepit (2007) are supported by McClenathan et al (2002) who argue that the whole process of family presence would cause untold psychological trauma to family members. McClenathan et al (2002) utilised a qualitative survey design to explore critical care professionals opinions regarding family member presence. The survey was distributed to healthcare professionals attending the international meeting of the American College of Chest Physicians. All attendees who walked into the conference were offered the opportunity to complete the survey. The survey took just over two minutes to complete and was collected over the two day conference. Of the 554 surveys completed, 494 were physicians, 28 were nurses and 21 were allied health professionals.

Due to the way the survey was conducted a response rate could not be obtained. This could theoretically skew the results as only those with a strong opinion for or against family witnessed resuscitation may have taken the time and effort to complete the survey. Secondly, McClenathan et al (2002) state as their survey was not a rigorously controlled, prospective research study; this may have affected its reliability and validity.

Defence is given to the hypotheses that family witnessed resuscitation may be harmful to family members by Osuagwu et al (1991) who suggest that family witnessed resuscitation is a non therapeutic, regretful, and traumatic enough to haunt the surviving relative for as long as he or she lives. This is a strong statement especially when one considers that many family members are the first responders to the scene and to initiate CPR. Other authors suggest that due to frequent depictions of resuscitation and CPR on television programs such as Casualty and ER, the public are more aware of what to expect (Van der Woning 1999). McClenathan et al (2002) consider this but contend that the invasiveness and poor outcomes of ‘real life’
CPR attempts differ markedly from televisions almost universally successful and bland depictions.

These negative outlooks on family presence during resuscitation are not supported by all authors. In their study MacLean et al (2003) surveyed the practices of critical care and emergency nurses to identify their preferences and practices for having family members present during resuscitation and invasive procedures. They found that nurses believed that by having family members present it will help facilitate the grieving process and help relatives make decisions. Their study consisted of a thirty item survey postal questionnaire which was sent to 1500 members of the American Association of Critical Care Nurses (AACCN) and 1500 members of the ENA.

To establish content validity of the questionnaire utilised, a national panel of three critical care nurses, three emergency nurses and one physician rated the relevance and clarity of the survey. The questionnaire was pretested on four separate occasions. After each pre-test, items on the survey were reordered for clarity. The survey allowed participants to share any comments regarding their personal or professional experiences with family presence. Data were analysed using the Statistical Package for Social Scientists (SPSS®) Version 10.1. A response rate of 33% (n=984) was achieved. This poor response rate can be seen as a limitation of the study as the generalisability of the findings are limited to the search group. It should also be considered that nurses who did not respond may have different experiences and opinions of family witnessed resuscitation than those that did reply. The method of data collection relied heavily on memory and reports of respondents which may be seen as unreliable rather than field diaries which can be seen as more dependable.
Further support for permitting family witnessed resuscitation is given by Fulbrook et al (2007) who suggest that by having family members present they can see that everything is being done for their loved one and will help facilitate the grieving process. To improve understanding Fulbrook et al (2007) recommends further qualitative research in order to gain more insight and understanding into an already complex subject.

2.5.2 Preferences for written policy/guidelines

Policies were a prominent feature when reading the literature. Some authors view them as an aid whereas others see them as a hindrance. When one considers that policies and guidelines are recommended by bodies such as the ENA, the American Heart Association (AHA), the European Resuscitation Council (ERC) and the Royal College of Nursing (RCN), it is surprising to read that the majority of studies reviewed have no policy in place to guide staff members in relation to family presence. The majority of articles express concern at this lack of guidance and suggest why policies may or may not be of help to health care professionals.

Madden and Condon (2007) were pioneers in their field as their study was the first conducted within the Republic of Ireland to examine emergency nurses current practices and understanding of family presence during CPR in a large Irish hospital. The authors employing a quantitative approach to the collection of data explored emergency nurses knowledge of current policies and practices in addition to their preferences for policy development in relation to family witnessed resuscitation. The participants were selected from a convenience sample of one hundred nurses with greater than six months experience working in the emergency environment. Weight is given to this piece by the achieved response rate of ninety per cent. A survey questionnaire containing fifteen closed ended questions was employed to collect the data. Validity of the questionnaire content was established by a panel of experts.
from the ENA. To further establish reliability, the questionnaire was piloted to ten nurses from a different emergency department. This piloting resulted in the questionnaire being altered to gain further insight into the questions being answered.

The results identified the need for policy development with nearly three quarters of participants preferring the option of a written policy. Without these policies the authors state that nurses are put in difficult positions and that having policies may also prevent uncertainty as well as professional conflict. Badir and Sepit (2007) in their study also raise the issue of policies. The majority of respondents within the study had not had a positive experience of family witnessed resuscitation (88.8%). The authors argue that this high rate of negative experiences discovered could be as a result that no hospital within the study had a policy or protocol in place concerning family witnessed resuscitation.

Knott and Kee (2005) also lend support for policy development. They undertook a study to explore the beliefs and experiences of registered nurses concerning family witnessed resuscitation. Utilising a qualitative descriptive methodological design they interviewed ten nurses who worked in acute care settings who were likely to witness or participate in cardiopulmonary resuscitation. The interviews were of forty five minutes duration and were audio recorded and transcribed verbatim. The data were analysed using constant comparative methods. Their findings show that without policies, the decision to opt for family presence will be made by whoever is on shift that particular day and based on what is perceived as being in the patients best interest. Again this could lead to uncertainty and conflict amongst the resuscitation team.

Limitations evident within the Madden and Condon (2007) study include the chosen research methodology, as a quantitative approach did not allow perceptions of emergency nurses to be
explored. Research was undertaken within one hospital which may limit generalisability and opinions of nurses from different departments such as intensive care or coronary care were not considered. Knott and Kee (2005) do not recognise their limitations, but limitations can be seen. Readers may argue that the sample size of ten nurses would not be considerable enough to give sufficient information. This number can be justified when one considers that qualitative studies allow for smaller sample size as they are seen as more in-depth than their quantitative counterparts. Knott and Kee (2005) did not undertake a pilot interview prior to their study. This is unfortunate as the application of a pilot study would strengthen the rigour of the piece.

Authors such as Badir and Sepit (2007) argue that to increase familiarity concerning family witnessed resuscitation policies and guidelines should be explored and recommend further research to facilitate this.

2.5.3 Physician opinion versus nurse opinion

An issue that became apparent reading the literature was the differing opinions of health care professional regarding family witnessed resuscitation.

Kirchhoff et al (2007) using a quantitative approach analysed the attitudes of trauma surgeons towards family presence during trauma resuscitation. A postal questionnaire concerning beliefs and attitudes was the chosen method of data collection. The twenty one itemed questionnaires were mailed to surgeons working within German trauma centres. Questions focused on the surgeons current practice in addition to their beliefs and attitudes. The questionnaire was piloted and revised prior to implementation. Participants were given four weeks to reply. Of 545 questionnaires posted, 464 were returned achieving an excellent
response rate. The results were analysed with the aid of Sigma Stat® 3.0 software. Of the participants, 9.7% (n= 45) were female and 90.3% (n= 419) male. When the authors compared the results of the study a startling contrast was evident between the two sexes with women more in favour of the concept than their male counterparts. Of female respondents, 87% (n= 39) report family presence to be a positive experience versus 50% (n= 210) of male respondents. Unfortunately, there is little evidence available to compare attitudes of males and females with regard to family presence.

As with the study undertaken by McClenathan et al (2002), Helmer et al (2000) in their study compared physicians (predominantly male) and nurses (predominantly female), and reported a significantly greater support of family presence by the nurses. It may be argued that this finding may be due to the fact that women may be more tolerant of family presence due to their feminine instincts or due to their nurse training. Support is given to these findings by Yanturali et al (2005) whose study examined the current practices of family witnessed resuscitation in Turkish emergency departments. They found that physicians do not support the idea of family presence, with nurses favouring the concept more than their medical colleagues. The physicians state that they would be concerned about inflicting psychological trauma by allowing the practice. This view was not shared by family members.

The theme of nurse physician conflict was also apparent within the study undertaken by Fulbrook et al (2007). They found that two thirds of nurses surveyed believed that physicians do not want relatives to be present during resuscitation. These perceptions may not be an accurate reflection of physicians own views but as mentioned, previous studies undertaken do show marked difference between the medical and nursing professions (Kirchhoff et al 2007; McClenathan et al 2002). This marked difference may be seen as a difficulty when one
examines Fulbrook et al (2007) findings that show 37.8% (n = 37) of nurses surveyed rely on their physician colleagues to make decisions regarding family presence during resuscitation. Limitations uncovered within Kirchhoff et al (2007) piece of research include the fact that the approach to methodology does not give the opportunity to the participant to expand on their replies, so therefore it is difficult to understand why the replies are as such. As mentioned the questionnaire was revised prior to implementation. Unfortunately the authors do not inform what changes were made to the questionnaire nor do they impart who reviewed the questionnaire. By neglecting to relay this information, a weakness has developed within their study.

Care must be given to the results as they focus on trauma surgeon’s attitudes which cannot be generalised to other professions. Although the authors achieved an excellent response rate, postal questionnaires and the timeframe in this study may be seen by some to be too lengthy for accurate responses to be achieved. The authors propose that family witnessed resuscitation is overcoming resistance from physicians. Comparing the results with previous studies such as Helmer et al (2000) in which 97.8% of respondents considered family presence to be inappropriate and McClenathan et al (2002) in which 78% (n = 462) opposed the practice, findings from this study show that only 50% (n = 232) of physicians believe the practice to be inappropriate.

Badir and Sepit (2007) state for family witnessed resuscitation to be feasible a more unified and consistent approach is recommended. Therefore if family witnessed resuscitation is to be successful, physician’s objections and worries will have to be explored and addressed (Kirchhoff et al 2007).
2.5.4 Organisational constraints and issues of litigation

The issue of organisational constraints was a regular theme that ran through most research articles and was expressed by virtually all respondents. Litigation was another concern that was found whilst reviewing the studies.

These issues were seen in a study undertaken by Fulbrook et al (2007). Utilising a quantitative survey design, the authors examined the experiences of European paediatric critical care nurses concerning parental presence during cardiopulmonary resuscitation. The survey design consisted of a structured attitudinal questionnaire. One hundred and fifty eight paediatric critical care nurses made up the convenience sample selected. Data collected were analysed employing the Statistical Package for Social Scientists (SPSS®).

A surprising discovery revealed in the study, showed that the vast majority (87%, n= 90) of nurses believed that there should not be a dedicated nurse to support parents when they are present during resuscitation. This is in contrast to previous studies that show the importance of having a dedicated member of the resuscitation team to look after the family (Fulbrook et al 2005; Albarran and Stafford 1999; Alridge and Clarke 2005). Fulbrook et al (2007) are unable to explain this high percentage but suggest that staffing levels and space constraints may not permit family witnessed resuscitation and nurses may be concerned that other patients care may be compromised. Ellison (2003) also found organisational constraints such as this in her study. She recommends that resource commitments need to provided and that nurse shortages and space constraints ought to be resolved prior to the implementation of family witnessed resuscitation.
Twenty two per cent of nurses surveyed by Fulbrook et al (2007) expressed a concern of legal wrangling when family witnessed resuscitation was performed. Meyers et al (2000) argue that this concern is unfounded. In her study she also found comparative results but believes that nurses should recognise that the parents decision to remain in the resuscitation room is not an attempt to detect mistakes or assess the nurses competence in CPR skills, but rather it is indicative of their need to remain with their loved one. This insight is supported by other authors including Robinson et al (1998) who reported that by not allowing family members to be present during resuscitation, may not necessarily reduce the risk of litigation but on the contrary may exacerbate and intensify it.

This fear of litigation was also found in the study undertook by Kirchhoff et al (2007). Of the physicians surveyed, 58.6% (n= 272) believed that family presence may lead to litigation and medico legal lawsuits. This concern is further exacerbated by Helmer et al (2000) who states that fear of lawsuits is a good reason to exclude family members from resuscitative procedures. However, experts in medical malpractice convey that family presence actually decreases the likelihood of legal action by strengthening the bond between the resuscitation team and the family (Kirchhoff et al 2007). Noteworthy to add is that there have been no medical malpractice suits involving families who were allowed to witness resuscitation (Madden and Condon 2007).

It must be remembered that the sample within the Fulbrook et al (2007) study is not representative of the paediatric critical care nursing population. Also the findings are not representative of all critical care nurses experiences or attitudes as the majority of the respondents are based in paediatric settings and transferability to the adult arena is questionable. The method of data collection can also be seen as a weakness as only those...
with an interest in the topic may complete the questionnaire. Fulbrook et al (2007) encourage and recommend further qualitative research around the topic of family witnessed resuscitation to improve understanding within the area.

### 2.5.5 Nurses beliefs, attitudes and educational needs concerning family witnessed resuscitation

The literature review uncovered a diverse range of beliefs and attitudes concerning family witnessed resuscitation.

Meyers et al (2000) undertook a study to explore the attitudes and experiences of family members and health care professionals regarding family witnessed resuscitation. Utilising quantitative and qualitative methods a descriptive study was undertaken. The sample consisted of 39 family members and 96 health care professionals of whom 60 were nurses and 36 physicians. Data were collected with the aid of a 33 item survey to interview the health care professionals. An attitudinal and Likert scale were also utilised to obtain data. The participants were surveyed prior to and following instances of family witnessed resuscitation.

The results show that the majority of health care professionals displayed a positive attitude towards the practice with support for the idea of family presence during an invasive procedure at 73% (n= 70) and during CPR at 76% (n= 73). It must be noted when examining these findings that there may be a discrepancy due to recall error. This is due to the fact that the data were collected two weeks after the event. The perceived benefit of family presence included the notions that it helped meet the family and patients spiritual needs (78%, n= 75) and the family could appreciate all that is being done (93%, n= 89). Prior to the resuscitation, 38% (n= 36) of health care professionals were fearful that the family may interrupt the
resuscitation but this fear was discovered to be unfounded as all providers judged families' behaviour to be appropriate.

This is comparative with the data from Holzhauser et al (2007). They undertook a survey to determine if staff attitudes to family presence changed post-implementation of a family witnessed resuscitation programme. They found that only a small percentage of their study believed relatives distracted staff or were in the way (9%, n= 3). Both studies show that providers initially opposing family witnessed resuscitation have striking shifts in opinion when their experiences do not confirm their concerns and the benefits to families become apparent. In both studies reward is given for this change in attitude to educational programmes concerning family presence.

The benefit of education is evident in the study undertaken by Ellison (2003). Employing a quantitative descriptive correlative study with a qualitative component she explored nurses' attitudes towards family presence during resuscitative efforts and invasive procedures. The sample was randomly selected from nursing units within an acute teaching hospital and from members of the New Jersey ENA. Two hundred and fifty surveys were distributed to each group achieving a response rate of 42% (n= 208). The survey tool consisted of thirteen questions comprising of seven close-ended and six open-ended questions. The results showed that there was a positive correlation between educational status and acceptance of family witnessed resuscitation. Nurses whom were certified with the ENA had more positive attitudes toward family witnessed resuscitation than those who did not.

This again supports the idea proposed by MacLean et al (2003), that education can favourably affect attitudes concerning family presence which was seen in the studies
undertaken by Meyers et al (2000) and Holzhauser et al (2007). MacLean et al (2003) revealed in their study that an educational class on family presence given to forty six critical care and emergency nurses changed the percentage of nurses who would offer the option from 11% (n= 5) to 79% (n= 36).

It must be noted that the study by Holzhauser et al (2007) explored medical adult patients and different perceptions may become apparent when dealing with paediatric or traumatic resuscitations. Another limitation within this study includes the poor response rate probably due to the fact the researchers utilised a postal survey which is renowned for poor return. Both Holzhauser et al (2007) and Meyers et al (2000) recommend further studies to explore health care professional’s opinions and experiences concerning family witnessed resuscitation with more impetus for a qualitative approach. This is supported by Madden and Condon (2007) who illustrates the need to heighten nurses knowledge and awareness concerning family presence and indicate the need for education and policy development.

2.6 CONCLUSION

Reviewing the literature provided a plethora of ideas and perspectives. This enabled the author to better understand what studies had been undertaken in the past concerning family witnessed resuscitation. Critically reviewing the literature, gaps became evident which led the author to undertake the study in the manner in which it was completed. The literature review aided the author in identifying the research design which will now be discussed in the following chapter.
CHAPTER 3
3. METHODOLOGY AND APPROACHES TO DATA COLLECTION

3.1 INTRODUCTION

In this chapter the author will provide rationale as to why the methods and approaches to data collection were selected. Rationale and justification for choosing a qualitative paradigm will be provided. How concepts derived from the literature review were utilised in the development of the conceptual framework will also be discussed. One's personal perspective of the world and research will be offered as to do so it is believed it will increase rigour and trustworthiness within the study. The setting and sample will be examined. The management of the interview in addition to how one managed and analysed the data will also be discussed. The author also intends to show how scientific rigour, trustworthiness, and ethical principles were ensured throughout the study.

3.2 DEVELOPMENT OF CONCEPTUAL FRAMEWORK

To guide the study, concepts and ideas were drawn from various studies and research findings. Analysis of literature pertaining to family witnessed resuscitation revealed key themes. These themes and attributes guided the study and provided a conceptual framework which helped define the parameters of the overall study. Maxwell (1996) explains that conceptual frameworks are a system of concepts, assumptions, expectations, beliefs, and theories that supports and informs your research. Put simply, conceptual frameworks act like maps that give coherence to empirical inquiry. The author believes the study was influenced
by the theories of Husserl (1859-1938) which will be discussed later in the chapter. These phenomenological theories guided the research while simultaneously allowing new data to emerge, a factor reflected in the data analysis phase of the study.

3.3 PERSONAL PERSPECTIVE OF THE WORLD AND RESEARCH

Research I believe plays a pivotal part within the nursing field. It questions and gives insight into our professional practice. It is the basis of developing new and improving methods of care delivery. With the changing environment within the health services over the last few years, the need to justify ones practice is greater now than it has ever been. Clinical effectiveness can only be achieved when one continually questions their practice and strives to change and improve traditional procedure. I believe by doing this the nursing profession can be further enhanced and nurses further empowered. Undertaking this approach it is believed that the most optimal environment for patient care will be provided.

Prior to commencing the study, I struggled with which paradigm or world view I believed I was rooted in. This wavering of alliance was resolved having read around the areas. Exploring the positivist approach of empiricism it became clear I had no allegiance with this methodology due to the fact that I believe the world has many more facets than just what we experience through our senses. Concepts such as anguish, pleasure, sorrow and many others could never be explored if one was to take a true positivist approach. My own personal perspective is that the world is viewed by each person uniquely and their surroundings interpreted exclusively. This interpretivist paradigm underlines how one person sees the world, can only be appreciated when one considers the context in which their world is being viewed. Put simply one needs to look through that persons lens to explore and gain
understanding of their world. My own paradigm being interpretivist, best fits the purpose of the study as I wished to explore emergency nurses experiences of family witnessed resuscitation in their own surroundings.

3.4 METHODOLOGY – JUSTIFICATION FOR CHOSEN

The design of the research study must fit as tightly as possible with the research purpose. The purpose of this research was to explore emergency nurses experiences of family witnessed resuscitation. Breaking down the question one can see that the experiences of a phenomena i.e. family witnessed resuscitation, are required for the purpose to be achieved. Therefore a qualitative approach was chosen. The selection of a qualitative approach was also determined by the author’s beliefs and values, the resources which were available as well as the stringent timeframe.

Qualitative researchers study things in their natural setting, attempting to make sense of, or interpret, phenomena in terms of the meanings people bring to them (Denzin and Lincoln 1994). The merits of undertaking a qualitative approach are that the author can understand the participants interpretation and motivations rather than just explain them. On the other hand, quantitative research studies numerical data for the purpose of describing phenomena or assessing the magnitude of relationships among them (Polit and Hungler 1997). The quantitative approach therefore would not adequately address the research question and would not enable the author to include his own paradigm and perceptions of the world.

In retrospect understanding the phenomenon could have benefited and been enhanced by undertaking both a quantitative and qualitative approach. This method triangulation could
have consisted of a quantitative approach utilising a questionnaire which would have been followed up by in-depth interviews to elaborate on the responses from the questionnaire. Unfortunately due to financial and time constraints this approach was not feasible. In an attempt to relieve this problem questions for this studies interview were developed and guided after reviewing the study completed by Madden and Condon (2007).

Having decided on the method of research one had to decide which qualitative methodological approach would be most suitable to achieve the purpose of the research. An ethnographic style was considered but was disregarded at an early stage due to the fact that it is concerned solely with description and lacks theoretical basis (Cirgin Ellett and Beausang 2001). Ethnography, the oldest qualitative approach, is merely concerned in giving a detailed description of what is studied rather than determining why the people being studied act the way they do. An additional reason this approach was not undertaken was that the act of ‘going native’ would not have been viable due to the infrequent occurrences of family witnessed resuscitation within the chosen setting.

A grounded theory approach was also considered to examine emergency nurses experiences of family witnessed resuscitation. A key concept of grounded theory is its strength in allowing researchers to start afresh and not be influenced by the present knowledge, thereby opening up the possibility of new perspectives on old problems (Parahoo 2006). The purpose being to generate hypotheses and theories. As a novice researcher it was believed that it was impractical to commence a research study without some pre-existing theoretical ideas and assumptions concerning previous studies, therefore a grounded theory approach was also disregarded.
Having explored these methodological approaches, phenomenology was deemed the most appropriate process to answer the proposed question. Both phenomenology and grounded theory share a number of characteristics. They both focus on the richness of human experience, seek to understand a situation from the subject's own frame of reference, and use flexible data collection procedures. Nonetheless, they are based on different intellectual assumptions and, flowing from these, have clear differences in purpose and methodological prescriptions (Baker et al 1992). The greatest value for undertaking a phenomenological approach to the study lies in the fact that it is the only approach available which deliberately takes a participant’s subjective perceptions as its focus. Hallett (1995) argue that these are the perceptions which have the most value and are most worth studying.

Phenomenology has its intellectual roots in philosophy and was first conceived by the German philosopher, Husserl (1859-1938), at the beginning of the twentieth century. Husserl sought to develop a rigorous descriptive science of consciousness in which consciousness is always consciousness of, and developed a method of inquiry for this purpose (Baker et al 1992). Husserl influenced other German philosophers who developed or reworked his original formulations. One philosopher, Heidegger (1889-1976), took Husserl’s work in a new direction and created hermeneutic analysis which is seen as an interpretive phenomenology conflicting with the descriptive Husserlian approach.

The pivotal move in Husserl’s philosophy is what he refers to as phenomenological reduction, a procedure which is associated with the metaphor of ‘bracketing’ (Paley 1997). ‘Bracketing’ as described by Husserl is where all judgements about the external world must be suspended. This description challenges recent definitions of ‘bracketing’ given by various nurse researchers. Baker et al (1992) states that ‘preconceptions should be identified and put
aside’ which is concurred by Jasper (1994) who claims that ‘bracketing’ involves the ‘deliberate examination of the researchers own beliefs about the phenomenon and the temporary suspension of these’. This confusion is further confounded by Cohen and Omery (1994) who suggest that ‘reduction is the process of looking at the experience naively, without the preconditions, the prejudices, and the biases that one usually brings to any description.’ The author wished to apply the concept of ‘bracketing’ to the study to reduce bias and preconceptions which would enhance trustworthiness. Considering all approaches to reductionism it seemed desirable to examine ones beliefs and temporarily suspend these. Some may argue that this it is not legitimate to label this technique as ‘bracketing’ but it is believed by the author that by recognising this, credibility will be maintained.

3.5 SETTING

The research was conducted in a busy emergency department situated in a general hospital in the Republic of Ireland. The emergency department provides emergency care for a population of 131,615 and there were in excess of 35,000 attendances to this department in 2007 (HSE, 2008). The patients seen in the department include surgical, orthopaedic, medical, paediatric, obstetric/gynaecological and psychiatric emergencies. The department also deals with trauma presentations. The medical team include one consultant in emergency medicine, one medical officer, one emergency registrar and three senior house officers. The nursing staff consists of eight clinical nurse managers and seventeen staff nurses. The number of patients seen in the department has risen dramatically in the last few years. Statistics show the number of patients seen in 2006 shows a marked percentile increase from 1996 (HSE, 2008). The emergency department contains one resuscitation area, four cubicles for the treatment of majors and six cubicles for the treatment of minors, paediatrics and gynaecological presentations. Currently
within the setting there is no room or space available for relatives to wait when their loved one is being resuscitated, instead the staff in the emergency department use offices no longer occupied by the outpatients department in the interim. It must also be noted that the resuscitation bay is quite small (4.2metres x 3.5metres) and opens into the patient waiting area as there is no separate entrance for ambulances other than the main emergency department entrance. There is no designated resuscitation/trauma team in place although there is a cardiac arrest team consisting of different team members who attend all cardiac arrests within the hospital including the emergency department.

3.6 ACCESS TO SAMPLE

A sample is a proportion or subset of the population to represent the entire population (Parahoo 2006). The population for this study consists of emergency nurses working in an accident and emergency department. The sample was selected using a purposive approach as this was believed to be the most effective way of obtaining a sample that would accurately reflect the population under study (Polit et al 2001). Purposive sampling allowed the author to deliberately choose participants who can provide necessary and enriching information (Burns and Grove 2003). This enabled the author to select participants who were able to recall their experiences concerning family witnessed resuscitation. The research question helped guide the author in the selection of participants, as to ignore this, the sample may be chosen out of convenience which may lead to the trustworthiness of the study being questioned (Sandelowski 1995). It has been argued that it is difficult to evaluate the precision of the researchers judgement when purposive sampling is used therefore rationale and criteria for eligibility has been included as to why the selected subjects were included or excluded from the study.
Qualitative studies generally use small, non random samples (Polit and Hungler 1997). Seven nurses were selected who were prepared to share their experiences of family witnessed resuscitation. The number chosen to participate was derived from the purpose of the research question. It is argued that the larger the sample the more representative of the population it is likely to be (Polit and Hungler 1997) but as the research undertaken was of an in-depth nature this number is believed to be sufficient. This is supported by Cormack (1996) who maintains that the in-depth nature of qualitative research allows for a small selective sample.

3.7 ELIGIBILITY CRITERIA (INCLUSION/EXCLUSION)

Inclusion Criteria

- A registered nurse with An Bord Altranais
- Nurses with at least two years post registration experience
- Nurses with at least six months experience in the emergency setting
- Nurses willing to be involved in the study
- Nurses currently working within the emergency setting

Exclusion Criteria

- Health care professionals other than nurses working within the emergency setting
- Nurses with less than two years post registration experience
- Nurses with less than six months experience in the emergency setting
- Nurses working in areas other than the emergency setting

Nurses were chosen as this is the target group that was to be investigated. It is recognised that other health care professionals may have experiences and opinions regarding family
witnessed resuscitation but for the purpose of the research question these were excluded from the study as nurses experience of the phenomena were only to be studied. The participants had to have at least two years post registration experience as it was believed that this exclusion criterion would provide nurses with rich nursing experience of working with patients and family members. Therefore they could compare experiences of dealing with patients and relatives in general with dealing with patients and relatives following family witnessed resuscitation.

Participants had to have a minimum of six months nursing experience working within the emergency setting. The author believed this timeframe was sufficient for nurses to have experienced family witnessed resuscitation. The author considered omitting staff that did not work full time within the department but did not include this in the inclusion criteria as it was observed that the majority of staff who worked part-time had considerable experience in the emergency setting. To eliminate these nurses would have reduced the amount of valuable and informative experiences encountered.

3.8 SAMPLING AND PLANNING ISSUES

Prior to undertaking the study several issues had to be addressed. An information sheet outlining the study was sent to all appropriate nursing staff within the emergency department (Appendix II). This was sent in the form of a letter as it was believed that this approach would be more personal and create greater interest. The information sheet utilised non-jargon language and gave an explanation of how the research would be undertaken. The aim of the study was fully explained and they were asked to decide voluntarily whether or not to participate.
In addition to the information sheet a consent form was also sent to all appropriate nursing staff within the department (Appendix III). The consent form made clear that the information that they were providing was confidential and anonymity would be preserved. According to Waltz et al (1991), participants should be free to participate or withdraw from participation without recrimination or prejudice. Therefore the consent form clarified they could withdraw their participation from the project at any stage of the study without being penalised or disadvantaged in any way.

A letter outlining the study was sent to the hospital’s Director of Nursing seeking permission to conduct the research study prior to commencement (Appendix IV). The opportunity to meet to discuss any questions or issues that arise regarding the study was also given. A counsellor from the Health Service Executive – South was also informed in writing prior to commencing the study (Appendix V). A counsellor was contacted as the author believes the subject of resuscitation to be of a sensitive nature. It was recognised that issues surrounding family witnessed resuscitation may be emotionally upsetting for some participants. Therefore information regarding counselling was available if staff members required such.

An important note to consider is that the research was conducted within the author’s workplace. Some authors may argue that this may bias the results due to participants trying to please the author giving responses that they believe to be the ‘right’ one. The author disagrees with this idea believing that knowing the participants, will add credence to the study. Participants will feel more comfortable in giving responses to someone familiar versus someone they do not know.
3.9 DATA COLLECTION

The method of data collection chosen was an interview. This method was chosen as it is fitting for the information required by the research question posed. It is the method supported by Baker et al (1992) who states that the chosen method of data collection should be congruent with the research question. Further support for the method of data collection is given by Kvale (1996) who argues that in phenomenological research the interview is considered the foremost method of gathering data. The interview provides a situation where the participants descriptions can be explored, illuminated and gently probed (Kvale 1996). As the aim of the study was to explore nurses experiences of family witnessed resuscitation an interview was seen as the most appropriate as Wimpenny and Glass (2000) state this approach is the most suitable for investigating the human experience.

Prior to commencing the study, other methods of data collection were considered. These included focus group interviews and observational methods. Having become familiar with these approaches it was decided that a face to face interview would be the most suitable. Reasons for this include that participants may not be able or willing to share valuable, honest and truthful experiences if interviews were conducted within a focus group. As the subject is of a sensitive nature it may be seen as inappropriate to gather information in a collective way such as focus group interviews. A focus group approach to data collection would not be congruent with the research question as the purpose of focus group interviews as suggested by Parahoo (2006) is to gather people who collectively can discover different perspectives on a phenomenon. As the author wished to determine an individual’s experience of family witnessed resuscitation this approach would be seen as unsuitable.
Observational methods of data collection were also considered by the author but it was believed that observing participants concerning family witnessed resuscitation would not have been viable. This is due to the fact that resuscitations within the chosen setting are sparse and the author may not be present for each and everyone. Observational methods of data collection would also not be a method that would be congruent with the research question posed.

The method of interview selected was a semi-structured approach. The semi-structured interview was preferred as it allowed flexibility in the phrasing and order of questions posed (Kvale 1996). This flexibility enabled the author to modify words used within the interview. By modifying the words used, the meaning remained unaffected but enabled the participants to fully understand what was being asked of them. This approach also enabled participants the opportunity to expand on their answers giving further insight into the experience as well as the author to direct and re-direct when appropriate. Regardless of flexibility the author had set questions prepared. These can be seen in Appendix VI. The formation of the questions were guided and informed by previous studies concerning family witnessed resuscitation. Demographic and biographical data were obtained at the commencement of the interview. Phenomenological methods were used for the questions such as ‘How did you feel...?’ ‘What was it like...?’. These questions enabled the author to follow a set direction and prevented the interview from deviating from the intended purpose. The questions allowed the authors to speak without restraint and permitted the author to seek clarification when the need arose. A structured approach to the interview would not permit this flexible and versatile approach. A structured interview by definition would be pre-determined, standardised and highly structured (Parahoo 2006). This would provide the author with little scope for clarification.
and elaboration which as a result would not uncover the participants experiences of family witnessed resuscitation.

The face to face interview provided non-verbal clues which may have been lost with other forms of data collection. The benefit of face to face interviews is that they offer the possibility of modifying ones line of enquiry, to follow up on interesting responses and investigate underlying motives in a way that other methods cannot (Robson 2002). In comparison to questionnaires the physical presence of the researcher during an interview can give more significance to the data retrieved (Parahoo 2006). Body language and facial expressions can be noted which can give greater insight into how the participant feels about certain situations. A final motivation which supported the idea of utilising interviews was the familiarity the researcher has concerning the technique. As a nurse who routinely interviews patients on a daily basis be it in a more informal manner, the author was comfortable with the process. Therefore having explored other methods of data collection, the interview was deemed the most appropriate for gathering the data.

3.10 PILOT INTERVIEW

A pilot interview was undertaken prior to beginning the study. The author believed that steps within the research process and interview can be developed and refined following the interview being piloted (Prescott and Soeken 1989). As a novice researcher, the objective of the pilot interview was to familiarise the author with the interview process and address any concerns that may become apparent prior to the main interviews being undertaken. Cormack (1996) advises undertaking a pilot interview as it will enable the researcher to identify any potential problems with the research design. Employing a pilot interview before
commencement of the study is recommended by Burns and Grove (1999) who state by doing so will add robustness to the research piece.

Prior to undertaking the interviews it was decided to read around the area to gain insight into the process. Kvale (1996) explains that reading around the area may give some guidelines, but practice remains the main road to mastering the craft of interviewing. Having undertaken a pilot interview self confidence in dealing with the process was acquired and the ability to create safe and thought-provoking interactions became apparent. The pilot interview also enabled the author to become familiar with the tools required such as the Dictaphone. Having carried out the pilot interview the author was aware of the need for the interview not to be interrupted and in consequent interviews; participants were asked to turn mobile phones and pagers off. The interview was piloted with an emergency nurse from the chosen setting. This nurse was asked to comment on the performance as well as on the interview schedule. This individual was excluded from the main study. By undertaking the pilot interview the author became more comfortable, a better listener, and more attuned to themes that emerged in the course of the interviews which aided data analysis later in the process.

3.11 MANAGING THE INTERVIEW

Consent to participate within the interview was acquired prior to commencing interviews (Appendix III). The interviews were conducted in the participants hospital but away from their workplace. This helped maintain confidentiality as well as providing an area that was free from disruption. The area was made as comfortable as possible and light refreshments were provided so that the participants were at ease with the interview process. The author
ensured that all paperwork was available and that the Dictaphone and tapes were in working order. The interview was at a time that was suitable to both the author and the participant. Again this prevented any disruption and enabled the participant to take their time whilst giving their responses. Before the interview began, mobile phones and pagers were silenced so that the interview could not be interrupted. On one occasion an interview had to be rescheduled to a later date due to the emergency department requiring the nurse back due to an increase in activity. The interview was rescheduled as Easton et al (2000) suggest that it is far better to start over under calmer circumstances than to attempt to plough through a chaotic interview.

In the course of the interview, participants were assessed for verbal and non-verbal clues which indicated their level of comfort. The author was able to gently probe for more information when the participant indicated comfort by open body language and lengthy, relaxed responses to the previous questions. Fortunately, no participant became anxious or upset during the interviews but the author was aware that this may occur due to the sensitive nature of family witnessed resuscitation. Support would have been provided and the interview would have been suspended immediately if the interviewee became emotional or upset in any way.

Following the interview, time was spent discussing issues surrounding the topic and the interview. This period enabled the author to give support, guidance, information and referrals if required. The audio recorded material was immediately transcribed verbatim so that no precious information could be lost. The material including audio recordings, transcripts, discs etc. were locked in a firebox in a sealed filing cabinet. This preserved the participants anonymity and upheld confidentiality. The giving of one’s story is a deeply valued gift and
the author has a responsibility to care and respect that gift and to use it as it was intended, that others may benefit from the participants story (Donalek 2005).

3.12 ESTABLISHING SCIENTIFIC RIGOUR/ TRUSTWORTHINESS

The criteria for measuring reliability and validity of quantitative research instruments are not appropriate in qualitative pieces. Qualitative research is trustworthy when it accurately reflects the experiences of the participants (Streubert and Carpenter 2003). Streubert and Carpenter (2003) cite the following terms of Lincoln and Guba (1985); credibility, dependability, transferability and confirmability in regards to rigour in qualitative studies.

Credibility refers to the truth of the studies findings, as viewed through the eyes of the participants (Devers et al 1999). This was established by the process of member checking. This is were the data retrieved and analysed is returned to participants to enquire ‘is this what they were saying?’. The analysed data was given to one of the participants and the information was seen as valid. Colaizzi (1978) advocates this practice stating the phenomenological researcher should return to the informants to validate that the findings reflect their perceptions of their experience. Undertaking reflexivity and prolonged engagement with the subject using the phenomenological approach where the author assessed his own biases and bracketed them also lends to the credibility of the study.

Once credibility has been determined the question may be asked: how dependable are these results? Dependability refers to the extent to which the research would produce similar findings if carried out as described (Cirgin Ellett and Beausang 2001). By illustrating as clearly as possible the evidence and thought processes that led to the drawn conclusions, the
author believes will enforce this consistency. This audit trail of the steps undertaken is achieved with the inclusion of a hardcopy disc containing all transcribed material (Appendix X) the inclusion of the summary of the literature review (Appendix I) and the framework of data analysis utilised (Appendix IX).

By providing substantial description of the transactions and processes observed during the data collection process, transferability will be attained. Transferability refers to the applicability and fittingness of the study applied to another similar context. It is further achieved by utilising a purposive sampling approach to the study, as the inclusion and exclusion criteria are clearly outlined. Verbatim quotations taken directly from the transcribed interviews also contribute to accomplishing transferability.

Confirmability combines the above three terms, as it refers to obtaining direct and often repeated affirmation of what the researcher has heard, seen, or experienced possibly by using multiple sources of data (Cirgin Ellett and Beausang 2001). The intention of confirmability is to identify the evidence and thought patterns that led to the researchers conclusions (Streubert and Carpenter 2003) in order for the study to be replicated. As qualitative studies cannot be replicated in the same way as quantitative studies, confirmability will be achieved by including how one went about developing the conceptual framework. Also by leaving an audit trail and including a computer disc containing all material obtained during the project, the researcher hopes to illustrate as clearly as possible the evidence and thought processes that have led to the studies conclusions.
3.13 METHODOLOGICAL LIMITATIONS

The study has limitations due to the methods utilised to complete the study. A major limitation of undertaking a qualitative study as outlined by Parahoo (2006) is the belief that the interactive nature of qualitative studies prevents the author from being objective. One can see why this may be seen as a concern because the author may get so involved within the study that they become subjective in selecting which data to accept and interpret. To counteract this as already discussed the author utilised the phenomenological concept of bracketing to reduce biases and preconceptions which could impinge on the studies objectivity.

Whilst a quantitative approach would aid replicability and generalisability the author believes a qualitative method is more appropriate for examining experiences as nursing’s philosophy is congruent with qualitative approaches (Parahoo 2006).

Another limitation of the qualitative process is the inability to statistically analyse and interpret data but the author argues that by utilising a qualitative approach versus quantitative methods a full understanding of human phenomena can be gained which cannot be acquired from empirical observations such as experiments and surveys.

3.14 ETHICAL CONSIDERATIONS

Ethical implications were considered at every stage of the research process. The study followed the ethical principles as laid out in The Declaration of Helsinki (World Medical Association, 2004). These principles include that the participant has the right not to be harmed, the right of full disclosure, the right to decide to take part or withdraw at any time.
and the right to privacy, anonymity and confidentiality (International Council of Nurses, 2003).

The nurse has an obligation to ascertain that the research is sanctioned by the appropriate body and to ensure that the rights of the patient are protected at all times (An Bord Altranais 2000). Therefore, permission to undertake the study was obtained from the Health Service Executive (HSE) (Appendix VIII) and Waterford Institute of Technology (WIT) ethics committees (Appendix VII).

The principles of beneficence, justice and autonomy were adhered to throughout the research process. The principle of beneficence relates to the study benefiting the individual whom participates as well as society in general (Parahoo 1997). The author recognises that issues surrounding FWR may be emotionally upsetting for the interviewee. An essential component of the interview was the awareness of sensitivity regarding the topic. If during any of the interviews the participants had become emotional or upset the interview would have been suspended immediately. Fortunately no incidences such as this occurred during the collection of the data. Following the interviews, the participants were given the opportunity to express any issues that may have emerged during the interview. This debriefing session enabled the interviewees to convey any concerns that may have arisen from discussing their experiences of family witnessed resuscitation. To further aid debriefing a counsellor employed by the HSE was also informed of the study prior to commencement (Appendix V). Information regarding counselling obtained from the counsellor was also made available to participants if they required such.
Prior to commencing the interviews informed consent was obtained from all participants. The aim of attaining informed consent is to ensure that the potential participants fully comprehend the potential risks and benefits of being involved in the study (Parahoo 1997). To facilitate these principles of autonomy an information sheet was delivered to all potential candidates (Appendix II). The information sheet gave a brief synopsis of how the study was to be undertaken as well as the proposed aim of the study. Participants were fully informed about the nature and importance of the research and were in a position to decide whether or not to participate in the study. To ensure accessibility of the researcher, personal contact details were included on the information sheet, potential candidates could therefore prior to consent to participate could discuss the project if they so wished. The consent form can be seen in Appendix III.

All participants in accordance with the principle of justice were treated fairly and their privacy protected (Polit and Hungler 1997). Participants were treated respectfully and courteously at all times and their selection was based upon the selection criteria for inclusion in the study and not on any other criteria. The interviewee’s anonymity was maintained throughout the study. No names could be linked to any of the interviews and no information obtained from the interviews was reported in a manner that could possibly identify the partaker. Analysis of the data was facilitated with the aid of coding known only to the author which contributed to confidentiality. To further assist confidentially and anonymity, the transcribed material obtained from the interviews were kept in a locked firebox which was stored in a locked filing cabinet.
These ethical principles can be used to guide the research in addition to addressing issues that may arise during the research process. Adhering to these principles, one can meet the goals of their proposed study whilst maintaining the rights of the research participants.

3.15 DATA MANAGEMENT AND DATA ANALYSIS

Jacelon and O’Dell (2005) summarise the process of data collection and analysis by comparing it to a Celtic knot pattern where the line of the pattern continually turns back on itself. This simple comparison was useful in reminding the researcher to continually re-evaluate and return to the data in order to guide the process.

Data analysis can be said to be the process of breaking down, examining, comparing, conceptualising and categorising data (Strauss and Corbin 1998). The analysis of the data was based on the research question and guided by the conceptual framework of the study. In keeping with a qualitative approach to the study, the analysis began once the data collection commenced. Reasoning for this is that initial data analysis therefore guided later data collection. This is supported by Mariano (1995) who describes data collection and data analysis as proceeding “hand in hand”. Due to the large volume of data one collates utilising a phenomenological approach to gathering information, the first thing required for data analysis is a strategy for organising the data.

Computer software was considered as an approach to qualitative data analysis by the author. There is debate regarding the pros and cons of using data analysis software for qualitative research (St. John and Johnson 2000). Proponents of data analysis software describe many benefits of its use including the easy retrieval of category information whilst decreasing the
time required to perform tedious manual tasks (Beck 2003). Software packages also enable researchers to handle large amounts of qualitative data, enhance the flexibility and comprehensiveness of data handling, permitting more rigorous data analysis, and allowing for a more visible audit trail for data analysis (Beck 2003). Whilst it is recognised that software packages are less time consuming and enable the researcher to handle large volumes of data more efficiently, they were not considered appropriate for this study due to the principle of a phenomenological approach which demands the researcher to ‘dwell within the data’. It was believed that by analysing data with software the focus may be transferred from the meaning to the idea of quantity. A concern that the researcher believed could arise if a software package was employed was that the researcher may become distant from the data. St. John and Johnson (2000) believe this distancing may result in loss of meaning and context and create sterile and dehumanised data. The timeframe was another concern when one considered the approach to data analysis. As a novice researcher the unfamiliarity concerning software packages would have wasted precious time than actually saving it.

Regardless of the approach employed to analyse and manage the data, computers had to be used for the storage of information due to the vast volumes created. Computers play an integral part of the research process from proposal through reporting findings (Jacelon and O’Dell 2005). Data were labelled and stored using Microsoft Office Word 2007 ® and Microsoft Office Excel ® which facilitated coding and theme development.

Prior to commencement of coding the data, the researcher immersed himself in the data to comprehend its meaning in its entirety as recommended by the framework developed by Colaizzi (1978) (Appendix IX). Bradley et al (2007) state that by reviewing data without coding helps identify emergent themes without losing connections between concepts and
their context. Once the data was reviewed the process of coding was undertaken. Through the process of coding, the researcher fractures the data and organises it by the ideas contained within (Jacelon and O’Dell 2005). According to Miles and Huberman (1994) codes are tags or labels which can be assigned to whole documents or segments to help catalogue key concepts while preserving the context in which these concepts occur. With this in mind each interview transcript was coded as respondent 1, 2 etc and each line of transcript was numbered and labelled clearly. For example RSP1P2L5 would indicate that that quote could be found in respondent 1 interview, page 2 on line number 5. Therefore material retrieved from the transcripts could be sourced easily and efficiently. This approach also strengthens the studies audit trail.

Each interview transcript was read and re-read and sections were collected under different headings, such as ‘space constraints’, ‘interference’, ‘decision making’, ‘discomfort’, ‘fear’ and ‘learning’. All interview sections that were related were sorted under the same heading aiding retrieval of data and again strengthening the audit trail. Whilst reading the transcripts, the audio recorded interviews were also listened to so that attention could also be paid to the way they replied to certain questions. This was considered to be an essential part to the analysis, as the rich language displayed by the interviewee helped gain further insight into the emotional issue of family witnessed resuscitation. Listening to the recordings also enabled the researcher to take each of these significant statements and formulate meaning in the context of the interviewees own terms.

Once the data was arranged into manageable pieces through coding, the process of interpretation began. This phase of the research process overlapped with the data collection and coding, extending to even after the interviews were completed. The meanings as stated
were organised into a collection of themes. Beck (2003) states that for novice qualitative researchers understanding the concept of theme is critical to accurate data interpretation. DeSantis and Ugarriza (2000) believe a theme to be an abstract entity that brings meaning and identity to a recurrent experience and its variant manifestations; it captures and unifies the nature of the experience into a meaningful whole. Patterns became apparent from coding the data and themes were developed such as ‘barriers to family witnessed resuscitation’ and ‘judging situations and feelings concerning guidelines and policies’. These themes were then utilised to present a rotund portrayal of the experience. These findings as already discussed were returned to one of the participants to validate the findings. This member checking also enabled the author to ensure that no material was omitted. Equipped with the framework developed by Colaizzi (1978) (Appendix IX), the author was able to fully develop and understand the experiences as portrayed by participants.

3.16 CONCLUSION

In this chapter the author conveyed the approaches utilised for data collection in addition to discussing the methodological approach. Justification was provided for the selected method. The sample and setting were discussed with the inclusion of the eligibility criteria. Issues surrounding the sample were also relayed. How one accomplished collecting the data, highlighting the role of the interview was also presented, with explanation given for undertaking a pilot interview. The importance of trustworthiness and how one established such was discussed recognising the importance of maintaining credibility, dependability, transferability and confirmability. Principles of ethical consideration were also explored and how they were maintained throughout the study was discussed. How the data was managed
and analysed was also summed up with explanation given for the framework analysis chosen. This data management and analysis led to the findings and discussion which can be found in the following chapters.
CHAPTER 4
4. PRESENTATION OF FINDINGS

4.1 INTRODUCTION

Following on from the methods section this chapter will presents the findings that were uncovered following analysis of the interviews. They have been broken down into separate themes and subthemes. These themes and subthemes will be supported by verbatim excerpts from the completed interviews. Visual aids will help impart demographic data in addition to the themes and subthemes that were identified. The findings from the study are as follows:

4.2 DEMOGRAPHICS/BIOGRAPHICAL DATA

The majority of the participants involved in the study were female (86% n=6) in the 30- to 40- year age group (the average age being 32 years).

Of the participants 57% were employed as staff nurses within the emergency setting. Clinical nurse managers made up the remainder 43%. It must be noted that staff nurses have more direct contact with patients than their senior counterparts.

The working pattern of the nurses interviewed showed that 71.5% (n=5) worked full time.

Professional qualification data showed that all nurses interviewed were registered as general nurses with one dual qualified in psychiatric nursing. One nurse interviewed had previously worked as an emergency medical technician, this was listed as other. [Figure 1]
The staff interviewed had significant nursing experience working within the emergency area with the majority having over seven years experience (71.5% n=5). [Figure 2]

The data shows that the nurses interviewed had a high level of nursing qualifications. Five of the nurses had successfully undertaken a postgraduate diploma in emergency nursing. Nurses trained to degree level were 28.5% (n=2) and masters level 14.3% (n=1). [Figure 3]
Note:

Excerpts from the interviews will be provided as examples in the following discussion and presentation of data. A coding tool is used as already discussed. It is as follows:

(RSP?P?L?) = RESPONDENT NUMBER PAGE NUMBER LINE NUMBER

Example:

‘The resuscitation area in the hospital in which I work would not allow a large number of people to be present other than the resuscitation team.’

(RSP7P3L9)

This excerpt can be therefore found in interview 1, page 3 and on line 9.
4.3 PRESENTATION OF FINDINGS

Themes that emerged from the study were:

I. Barriers to family witnessed resuscitation
II. Facilitators to family witnessed resuscitation
III. Experiences of family witnessed resuscitation
IV. Judging situations and feelings concerning guidelines and policies
These themes were further broken down into subthemes:

I. Barriers to family witnessed resuscitation
   i. Emotional considerations
   ii. Infrastructure and nursing opinion
   iii. Relative disruption

II. Facilitators to family witnessed resuscitation
   i. Relatives
   ii. Patient
   iii. Staff

III. Experiences of family witnessed resuscitation
   i. Positive experiences
   ii. Negative experiences
   iii. Options concerning experiences

IV. Judging situations and feelings concerning guidelines and policies
   i. Judging situations concerning family witnessed resuscitation
   ii. Nursing issues concerning family witnessed resuscitation
   iii. Opinions concerning policies and guidelines

These themes and subthemes will be now be looked at individually.
4.4 BARRIERS TO FWR

Barriers to FWR

- Emotional Considerations
  - Traumatising
  - Upsetting
  - Stress
  - Space Constraints

- Infrastructure/nursing opinion
  - Staff Shortages
  - Severity of injury

- Relative disruption
  - Aggression
  - Interference
4.4.1 EMOTIONAL CONSIDERATIONS

The effort to resuscitate is beset with human emotion. Staff have to deal with the potential loss of life whereas families deal with the possible loss of a loved one. A primary concern for the nurses interviewed was emotional considerations that should be taken into account when considering family witnessed resuscitation. A number of the participants believed that the resuscitation may be traumatic and upsetting for both staff and relatives if family presence was undertaken. They felt that this traumatisation could further lead to interference with the resuscitation. One nurse explains:

‘They could be more of a distraction in the care of the patient, you know if they were distressed and all that...sometimes the focus would be taken off the patient and it can distract you and add more upset to a very busy time in the resuscitation room.’

(RSP4P3L16)

Other nurses interviewed expressed concerns that by having family present during resuscitation, this may lead to increased stress amongst nurses and the team.

‘It certainly creates a stressful environment and then you have to carry on with your normal nursing duties after trying to resuscitate somebody and dealing with a distraught family.....it’s hard.’

(RSP1P2L4)

4.4.2 INFRASTRUCTURE AND NURSING OPINION

Nurses interviewed also expressed concern surrounding infrastructural problems that prevent family witnessed resuscitation from being a current option. Infrastructure problems encountered included space constraints and staff shortages. Some nurses interviewed worked around these hindrances but they still continued to be an issue that could raise concern.
‘I suppose space constraints would be one thing so you couldn’t have a big number of family in... not all family members could be inside a small space area.’

(RSP3P3L10)

Space constraints played a big part in deciding to allow family witnessed resuscitation in the hospital in which the study was undertaken as one nurse explains:

‘The resuscitation area in the hospital in which I work would not allow a large number of people to be present other than the resuscitation team.’

(RSP7P3L9)

Other participants raise the issue of staffing levels. They all recognise the need for a designated staff member to stay with the family with one nurse stating:

‘I think its easier if one nurse deals with the family and one deals with the patient as such because at least that way the relative has some bit of a link... everybody else then can stay within their role of the resuscitation team and the family have a familiar face and this nurse will be able to spend time with the family.’

(RSP4P4L19)

Unfortunately the availability of staff to carry out this role is not always feasible. Some nurses believe that by having an extra nurse in an already space constrained area would not suffice.

‘The practice is not possible due to staff shortages and that but if at all possible it can be quite good but its going to be an extra pair of hands in the resuscitation room but yet they’re not actually actively doing any work.’

(RSP6P3L12)

Nurses considered family presence an option dependant on the severity of the injury. They considered it to be a barrier in allowing family to be present during resuscitation. One nurse explains her rationale for this:

‘The severity of the patients injuries if they were very badly scarred or damaged then sometimes that could be more distressing for relatives to see you know. I wouldn’t allow the family in to a trauma until we had them someway stabilised. The family may get weak with the site of blood and anything like that, you might end up having to mind a family member one on one in the room as well.’

(RSP4P2L21)

Another nurse expresses that they may be affected psychologically by seeing a traumatic resuscitation but feels if they felt strongly about being present she would allow them in:
‘If the person was coming in post a trauma and was very badly damaged or had huge injuries, the actual relatives themselves might have bad memories of the actual event...but if they wanted to come I certainly would not stop them from doing so.’

(RSP5P1L13)

4.4.3 RELATIVE DISRUPTION

Other barriers to the practice of family witnessed resuscitation found in the study were the possible threat of relatives disrupting the process. These disruptions could be due to the relatives becoming aggressive or agitated and therefore interfering with the resuscitation. Relatives may also become emotionally traumatised by witnessing their loved ones in the last moments of their lives. In regards to aggression one nurse stated that the resuscitation was disrupted due to a relative becoming agitated and aggressive as she explains:

‘The father was very anxious and very angry...shouting and had to be calmed down. A nurse took him outside for a few minutes because he was disruptive. He was advised about what was going to happen and that when he came back in he would have to take a seat or stand back and let us do what needed to be done... I think it was just from the whole shock of seeing his son getting knocked down’

(RSP2P1L9)

To prevent disruption one nurse explains that each situation has to be dealt with individually:

‘I would have to judge each situation individually; I would step in if I felt someone would not be suitable to come into the resuscitation such as someone who is too upset, agitated or aggressive.’

(RSP7P2L15)

Participants believed that relatives behaviour within the resuscitation room does play a part in how staff perform. One nurse expresses concerns that relatives have become too emotional in the past and interfered with the resuscitation:

‘They have jumped on the person that’s being resuscitated and they blame you instantly which is as we all know a natural thing... that somebody would blame us...that why can’t we resuscitate them or that were not doing enough ...but all these things are very hard and they do interfere with your resuscitation.’

(RSP1P4L13)

This is supported by another nurse who explains that:
'People do get very emotional…they throw themselves on top of people…by them becoming so upset it would have to interfere with the treatment.'

(RSP5P4L4)

One nurse who participated in the study expressed concern that by having family members present the resuscitation may be prolonged due to the fact that the family may wish you to try other avenues of treatments which would be futile. She explains:

‘They may interfere with the resuscitation. They might try and say oh no try something different and you know I mean what we have done is obviously the treatment for the illness they have or trauma they’ve suffered.’

(RSP4P3L23)
4.5 FACILITATORS TO FWR

Facilitators to FWR

- Patient
  - Staff
    - Increase confidence
    - Sense of pride
  - Awareness of family
- Relatives
  - Last moments
  - See everything being done
  - Grieving process
  - Decision making
- Comfort of family presence
4.5.1 FACILITATORS TO FWR: RELATIVES

A relative being permitted to spend the last few moments with their loved one was a theme that was uncovered within the study. One nurse believed it was an important aspect of family witnessed resuscitation:

‘I think it’s very valuable for family to see what’s happening, to feel that they’re present especially if it looks like they might not make it, that they can spend that last bit of time with them.’

(RSP3P1L10)

One nurse recalled her thoughts from a previous experience:

‘The daughter was absolutely delighted to be with her father. She was telling him goodbye. Her mother had previously died and she was telling her father he was going to be with…that she loved him. It was obviously very upsetting for her; we were upset as a staff because obviously you know it is a very sad event for anybody. She thanked us afterwards…to be able to do that for her father and I just felt if it was a relative of mine, I would like to know that I was holding their hand when they were taking their last breath.’

(RSP5P2L4)

Another nurse agreed:

‘I don’t know if they’re actually aware or if they’re unaware of somebody’s presence but for me on a kind of a psychological point of view I’d like to think that there was somebody there with them.’

(RSP6P1L9)

Another facilitator to family witnessed resuscitation from a relatives perspective given by the nurses in the study related to the concept that by being present relatives could see all that was being done for their loved ones and play a part in the decision making. One nurse explains the benefits of allowing family to be present during resuscitation:

‘It’s a good idea to bring in family to witness that all measures have been taken and that we are doing everything possible for their loved one and help them to realise that really there isn’t anything more that can be done.’

(RSP1P1L5)

One nurse reveals that by allowing family to be present they can play an integral part in the decisions made:
‘They can see it for themselves instead of being left outside, that they’re part of their relatives care and they can make decisions with the medical team whilst they’re present.’

(RSP3P1L11)

Another nurse expresses caution concerning relatives participation in decision making regarding their loved ones care:

‘If they can see that every attempt was made to resuscitate their loved one, they could play a part in the decision to end but this could be too traumatic a decision for relatives, are they going to feel guilty about that decision once we have stopped, will they be thinking could they have kept going longer? It’s just something to think of down the road for them long-term.’

(RSP4P3L4)

Nurses whom participated also believed that the grieving process could be facilitated when family members were present during resuscitation. One nurse who had been involved with a couple who had lost their child following a car accident explains:

‘At least by being present during the resuscitation they were able to grieve for the child right away and I suppose they knew it wasn’t going to be a good outcome, and it helped them come to terms with their loss.’

(RSP5P4L21)

Another nurse concurred:

‘Of course relatives are emotional, but they’re rightly emotional as their family member is being resuscitated and may die, but I believe by just being present in the resuscitation room with their loved one, will help them begin to grieve.’

(RSP7P3L16)

4.5.2 FACILITATORS TO FWR: PATIENT

Participants in the study were of the opinion that family witnessed resuscitation would provide comfort to the patient. This was evident when nurses talked about parents of children being present in the resuscitation. This was conveyed by one nurse who was involved in a resuscitation involving an infant:

‘I think probably because naturally children need their parents with them all the time for comfort so it works both ways; it’s for the child who’s the patient and for the
mother - they need comfort from each other. The patient did die but I just feel it was such a comfort for her to be with him.’

The nurses questioned whether or not patients were aware of family being present during resuscitation. Regardless of this one nurse reveals that she believes it to be a benefit to both relatives and patient for family to be present during resuscitation:

‘I don’t know if their actually aware or if their unaware of somebody’s presence but for me on a kind of a psychological point of view I’d like to think that there was somebody there with them.’

4.5.3 FACILITATORS TO FWR: STAFF

Staff who participated within the study expressed that practising family witnessed resuscitation had positive effects on them both personally and professionally.

Nurses suggest that the practice helps increase confidence with one participant voicing his improvement:

‘It gives me more confidence in the resuscitation room when family members are present. I feel I am doing a service, I’m doing a job, we’re trying to save this person it doesn’t always work but unfortunately that’s life and that’s the emergency department in general.’

A colleague concurs:

‘I think if anything it gives confidence, more confidence, because you know what your doing, we’re all qualified to do our job but to have a family member watch gives us more confidence and pride in what were doing so they can watch and see that everybody is trying their best for their relative.’

An increased sense of pride is also raised within the study. One nurse proposes that the practice has had an insightful impact on his nursing:

‘I just feel I have more pride in my work when the family are there, and the family can see me doing something. I wouldn't be afraid in having family present I don’t
believe they’re in there to judge me or to see if I’m competent in my work I don’t believe that would be the case. It has had a profound effect on my nursing; I have more pride in my work when they’re there.’

(RSP2P3L8)
4.6 EXPERIENCES OF FWR

- Positive Experiences
  - ability to empathise
  - relatives right
  - facilitates learning/experience
  - fear of the unknown
  - discomfort of having family present
  - situational perspective
  - personal feelings

- Negative Experiences

- Nurses Experiences of FWR

- Preferences concerning FWR
4.6.1 POSITIVE EXPERIENCES OF FWR

Positive experiences recounted by participants included the nurses ability to better empathise with the family and patient when witnessed resuscitation was performed. A greater awareness of patient and family needs became apparent with one nurse conveying her thoughts:

‘It’s probably made me more aware of the need for families to be present...they are still part of a family unit and they should have equal say in their care and what happens to them.’

(RSP3P5L10)

Another nurse concurs stating that allowing families to be present personalises the resuscitation:

‘You can often sometimes put yourself well you try to put yourself in their shoes and what they’re feeling.........it gives a face to the patient.’

(RSP4P4L4)

From previous experiences of dealing with family witnessed resuscitation, nurses feel family have the right to be present during resuscitation with one nurse stating strongly:

‘If the family wish to be present it is their right to be present, who am I to stop somebody from coming in?’

(RSP7P2L13)

This idea is reinforced by another nurse who suggests:

‘We can’t as medical or nursing personnel take over the rights…of the patient just because they are a patient in a hospital, they’re still part of a family and they should decide what happens to them.’

(RSP3P5L11)

Some nurses express the idea that the practice of family presence aids them in their professional development as it gives them valuable experience of dealing with patients and their families. This is seen when one nurse suggests that the practice has helped her professionally when it comes to dealing with situations involving relatives:

‘Sometimes it can help you know your ability to deal with relatives in those situations sometimes it gives you more experience with that you know when unfortunately it does happen again for whatever reason so it can be a positive thing for both nursing and relatives as well.’

(RSP4P2I4)
4.6.2 NEGATIVE EXPERIENCES OF FWR

Negative experiences as recounted by the nurses included the fear of the unknown and discomfort surrounding the practice. Fear of the unknown was expressed by one nurse and she gives a suggestion as to why this may be the case:

‘Some staff would be afraid of the idea of witnessed resuscitation. I’m not sure why but maybe it is due to lack of education or age as the younger nurses seem to embrace the idea; in my experience anyway.’

(RSP7P3L3)

This was not seen as the universal thought as some argue experience is essential when dealing with family witnessed resuscitation. One nurse explains:

‘Experience plays a big part when it comes to allowing families in during resuscitation, as you’re more aware of what could happen. Having experience helps you in making those decisions.’

(RSP7P3L3)

Discomfort was mentioned by one nurse who states that the practice may be seen by some to be a hindrance and an extra burden to carry during resuscitation. She explains:

‘I think some nurses and doctors might not be comfortable with family presence especially doctors because I feel their work is a little more scrutinized. Families may remember minute little details or remember them as in what happened…it just might make them a little more nervous with someone literally standing over their shoulder.’

(RSP6P3L3)

4.5.3 PREFERENCES CONCERNING FWR

Preferences concerning family witnessed resuscitation were another theme that became apparent from the study. Nurses expressed the need to be honest with relatives if family were to be present during resuscitation. This was identified by one nurse:

‘I feel that family first of all need to be told the truth of what’s happening with their relative, they need to be, I’m not saying giving the worse possible picture initially, but they need to be told that the outcome may be a bad outcome.’

(RSP5P2L22)
Difficulties were also expressed by nurses concerning the activity of the department and how challenging it is to continue work following any resuscitation. One nurse explains:

‘After trying to resuscitate somebody, you go along and you have to carry on your normal nursing duties without being able maybe to take a break or even to take a break what good is it to you because you still have six hours of a shift left in front of you its very hard to go on so it affects your nursing.’

(RSP1P4L6)

Nurses also had opinions regarding their personal beliefs of family witnessed resuscitation. Prior to permitting family presence some nurses prefer to make the patient acceptable to be seen by family members as one nurse explains:

‘I would prefer to have maybe covered some of the wounds or tried to make the person someway presentable to the family.’

(RSP5P3L10)
4.7 JUDGING SITUATIONS/ GUIDELINES/ POLICIES

Judging situations and feelings concerning FWR

- Trauma versus other
- Children versus adult
- Other conditions
- Arguments for
- Arguments against

Policies/guidelines
4.7.1 JUDGING SITUATIONS

From the study it became apparent that all resuscitations are judged on an individual basis. Whether the patient was a medical arrest or a traumatic arrest played a vital role in allowing family members to be present or to exclude them. One nurse gives reason as to why this may happen:

‘I feel that if I was someone who wasn’t used to looking at major open wounds or huge traumas and that that would be my last memory of my relative and I don’t think I’d like that for anybody.’

(RSP5P1L19)

The patient being a child also played a decision as to allowing family members to be present. The majority of the nurses interviewed believed that the parent of a child had the right to be present during resuscitation. One nurse voices that:

‘Where a child is concerned its mom and dad… they really need to be there probably from the beginning.’

(RSP1P2L1)

Another nurse suggests that not involving the parent would be wrong:

‘Probably as nurses were more aware of the need for a parent to be with a child during resuscitation and we automatically, well I would automatically, always invite a parent to be present with a child in the resuscitation room whereas I probably am not as quick to invite relatives of an adult.’

(RSP3P2L1)

Reasons for these differing opinions concerning adult and paediatric resuscitations are unclear but one nurse suggests:

‘It may help the child in the resuscitation to know their parent is present and definitely it’s not fair on a parent to be left outside not knowing what’s happening to their child that they’ve always cared for.’

(RSP3P2L7)

Other conditions pertaining to permitting family witnessed resuscitation included what the outcome was likely to be with one nurse proposing:

‘That if the patient is not going to make it then you should basically let the family see you doing CPR.’

(RSP2P2L3)
Whether the family member was a health professional also played a part in the decision with one nurse from an incident involving a nurses father explained:

‘As the daughter was a nurse and it was something she wanted to do, we did offer her the choice of being present.’

(RSP5P2L13)

Other issues raised centred on the idea that each resuscitation is ‘case specific.’ One nurse gives an example:

‘If it was a case in which the gardai would be involved following the resuscitation then that needs to be taking into consideration.’

(RSP7P2L16)

4.7.2 POLICIES/ GUIDELINES

Nurses who participated gave arguments for and against policies concerning family witnessed resuscitation with the majority in favour of having some ordinal process concerning the idea. One nurse explains that a policy may serve as a direction when deciding to allow relatives be present.

‘Every situation is different so you know I mean sometimes it can help give guidance to whether or not people should be brought into the resus area.’

(RSP4P2L16)

Other nurses suggest that protocols would prevent any confusion amongst staff as well as act as some support for those working with the relatives.

‘A protocol or policy should be in place because at least there would be no question of what will we do now.’

(RSP5P3L18)

‘A policy would go along way in providing back up for the staff.’

(RSP6P2L14)

One nurse interviewed believed that family witnessed resuscitation is more a nursing issue than other health care professionals due to the fact that we think of the larger family needs than just the patients. She suggests that:
‘It’s probably more a nursing issue since nurses tend to think more of the wider circle as in the family sitting outside.’

One nurse interviewed believed the idea of having a policy would be of no benefit as there is no continuity of staff in the area and each resuscitation should be treated as an individual case.

‘I don’t believe a policy would help because we don’t have an established resus, you know your team is different all the time...you can’t judge...you can’t put a blanket policy for every family or every patient...its very case specific.’

4.8 CONCLUSION

The findings within this study show that personal, organisational and social factors all influence nurses towards the practice. It is believed by the author that if the practice of family witnessed resuscitation is to be introduced effectively these considerations need to be contemplated prior to guidelines and policies being introduced. The following chapter will now discuss these findings.
CHAPTER 5
5. DISCUSSION OF FINDINGS

5.1 INTRODUCTION

In this chapter the findings from the preceding section will be discussed. Each theme will be discussed individually. The author intends to relate the findings with previous studies and rationalise as to why the findings are as such.

5.2 DISCUSSION

5.2.1 BARRIERS TO FWR

In the study a common concern of having family present during resuscitation is the fear of distraction. This finding is comparative with the study performed by Fulbrook et al (2007) who reported that 33.7% (n= 33) of nurses studied felt that nursing and medical staff would find it difficult to concentrate with parents watching. Earlier work by McClenathan et al (2002) support these findings, they found that the one reason for not allowing family member presence during resuscitation was a fear of distracting the CPR team.

Another concern was the fear that family presence may increase stress amongst the resuscitation team. Madden and Condon’s (2007) study concurs with this as they found that 50% (n= 45) of respondents believed that family witnessed resuscitation would increase levels of stress on the emergency team. They suggest that this may be due to inexperience and lack of skills and knowledge in performing CPR which therefore would make staff nervous if family members are present. The author argues that this may not be true for the
participants within this study as the staff interviewed had significant nursing experience working within the emergency area with the majority having over seven years experience. When one considers that emergency staff use a variety of methods to deal with the stress of resuscitation including a small degree of humour, the author believes the presence of a relative may inhibit this coping mechanism and therefore add to increased levels of stress.

Space constraints and staffing levels were seen as important issues when considering family presence by the participants within the study. The majority did not feel it was practical to undertake the concept due to unavailability of staff and inadequate space. When one considers the size of the resuscitation area within the setting, one can see how space constraints would cause a problem. It is noteworthy to state that all staff felt that it is important to have a designated staff member to guide and support the family. One participant was concerned that if family members were present during resuscitation a nurse may be removed from the resuscitation team to support the family, a finding reiterated in Badir and Sepit’s (2007) study.

Most participants expressed concern that relatives may retain memories of their loved one not as the person was in life but as the person was during the resuscitation. This result is in concordance with McClanathan et al (2002) who revealed that the most common reason chosen for not allowing family presence was a concern for the psychological trauma to the witnessing family members. An interesting finding from the study is that the majority of nurses regardless of the patient’s injury would allow the family to be present but only after the patient was stabilised and visually presentable.
Another barrier to family witnessed resuscitation indicated by participants was relatives becoming too emotional and aggressive. This fear is echoed in Holzhauser et al’s (2007) study which showed that relatives became more agitated and angry when they could not go into the resuscitation area. These findings contradict the study completed by Hanson and Strawser (1992) who in their nine year study of family witnessed resuscitation had no evidence of relatives interfering. This concern became reality for one participant within the author’s study, where she had to have one relative removed from the area due to his aggressive behaviour. Ellison (2003) believe these heightened emotions may be secondary to cultural differences between professional/organisational and client/families. The author concurs with this when one considers the cultural disparities and religious diversities present in contemporary Ireland today, such as the travelling community and the Eastern European community.

The resuscitation being prolonged was another argument against the practice of family presence. Some participants believed that futile attempts at resuscitation may continue and decision making may be delayed if family were present. In their study, Badir and Sepit (2007) found comparable results where over half of respondents believed that the resuscitation team would be more likely to prolong the resuscitation attempt if a family member was present.

5.2.2 FACILITATORS TO FWR

Issues concerning facilitators to family witnessed resuscitation were also raised within the study. An important issue obtained from the study was how nurses believed family presence could facilitate the grieving process. Some nurses believed it to be very valuable for family to spend the last few moments with their loved one. This provides conflicting evidence to a
study undertaken by Holzhauser et al (2007) who states that relative’s last memories of their loved one will be of resuscitation and would likely cause a maladaptive grieving process. This is not supported by MacLean et al’s (2003) study which showed that family presence facilitates closure and healing for relatives and assists the grieving process. The author has to agree with the findings from MacLean et al (2003) especially when one considers the study undertaken by Robinson et al (1998) who described a trend towards reduced symptoms of grief and post traumatic stress in family members of adults who had witnessed resuscitation.

Nurses within the study were unsure whether patients had an awareness of relatives being present during resuscitation or whether their present gave any comfort. Unfortunately, there is little empirical data available to ascertain whether patients are aware of family whilst being resuscitated most likely due to the low survival rates following CPR, but certain studies have explored patients experiences whilst undergoing invasive procedures. One such study undertaken by Eichhorn et al (2001) found that patients undergoing an invasive procedure felt safer and less scared when family members were present. Another study found that 99% of children undergoing an invasive procedure stated that having a parent present provided the most comfort to them (Broome 2000). This finding is refuted by Boudreaux et al (2002) who argues that evidence derived from randomised control trials is equivocal as to whether family presence has a positive effect on children’s pain during an invasive procedure.

Some participants within the study believed that family by being present would be able to participate in decision making regarding their relatives care. Knott and Kee (2005) found in their study that family presence can be used as a powerful tool in making families decide to continue or stop resuscitative efforts. One nurse disclosed within the study her concerns about involving family members in decision making as she believed it may cause long lasting
psychological damage. This concern was also noted in Badir and Sepit’s (2007) study which showed that 75.9% (n=211) of respondents believed family members should not be involved in decisions regarding the patient. In contrast Ellison’s (2003) study showed that nurses believed that family presence would assist the team in end of life decisions based on quality rather than prolonging life. All nurses interviewed acknowledged that families can be supportive to patients in crisis and recognised that family presence gives relatives the opportunity to see all that is being done for their loved one. Meyers et al (2000) shows similar findings where nurses believed that family presence gave family members a chance to witness and know the efforts that had been made for their loved one, thus decreasing uncertainty and worry and increasing peace of mind among family members.

5.2.3 EXPERIENCES OF FWR

An interesting finding from the study was the belief that nurses had concerning the increase in professional confidence and personal pride whilst family presence was being undertaken. This finding is echoed in the study undertaken by Knott and Kee (2005) where nurses expressed their ease with family witnessed resuscitation as they were comfortable with their knowledge and skills surrounding resuscitation. Similarly, Meyers et al (2000) report that family presence encouraged more professional behaviour among staff members. Staff in the study modified conversations at the bedside and promoted a more careful choice of words. The author as already stated believes that this change in professional behaviour may result in increased anxiety and stress levels due to a coping mechanism such as less black humour being curtailed. Therefore staff may have to find alternative ways to enable them to cope, for example by debriefing immediately afterwards. Fulbrook et al (2007) also explored this finding but found that staff were split on whether performance of the team would be positively affected by family presence.
Findings show the majority of participants believe that relatives have a right to be present with their loved one. One nurse stating that ‘who are we to stop them?’. Ellison (2003) found that in her study, nurses believed that family presence was a right and not an option. Meyers et al (2000) provide supporting evidence when nearly all family members surveyed indicated that they had a right to be present during invasive procedures and CPR.

Nurses within the study suggest that family presence enables the staff to better empathise with the relatives as the resuscitation is humanised. Family presence conveyed a sense of personhood about the patient with similar findings reported by Meyers et al (2000). The presence of relatives as indicated by nurses in the study helped create a stronger bond between nurse and relative. Most nurses within Fulbrook et al’s (2007) study were of the same opinion believing parental presence helped to create a stronger bond between them and the nursing team. This provides conflicting evidence to Badir and Sepit’s (2007) study, which reported that almost three quarters of nurses believed that family presence during CPR would not strengthen the bond between the nurse and the family. Regardless of argument the author believes that family presence provides the opportunity to promote open communication between staff and family.

A number of nurses within the study believed that family presence enhanced their professional development as it provides experience and familiarity in dealing with relatives. To the author’s knowledge, this finding was not observed in any articles investigating nurses experiences of family witnessed resuscitation. Meyers et al’s (2000) findings do show that over half of health care providers believed that family presence promoted heightened professional behaviour. The author believes this finding to be related to the idea that family
witnessed resuscitation is seen as a new concept within the Irish health service and that participants are taking every opportunity to further their professional development.

A negative experience discovered from the study was the fear of the unknown and discomfort with family presence. Comparable evidence is seen in other studies which reported that this discomfort with family members may due to the pressure of family members watching and the fear of errors (Madden and Condon 2007) especially if it was related to poor patient outcomes (Meyers et al 2000). One nurse within the study believes that this fear could be exacerbated by old belief systems as in that’s the way it has always been done, which are hard to break down. This idea is supported by nurses within Ellison’s (2003) study.

A concern expressed by nurses within the study was when to allow family to enter the resuscitation area. A number of nurses believing that patients should be made visually acceptable prior to allowing relatives to be present. Holzhauser (2007) found similar findings where nurses considered it more appropriate for relatives to see patients when tubes are removed and patient is clean and peaceful. Work by Kirchhoff et al (2007) support these findings where the minority of respondents would permit family presence during the entire resuscitation process with nearly half of respondents only allowing family presence after completion of invasive procedures. The outcome of the patient was also considered by interviewees to contribute to allowing family presence with one nurse suggesting that if the patient was likely to die the family should be present. Other conditions were also reported including the family’s medical knowledge, the age of the patient and the suddenness of the event. Knott and Kee (2005) drew comparative findings when respondents considered family presence an option that depended on condition or circumstances surrounding the need for resuscitation.
Similarly to previous studies (Knott and Kee 2005; Fulbrook et al 2007) nurses consider a patient's age when determining suitability of family presence with all participants believing that a parent of a child had a right to be present during resuscitation. It is noteworthy to add that no participants were paediatric trained as previous authors have suggested that this may be a factor (McClenathan et al 2002). The author assumes this finding may be due to the fact that participants believe it is essential for parents to know exactly what is happening to their child. This is established by one nurse who suggests that parents need to be there from the beginning.

5.2.4 JUDGING SITUATIONS/ GUIDELINES/ POLICIES

The majority of participants were in support of having guidelines in place to serve as direction concerning family presence. They believed a policy would prevent confusion among staff members and provide back up for staff. This finding is in keeping with already published literature. MacLean et al (2003) reported that respondents believed that policies would provide equal access to all they serve. Respondents in MacLean et al’s (2003) study also suggest that having a policy helps professionals decide ahead of time how to handle requests. From Madden and Condon’s (2007) study the need for policy development in emergency departments was identified as it would facilitate greater understanding of the practice among health professionals.

One nurse within the authors study was of the belief that having a policy would be no benefit as there is no continuity of staff working in the resuscitation area. This disapproval of policy development may be linked to lack of education surrounding the subject as without policies,
the decision to opt for family presence will be made by whoever is on duty that particular
day, and perhaps based on what is perceived as being in the patients best interest (Knott and
Kee 2005). The author believes this would lead to more confusion for the resuscitation team
as having a policy in place would reduce the possibility of a decision based on individual
staff’s personal opinions and experiences. This is turn will provide guidance for the health
care team when determining the feasibility of family presence for each patient and family.
This idea is supported by Madden and Condon (2007) who found from their study that nurses
who work on units without clearly delineated protocols for the practice may be in a difficult
position when confronted with a request by patients families to be present at resuscitative
efforts.

5.3 CONCLUSION

From the study, it can be seen that he majority of staff are in favour of implementing family
witnessed resuscitation. One then has to consider why no policy is in place within the hospital
setting. The author believes that as family presence is not traditionally practiced and is seen
as a new concept, therefore it may not be a consideration unless brought to the attention of
administration by nursing staff committed to implementing the policy.
CHAPTER 6
6. RECOMMENDATIONS AND CONCLUSION

6.1 INTRODUCTION

The author believes the study gave an insightful look into emergency nurses experiences of family witnessed resuscitation. Revealing these perceptive and astute experiences, the participants shared not only their stories but also provided invaluable information as to the current practice being undertaken in Irish hospitals regarding family witnessed resuscitation. Implications and recommendations for practice, the health service, education, research and policy will now be discussed individually.

6.2 CONSIDERING THE IMPLICATIONS AND RECOMMENDATIONS OF THE STUDY

6.2.1 IMPLICATIONS/RECOMMENDATIONS FOR HEALTH SERVICES

The findings show that the majority of nurses within the study undertake family witnessed resuscitation but they find that the burden of space constraints to be a barrier to the practice. As previously discussed, this is not surprising when one considers that the resuscitation area in the chosen setting is quite small and becomes overcrowded with just the resuscitation team present. There is a need in the chosen setting for infrastructural change. This reflection needs to be considered by health bodies when designing areas to be used for resuscitation. To further enhance this idea, when designing resuscitation areas it may be useful to draw on the experience of staff currently employed in that area so that issues can be rectified prior to them becoming a problem.
Another concern expressed by nurses within the study was the unavailability of trained health professionals to deal with bereaved family members. The majority of participants within the study believe that there should be a dedicated member of staff assigned to family members if family witnessed resuscitation is being undertaken. This finding has been echoed in previous studies and accounts for a vast majority of staff barriers to the practice. Unfortunately the current nursing shortage at present within the Irish health service is arguably affecting nurses ability to adequately address the physical and psychosocial needs of patients in crisis situations. Health services and managers need to be conscious of this issue when coordinating staff numbers and be willing to provide commitment of staff if they wish for positive changes to be made within the service. If family witnessed resuscitation is to be successful there has to be an adequate number of staff members to care for both the patient and family members.

6.2.2 IMPLICATIONS/RECOMMENDATIONS FOR POLICY

From the findings it is shown that nurses believe family members have a right to be present whilst their loved one is undergoing resuscitation. Albeit, discrepancies were found as to when it is acceptable for relatives to be present. Some nurses in the study were of the opinion that before allowing relatives into the resuscitation area, they would prefer if the patient was someway stabilised and visually presentable. This concept needs to be explored and considered prior to assembling guidelines on the practice of family presence. The findings show that the majority of decisions as to when allow family presence are made jointly between physicians and nurses. Findings also indicate that physicians are less comfortable with the concept than their nursing colleagues. This differing of opinion if any, will need to
be explored prior to implementing guidelines for if the policy is to work, acceptance from all
disciplines must be guaranteed for it to be successful.

Another concern found within the study is the idea that family presence may prolong
resuscitative efforts. One needs to decide whether this should be perceived as harmful when
one considers that all efforts should be executed prior to ending resuscitation. The author is of
the belief that a policy should have no timeframe associated with it, but suggests that the
family play a part in deciding when to end resuscitation. This idea is pertinent within the
study as nurses are divided as to whether family members should play a part in making
decisions regarding their loved ones care. These concerns should be further explored prior to
implementing guidelines. Participants within the study were of the belief that policies would
lead to unilateral treatment and equal access for all rather than relying on the opinions of
certain individuals or professions. Findings show that policies will help reduce confusion and
facilitate greater understanding. Without these guidelines nurses believe they will be put in
difficult positions if asked by relatives to be present during resuscitation. Policies will act as
guidance and aid professional development, giving opportunities to nurses to further become
empowered within their practice.

6.2.3 IMPLICATIONS/RECOMMENDATIONS FOR NURSING
PRACTICE/EDUCATION

This study has heightened emergency nurses knowledge and awareness surrounding the
subject of family witnessed resuscitation. Introducing the concept of family witnessed
resuscitation will lend the opportunity for nurses to develop their profession which in turn
will give further empowerment. The study has illustrated the need for support by ongoing
education in the clinical setting. This professional and educational development could consist
of specialised training in dealing with bereaved relatives. This training could be incorporated
into courses that are currently undertaken by staff members within the emergency department such as Advanced Cardiac Life Support (ACLS) and Advanced Trauma Life Support (ATLS). Integrating this training into these current courses would be cost effective and gain access to a high number of health care professionals.

Family witnessed resuscitation needs to be discussed openly among staff members working in the emergency setting. Appropriate information concerning the concept needs to be delivered to all health care professionals especially when one considers the dramatic shift in acceptance found by MacLean et al (2003) following an application of an educational class on family presence. The author is of the opinion that education that raises the consciousness of staff and addresses staff concerns is a necessity for changing the mind set and attitudes of staff. The author suggests that a multidisciplinary committee should be created in order to discuss and negotiate staff education programmes which may be needed to implement change in current practice. These changes will require a commitment of resources from hospital management but again these educational sessions could be incorporated into existing courses undertaken by emergency staff such as ‘Dealing with Death, Dying and Bereavement’ and therefore reduce cost implications.

The findings show that family presence impacts on coping mechanisms that may be utilised by nurses during resuscitations such as a small degree of humour. To counterbalance this negativity, the author suggests that debriefing sessions should become a common occurrence following any resuscitation. This will provide staff the opportunity to disclose any issues that may have occurred during the process. Findings also indicate that nurses are concerned that relatives may disrupt the resuscitation, but it is believed that educating staff about family presence will reduce this risk. It is further hoped these education sessions may diminish
incidents where family members would become aggressive, as nurses would be able to recognise and distinguish the relative’s suitability to enter the resuscitation area. The author believes that the practice of family witnessed resuscitation can only strengthen the bond between the nurse and family members.

6.2.4 IMPLICATIONS/RECOMMENDATIONS FOR RESEARCH

In contrast to preceding studies exploring family witnessed resuscitation, this study revealed that there had been incidents involving relatives becoming aggressive whilst being present during resuscitative efforts. The author questions that this finding may be due to diverse cultural attitudes that may exist in Ireland today. Lack of education concerning the practice is also believed by the author to have contributed to this episode of aggression.

Ambiguity regarding family member’s involvement in decision making is apparent from the study. As mentioned previously nurses are divided as to what part relatives should play in the care of their loved one. More research is required to investigate this uncertainty as problems and conflict may arise for health care professionals if family members do want to contribute to their relative’s treatment. In the current health service where patients and families are encouraged to be more active in their clinical care, one can see why this argument is relevant. Findings from this study show that nurses believe physicians may not be as comfortable with the concept of family presence as their nursing colleagues. This may be due to the fact that nurses are more aware of the larger circle of care that involves the patients family. Another suggestion is that physicians take on more responsibility than their nursing contemporaries and are more susceptible to litigation issues. Research is recommended to explore physicians
opinions concerning the practice and also to investigate why nurses believe they are more receptive of the practice than their medical colleagues.

Nurses within the study were uncertain whether patients were aware that family members were present during their resuscitation. Unfortunately as already discussed, little research has been completed exploring patients experiences due to the high mortality rates associated with resuscitation. Therefore it is difficult to ascertain what patients experience whilst they are being resuscitated. Research is encouraged in this area to further help understand more about this complex area.

This study was completed in a setting that has still yet to develop guidelines encompassing the practice of family presence. The author suggests that this research should be utilised in the development of said guidelines. It would be of benefit then to undertake a study post implementation of these guidelines to ascertain whether they were of any aid and also to investigate how nurses experiences differ following the policies introduction.

It is finally proposed that a large national survey of health care professionals be undertaken within the Republic of Ireland to gather their opinions regarding the practice of family witnessed resuscitation and the implementation of policies. This survey would hopefully also raise debate about a subject which has been long too left on the shelf.

6.3 POTENTIAL CONTRIBUTION TO BODY OF KNOWLEDGE

As far as the author believes this was the first study to explore Irish nurses experiences of family witnessed resuscitation. Despite the limitations of the study, the findings have further contributed to the existing body of knowledge and the practice of family witnessed
resuscitation in emergency care. This research study plays a key role in providing evidence on the value of family presence and it is hoped the study will contribute to the improvement of nursing practice as it is seen to be the way forward to achieve clinical effectiveness.

It is hoped others will draw upon the study and its findings to further enhance their own learning requirements as well as contribute to the current body of knowledge surrounding the practice.

The author intends to disseminate the findings to the participants who were involved in the study, medical and nursing personnel, management as well as other interested parties. The eventual aim is to have the findings published in significant nursing journals. By having the study published, it will act as a stimulus for further research in an area that the author believes is ripe for further investigation.

**6.4 LIMITATIONS OF THE STUDY**

The author recognises that the study has several limitations. By acknowledging these limitations and exploring where ones biases were engaged it is believed that the study will be more rigorous and establish further trustworthiness.

Due to resource and time constraints the sample was drawn from one hospital. This limits generalisation to the rest of the wider community. Sampling bias is also present as the population of this study was limited to nurses working within the emergency setting and the findings may not be representative of the experiences of nurses working within other areas. Furthermore, findings may not reflect the experiences of nurses who declined to participate in the study and as the study explored nurses experiences only, these findings may not be transferable to other health care professionals.
Due to the scarce numbers of studies undertaken within an Irish perspective the findings were compared to outside studies which adds to the limitations of the study.

Finally, the author may have shown bias in his opinions due to his own experience of family witnessed resuscitation but it is believed that by employing the method of ‘bracketing’ this will have been lessened.

6.5 CONCLUSION

This study has shown the commitment of nurses to introducing the practice of family witnessed resuscitation. They believe it will provide the opportunity to enhance their professional development and further empower their practice. If this change is to come about within the health service, commitment will be required from all health care providers as well as health care management. The subject of family witnessed resuscitation will continue to be a sensitive issue within health care but it is believed with the right approach and with the implementation of appropriate guidelines and policies an optimal service which the public require of us can be successfully provided.
6. REFERENCES


Moreland, P. (2005) Family presence during invasive procedures and resuscitation in the


Osuagwu, C.C., Martin, J. and Lenehan, G.P. (1991) ED codes: keep the family out...
"Rethinking traditional thoughts", *Journal of Emergency Nursing*, 17(6), pp. 363-364.


BIBLIOGRAPHY
7. BIBLIOGRAPHY


APPENDICES
### APPENDIX I

#### Summary of Literature Review

<table>
<thead>
<tr>
<th>Article Title</th>
<th>Emergency nurses current practice and understanding of FP during CPR</th>
<th>Nurses beliefs about family presence during resuscitation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Purpose</td>
<td>To examine EN current practices and understanding of FWR in an Irish Regional Hospital CUH</td>
<td>To explore the beliefs and experiences of RN re: FWR</td>
</tr>
<tr>
<td>Research Design</td>
<td>Quantitative descriptive design 4 sections: Demographic EN knowledge of policies and practices in re: FWR EN preferences for FWR policy development Lists barriers and facilitators on FWR</td>
<td>Qualitative descriptive methodological design</td>
</tr>
<tr>
<td>Sample</td>
<td>Convenience sample EN &gt; 6months experience in ED 100 nurses with 90 respondents</td>
<td>RN working in acute care settings who were likely to witness or participate in CPR 10 nurses</td>
</tr>
<tr>
<td>Data Collection</td>
<td>Survey Questionnaire 15 close-ended questions addressing the 4 sections Content validity of questionnaire established by ENA/panel of experts Questionnaire piloted on 10 EN in different ED Piloting resulted in questionnaire being changed which increased its reliability</td>
<td>Interview – face to face – 45minutes Tape recorded/transcribed verbatim Demographic data ???no pilot interview although the questionnaire used was previously used in other study Responses to interview were analyzed using constant comparative method of data analysis Comparing elements found in one interview with those in another interview read and reread This is repeated until emerging themes are identified and compared and common ideas can be extracted</td>
</tr>
</tbody>
</table>
### Results

**Policy development:**
- 33% unsure if policy exists
- Lack of info re: FWR
- Not included in induction

**Preferences re: FWR**
- 74% prefer written policy
- 24% prefer no written policy but would like the option of FWR
- 2.2% prefer no FWR regardless of policy

66% of EN took families in past to FWR

**Barriers**
- 58% conflict may occur amongst team members
- 50% believed it would increase stress
- 39% were fearful of litigation
- 27% believed family may interfere with the resuscitation

Four themes emerged from interviews

#### Conditions when FWR an option
- These factors affect family’s coping skills
- Suddenness of the event
- Family’s medical knowledge
- Age of the patient

1. long term illness different than sudden death
2. misinterpret what’s going on so therefore impact on behaviour
3. parents have a right to be there

* they expand by stating if FWR then need staff which is not always possible due to staff shortages and space constraints

#### FWR to force family decision making
- Family brought to bedside to understand situation which may lead to decision to end resuscitation
- FWR effective in educating family
- Staffs feeling of being watched
- Staff behaviour different in front of family

Comfortable with knowledge = comfortable with FWR

#### Impact of FWR on family
- Unpleasant memories of resuscitation may affect family
- FWR means the family is seeing everything is being done for their loved one
- Nurses concerned that family may remember relative in bad light

### Discussion

1st study conducted in ROI to examine EN current practices and understanding of FWR
Findings correlate with other research pieces

- Identified EN positive attitudes to FWR
- Identified the need for policy development
- Without protocols EN are put in difficult positions in re: FWR and the authors suggest policies may prevent conflict

Disapproval re: FWR may be related to lack of education
Conflict amongst the team correlates findings suggestive that physicians are less likely to agree with FWR than nurses

Increased stress may be related to inexperience and lack of skills/knowledge

FWR enhances the ability for closure after the resuscitation
Enables family to see the scope of care provided

- Lack of adequate space
- Inability to assign staff member
- The potential of negative psychological impact on families

Policy development is warranted
Most critical/emergency nurses prefer policies
Nurses more than physicians support FWR
Nurses who have been in FWR in past are more likely to support FWR

Has not achieved widespread acceptance regardless of professional endorsement

Having policies in place reduces possibility of individual staff’s personal opinions playing part in decision

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120
<table>
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<tr>
<th>Limitations</th>
<th>Recommendations</th>
<th>Relevance /10</th>
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</table>
| Main limitation being the research design as quantitative did not allow EN perceptions to be explored  
Research performed in only one hospital  
Research only looked at EN and the ED setting did not consider other areas such as ICU, CCU, wards etc. | The study heightened EN knowledge and awareness re: FWR  
Illustrated the need for support by ongoing education and policy development  
Findings contributed to the existing body of knowledge and the practice of FWR in emergency care | Encourage further research to investigate why barriers to FWR continue to exist |
| Research design does not take great number/population  
No pilot interview performed does not strengthen rigor of piece  
Good that they gave a sample of questions asked  
Analysis process allows biases to be present  
They do not recognize or mention their limitations | | 9/10  
7/10 |
<table>
<thead>
<tr>
<th>Article Title</th>
<th>Nurses attitudes toward family presence during resuscitative efforts and invasive procedures</th>
<th>Study examining attitudes of staff, patients and relatives to witnessed resuscitation in an adult intensive care units</th>
</tr>
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<tr>
<td>Purpose</td>
<td>To explore variables influencing nurses attitudes and beliefs about FWR during resuscitative or invasive procedures</td>
<td>To examine the attitudes of staff, patients and relatives to witnessed resuscitation in an adult intensive care units</td>
</tr>
<tr>
<td>Research Design</td>
<td>Quantitative Descriptive Correlational study Qualitative component</td>
<td>Quantitative Survey</td>
</tr>
<tr>
<td>Sample</td>
<td>Random selection 500 surveys with 208 respondents Response rate of 42%</td>
<td>Purposive selection Intensive care medics and nurses Patients/NOK before elective operation 50 medical respondents = 88% 50 nursing respondents = 94% 55 patients/NOK recruited</td>
</tr>
<tr>
<td>Data Collection</td>
<td>Postal survey questionnaires Likert scale Survey tool consisted of: 13 questions 7 close-ended 6 open-ended</td>
<td>Questionnaire Specific questions though room for comment Medical – postal Nursing – at end of day Patient – with them</td>
</tr>
<tr>
<td>Results</td>
<td>Increased knowledge = more positive attitudes re: FWR FWR interfered with their job due: Environmental limitations Demand on subjects time Lack of personnel Untoward family responses Lack of education Nurses believed FWR would enable relative: Advocate for their family member Provide emotional/spiritual support Facilitate grieving process Ensure correct procedures Ensure all alternative therapies are considered Assist in end of life decisions rather than prolonging life</td>
<td>Staff views Should relatives be giving option? 56% medics – yes 66% nurses – yes 70% medics – yes if family ask 82% nurses – yes if family ask 18% medics – no 16% nurses – no Reasons for allowing FWR: Provide explanation 50%M50%N Prevent interference 14%M14%N Emotional support 6%M14%N Right to be there 8%N See everything done 30%M33%N Reasons for not allowing FWR: Not be allowed be present 26%M18%N Distressing for relatives 8%M18%N</td>
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<tr>
<td>Provide knowledgeable explanations</td>
<td>Patients views</td>
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<td>Give comfort/reassurance</td>
<td>29% would want NOK present</td>
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<td>FWR right and not an option</td>
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<td>be present:</td>
<td>-see everything being done (5%)</td>
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<td>Lack the knowledge</td>
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<td>71% would not want NOK present</td>
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<td>Reasons against:</td>
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<td>Too distressing (55%)</td>
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<td>Overcrowding</td>
<td>Impede resuscitation (9%)</td>
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<td>*when the nurse is the patient they</td>
<td>Bad last impression (4%)</td>
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<tr>
<td>wish to have their family present*</td>
<td>NOK would make no difference (4%)</td>
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<tr>
<td>Personal limitations on the nurses</td>
<td>Reasons for:</td>
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<td>part:</td>
<td>Provide support (24%)</td>
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<tr>
<td>inability to manage issues relevant</td>
<td>Everything done (14%)</td>
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<td>to death and dying</td>
<td>Relative didn’t die alone (7%)</td>
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<td>Discomfort with family being present</td>
<td>Play part in decision making (2%)</td>
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<td>Fear of litigation</td>
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<td></td>
<td>Impede resuscitation (16%)</td>
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### Discussion

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<th>Patients views</th>
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<td>wish to have their family present*</td>
<td>NOK would make no difference (4%)</td>
</tr>
<tr>
<td>Personal limitations on the nurses</td>
<td>Reasons for:</td>
</tr>
<tr>
<td>part:</td>
<td>Provide support (24%)</td>
</tr>
<tr>
<td>inability to manage issues relevant</td>
<td>Everything done (14%)</td>
</tr>
<tr>
<td>to death and dying</td>
<td>Relative didn’t die alone (7%)</td>
</tr>
<tr>
<td>Discomfort with family being present</td>
<td>Play part in decision making (2%)</td>
</tr>
<tr>
<td>Fear of litigation</td>
<td>Reasons against:</td>
</tr>
<tr>
<td></td>
<td>Too distressing (33%)</td>
</tr>
<tr>
<td></td>
<td>Impede resuscitation (16%)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Discussion</th>
<th>Higher education = more positive attitude to FWR</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>ENA certified nurses = more positive attitude to FWR</td>
</tr>
<tr>
<td></td>
<td>Organizational constraints such as lack of space and lack of staff = negative impact on nurses</td>
</tr>
<tr>
<td></td>
<td>Supportive colleagues and nurses with specialized training = change in behaviour</td>
</tr>
<tr>
<td></td>
<td>Benefits to family members is that they see that:</td>
</tr>
<tr>
<td></td>
<td>all has been done for their loved one</td>
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<tr>
<td></td>
<td>they had supported their loved one</td>
</tr>
<tr>
<td></td>
<td>reduced family anxiety and fear</td>
</tr>
<tr>
<td></td>
<td>eased their bereavement</td>
</tr>
</tbody>
</table>

| CHAPERONE how important for FWR to be feasible – trained member of staff |
| Looking at FWR holistically |
| Respecting patients wishes if known |
| ? ethical issues will arise if allowing family to be present |
| ? ethical issues will arise if telling family to leave |
| If patient dies family will become main aim of care |
| Family more aware of CPR from television |
| Majority of nurses surveyed felt that relatives gained benefit from FWR |
| All agreed that views of patients and NOK should be sought before admission to intensive care |

### Limitations

<table>
<thead>
<tr>
<th>Limitations</th>
<th>Discussion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sample drawn from one hospital</td>
<td>Higher education = more positive attitude to FWR</td>
</tr>
<tr>
<td>Drawn from one professional nursing organization = limits generalization</td>
<td>ENA certified nurses = more positive attitude to FWR</td>
</tr>
<tr>
<td>Example of interview not provided – no example of open-ended questions asked</td>
<td>Organizational constraints such as lack of space and lack of staff = negative impact on nurses</td>
</tr>
<tr>
<td>Poor response rate - ?validity</td>
<td>Supportive colleagues and nurses with specialized training = change in behaviour</td>
</tr>
<tr>
<td>ICU nursing and medical staff</td>
<td>Benefits to family members is that they see that:</td>
</tr>
<tr>
<td>?transferable to the emergency setting</td>
<td>all has been done for their loved one</td>
</tr>
<tr>
<td>Results diverse from previous studies</td>
<td>they had supported their loved one</td>
</tr>
<tr>
<td>Patients opinions prior to elective surgery</td>
<td>reduced family anxiety and fear</td>
</tr>
<tr>
<td>?relates to ED</td>
<td>eased their bereavement</td>
</tr>
</tbody>
</table>
| Recommendations | Education surrounding FWR needs to be explored  
| | They look at nurse shortages as problems to implementing FWR  
| | Resource commitments need to be provided for the implementation of FWR  
| | Educational programs can change nurses attitudes to be more positive re: FWR  
| NOK should be sought before admission to intensive care (this could be useful for patients transferred from resuscitation room to ICU) |  

<p>| Relevance /10 | 6/10 | 5/10 |</p>
<table>
<thead>
<tr>
<th>Article Title</th>
<th>Family presence during CPR: A study of the experiences and opinions of Turkish critical care nurses</th>
<th>Family presence during CPR and invasive procedures: Practices of critical care and emergency nurses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Purpose</td>
<td>To determine the experiences and opinions of Turkish critical care nurses about FWR</td>
<td>To identify the policies, preferences and practices of critical care and emergency nurses for having patients families present during resuscitation and invasive procedures</td>
</tr>
<tr>
<td>Research Design</td>
<td>Survey questionnaire 43 questions/3 areas Descriptive</td>
<td>30 item survey design Postal questionnaire</td>
</tr>
<tr>
<td>Sample</td>
<td>Critical care nursing staff from 10 different hospitals 409 with response rate 278 (68%)</td>
<td>1500 critical care nurses AACCN 1500 emergency nurses ENA Response rate of 33% (n = 984)</td>
</tr>
<tr>
<td>Data Collection</td>
<td>Survey questionnaire/43 questions looking at 3 areas personal info of nurses experiences of FWR(yes/no) opinions of FWR(Likert scale) Pilot tested on 30 nurses Data were analyzed using SPSS</td>
<td>Postal questionnaire Validity of the tool established by rating of it by panel of experts Tool revised following rating Pretested questionnaire 15mins to complete Data analyzed using SPSS Significance &lt;0.01</td>
</tr>
<tr>
<td>Results</td>
<td>Demographic 19-50yrs = 96.4% &lt;10yrs exp nursing = 76.5% &lt;10yrs exp ICU = 85.1% Experiences of FWR inexperienced with FWR = 63.7% Not positive exp of FWR = 88.8% Negative experience = 33.5% NO hospital had protocol or policy in re: FWR Opinions of FWR Not necessary invite family 83.1% Not want relatives present 69.1% Reluctance of physicians 78.8% Confidentiality issue 88.1% Family not understand leading to confrontation 88.5%</td>
<td>Family presence policy Written policies allowing FWR 5% Written policies prohibiting 2% Allowed FWR regardless policy 45% Not allow FWR regardless policy 29% Preferences re: policy Prefer policy 37% Like FWR but no need for policy 39% How often bring family to bedside Taken family to bedside 36% Not taken family to bedside 21% How often family ask to be present Had asked them to be present 31%</td>
</tr>
<tr>
<td>Family member shouldn’t be involved decision making 75.9%</td>
<td></td>
<td></td>
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<tr>
<td>Who asks option of FWR?</td>
<td></td>
<td></td>
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<tr>
<td>Not nurses – 56.9%</td>
<td></td>
<td></td>
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<tr>
<td>Physicians – 55%</td>
<td></td>
<td></td>
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<tr>
<td>Joint – 77.7%</td>
<td></td>
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</tr>
<tr>
<td>Stressful for families 87.8%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Certain decisions during resuscitation upset family 74.1%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Not beneficial for patients 78.8%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cause stress to team 84.2%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Interfere with resuscitation 64.7%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No staff to stay with patient 71.5%</td>
<td></td>
<td></td>
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<tr>
<td>Limited space 70.9%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Long term effects on family 88.5%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prolong resus if family there 54.7%</td>
<td></td>
<td></td>
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<tr>
<td>Not strengthen nurse-patient 68%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No benefit to patient 73.4%</td>
<td></td>
<td></td>
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<tr>
<td>Not assist grief process 57.2%</td>
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</tr>
</tbody>
</table>

**Nurses comments about FWR**
- Provides emotional support
- Positive experience for families/staff
- Guidance and increases understanding
- Helps family make decisions
- Know that everything being done
- Facilitates grieving process
- Need to assess case by case
- Need for designated staff member
- Privacy/limited space
- Family behaviour/lack of education
- Staff stress/discomfort
- Limited space and staff
- Lack of privacy
- Legal issues

**Discussion**

**Nurses experiences of FWR**
- No respondents offered family option to be present with relative
- No written policy
- Unfamiliar with FWR

**Nurses opinions of FWR**
- Decision making re: FWR
  - Majority state family should not be given option of FWR
  - Majority of nurses believed it should be a joint decision
  - ¾ did not support idea of family making decisions in FWR similar to other studies (Fulbrook et al 2005)
  - Majority felt FWR may breach confidentiality

**Effect of FP on HCP’s**
- Large % not common practice and of no benefit to patient
- May hinder resus similar to Fulbrook et al
- Disapproval may be re: to lack of awareness of FWR and restricted visitor policy in Turkey
- Majority of nurses felt too stressful for family
- The concerns of HCP’s unfounded
- Nurses did not think enough personnel and limited space
- Findings similar to previous studies

**Influence of FWR on outcome**
- Nurses don’t believe FWR

**Most nurses support FW**
- Undecided re: written policy
- Degree of invasiveness influence decision
- Nearly all nurses support presence of parents during invasive procedure but this drops to half for FWR
- Education affects attitude can increase offer of option from 11% to 79%
- Family members often ask to be present during IP but lower % for FWR
- Nurses more experience of FWR than physicians (Helmer et al)
- ¾ of nurses were unaware that guidelines re: FWR were available from ENA
<table>
<thead>
<tr>
<th>Benefits patient</th>
<th>Concerned about traumatic effect on family</th>
</tr>
</thead>
<tbody>
<tr>
<td>FWR would not strengthen bond between nurse and family</td>
<td>FWR would not assist grieving process</td>
</tr>
<tr>
<td>These findings contradict previous studies</td>
<td>Nurses disagreed that relatives doubts about resus would lead to litigation</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Limitations</th>
<th>Limited to critical care nurses Research based in Turkey Transferability Results compared to studies outside of Turkey Participant responses presumed to be valid and reliable Postal not great</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recommendations</td>
<td>To increase familiarity re: FWR policies are recommended Nurses did not want to take responsibility for giving family option of FWR Concerned about confidentiality The need for ongoing education in re: to FWR This will enable nurses to collaborate with other members of the MDT More unified and consistent approach to FWR Future research should focus on views of other members of MDT</td>
</tr>
</tbody>
</table>

| Research did not undergo reliability testing and has no established construct validity Generalisability of the findings is limited to the search group due to the poor response rate Nurses who did not respond may have different experiences of FWR Research relied on memory and reports of respondents rather than field diaries |

<p>| Relevance /10 | 7/10 | 7/10 | 7/10 |</p>
<table>
<thead>
<tr>
<th>Article Title</th>
<th>Staff attitudes to family presence during resuscitation Part A: An interventional study</th>
<th>Family member presence during CPR: A survey of US and international critical care professionals</th>
</tr>
</thead>
<tbody>
<tr>
<td>Purpose</td>
<td>To see what staff attitudes to relatives presence in resuscitation were pre- and post-implementation of an FWR program</td>
<td>To assess whether critical care professionals support FWR</td>
</tr>
<tr>
<td>Research Design</td>
<td>Survey Questionnaire</td>
<td>Quantitative Survey</td>
</tr>
<tr>
<td>Sample</td>
<td>Non-probability Nursing/medical staff working in ED in Queensland, Australia Non probability has potential for bias therefore a census approach was used which meant that all eligible staff were surveyed Pre-test response rate = 51.2% Post-test response rate = 31%</td>
<td>Distributed to HCP’s attending the international meeting of the American college of chest physicians 554 surveys completed 494 physicians 28 nurses 21 AHP</td>
</tr>
<tr>
<td>Data Collection</td>
<td>Questionnaire of researchers own design Questions were based on r/v of lit. All questions dichotomous, multiple dichotomous, open-ended or a Likert scale Tested by pilot group Analyzed using SPSS</td>
<td>Survey Completed in &lt;2mins Handwritten questionnaires p&lt;0.05 Questionnaire completed/collected over 2days as HP’s attended conference</td>
</tr>
<tr>
<td>Results</td>
<td>Majority respondent’s nurses (54%) and medics (41.2%) Attitudes to relatives presence Pre-test Would increase stress/pressure on staff Conflict with patient confidentiality Expected negative behaviour of relatives Allow family in after patient stabilized, terminally ill or when patient deceased Post-test Family more agitated when not</td>
<td>The majority of HCP’s opposed FWR in adults More physicians (80%) opposed FWR Nurses alone (57%) opposed FWR Not in favour of paediatric FWR (85%) 22% would allow FWR during adult Respondents who disapproved of FWR gave reasons as: Psycho trauma to family (79%) Medico legal reasons (24%) Performance anxiety affecting HP (27%) Family members distract staff (4.7%)</td>
</tr>
<tr>
<td>Discussion</td>
<td>Decline in response rate between pre and post test – reasons for this may include:</td>
<td>Family interference – which is not backed up by previous studies specifically Hanson and Strawser</td>
</tr>
<tr>
<td>------------</td>
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<tr>
<td></td>
<td>Mail surveys have poor response rate</td>
<td>Fear of psycho trauma – physicians more than nurses were afraid of this – the authors argue that family can sometimes be the first responders only to be ejected from the resus room</td>
</tr>
<tr>
<td></td>
<td>Prior to starting research staff were eager maybe this waned</td>
<td>Television has given people some idea but again its argued that real-life CPR attempts differ markedly from TV’s almost universally successful and bland depictions</td>
</tr>
<tr>
<td></td>
<td>Prior to research negative became more positive outlook re: FWR</td>
<td>Allowing FWR after certain time is also discussed – there are no definite time guidelines indicating when FWR is appropriate – the authors believe that HCP’s may be more likely to accept this than full blown CPR</td>
</tr>
<tr>
<td></td>
<td>17 positive experience of FWR</td>
<td>75% of physicians had negative experience of FWR supported by previous studies compared to 47% of nurses surveyed</td>
</tr>
<tr>
<td></td>
<td>4 negative experience of FWR</td>
<td>Opponents to FWR indicate that</td>
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<tr>
<td></td>
<td>Reflect similar results of other studies</td>
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<tr>
<td></td>
<td>Study examined at two points pre and post implementation</td>
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<td></td>
<td>Education program helped increase positive outlook</td>
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</table>
patients want their relatives to remember them as they were but little evidence to support this

Those that support FWR contend that the patients family knows best whether they should be present or not but physicians argue they are more knowledgeable about risks and benefits of FWR

Education of staff members may reconcile differing opinions between family members and HCP’s

Contrary to study findings re: FWR and paeds previous studies find greater support for FWR during paed resus

The study confirms previous findings of nurse v physicians where nurses are statistically more likely to support FWR – they indicate this could be due to decreased legal liability or that nurses generally have greater emphasis on patient-family dynamics during training/work than medics do

**Limitations**

- Looked at adult patients (medical) and different perceptions may appear when dealing with paediatric or traumatic emergencies
- Postal survey poor response rate and unreliability
- Australian perspective
- Quantitative didn’t consider ‘lived experience’ during the timeframe
- Response rate could not be obtained due to the way the survey was conducted
- This could theoretically skew the results as those with a strong opinion on FWR may have taken part in the survey
- ? paediatric opinions not reflective
- Survey was not a rigorously controlled prospective research study which may affect reliability and validity
- Vast opinions of physicians rather than nursing

**Recommendations**

- Overall positive aspects for relatives to be present in resus
- Further study should focus on psychological effects of FWR on staff so therefore a qualitative study should be considered
- Hospitals which implement FWR should consider training staff members during BLS/ACLS an approach that is successful
- Rigorous scientific study of FWR before its widespread implementation

<p>| Relevance /10 | 4/10 | 5/10 |</p>
<table>
<thead>
<tr>
<th>Article Title</th>
<th>Family presence during invasive procedures and resuscitations: the experience of family members, nurses and physicians</th>
<th>Trauma surgeons attitude towards family presence during trauma resuscitation: A nationwide survey</th>
</tr>
</thead>
<tbody>
<tr>
<td>Purpose</td>
<td>To explore the attitudes and experiences of family members and HCP’s in re: to FWR</td>
<td>To analyse the attitude of trauma surgeons towards FP during trauma resuscitation</td>
</tr>
<tr>
<td>Research Design</td>
<td>Using quantitative and qualitative methods</td>
<td>Quantitative Postal Questionnaire conc. beliefs and attitudes</td>
</tr>
<tr>
<td></td>
<td>Descriptive study</td>
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<td></td>
<td>Surveyed participants following 43 instances of FWR</td>
<td></td>
</tr>
<tr>
<td>Sample</td>
<td>39 family members 96 HCP’s: 60 RN 36 phys 22 phys res 14 phys attend</td>
<td>Level one trauma surgeons 545 questionnaires Response rate – 464/545 (85%)</td>
</tr>
<tr>
<td>Data Collection</td>
<td>37 item family survey to interview family members 33 item HCP survey to interview HCP’s Family presence attitude scale Likert scale Survey inc. semi-structured interviews</td>
<td>Postal questionnaire 4/52 to reply 6Q demographic/background 4Q current practice 11Q beliefs/attitudes Analyzed SPSS</td>
</tr>
<tr>
<td>Results</td>
<td>Family member attitude Positive attitude towards FWR Right to be present (97.5%) HCP attitude Positive attitude towards FWR Nurses more positive than phys Attending phys more positive than res phys Support of FWR during IP’s (73%) and CPR (76%) Support of FWR during CPR – 79% att phy vs 19% res phy Family member perceived benefit Important/helpful to be with relative – 100% Comprehend the seriousness of situation – 95% Visit helped the patients even if</td>
<td>Demographic Female (9.69%) Male (90.3%) Residents – 139 – 30% Senior phy – 217 – 46.8% Chief phys – 108 – 23.3% General experience with FWR Knew about FWR – 37.9% Relevant topic – 75.2% Never allow FWR – 50% After completion of IP – 42% Entire resuscitation – 8% Experience of FWR – 36.2% Positive – 56% Positive/neg – 25% Negative – 19% General attitude towards FWR Stress factor – 38.7% practicing FWR v 76.9% not practicing FWR</td>
</tr>
</tbody>
</table>
unconscious – 95%
Provided comfort/protection to loved one
Described themselves as helpers
Presence had effect on HCP’s Reminder of personhood – thus encouraging staff to try harder
Opportunity to say goodbye – closure
Spiritual experience
HCP perceived benefit
Important to families – 80%
Helped meet family/patients spiritual needs – 78%
Understand condition – 89%
Appreciate all that’s being done – 93%
Chance to witness and know the efforts that are being made
Opportunity to educate the family
Empowered families
Personhood to the patient
Opportunity for closure
More professional behaviour
Problems family view
Not what expected – 17%
Not too upsetting – 95%
Understand the need for appropriate behaviour during FWR
Problems HCP view
Interrupt IP/CPR – 38%
Behaviour appropriate during FWR – 97%
Comfortable having family present – 85%
More nurses felt comfortable over physicians – 95% vs 64%
Performance same regardless of family presence – 84%
Outcome same regardless of family presence – 97%
Initiate future litigation – 29%
Treatment unaffected by FP – 78%
Screening to identify appropriate FP
More physicians than nurses concerned about psychological effects of FP on families
Malpractice lawsuits – 19.4% vs 45%
Family strain – 32.3% vs 88.5%
Communication constraint – 50% vs 76%
59.5% of respondents would want to be present for resuscitation of relative
Comparison male/female
Females tend to know more about FWR (44.4% vs 37.2%)
They’re stronger in promotion of FWR
Stronger preference to be present during FWR of relative
Comparison residents/senior/chief
Chief less informed than colleagues
Chief regard family care as relevant topic (chief 81.5%, senior 77.7%, residents 70.5%)
Permit FWR – chief 72.2%, senior 41%, residents 45.2%
Stress factor – chief 89.4%, senior 75%, residents 69.2%
Restriction to communication – chief 86.5%, residents 68%
Malpractice lawsuit – chief 58.6%, residents 41.6%
<table>
<thead>
<tr>
<th>Discussion</th>
<th>FWR beneficial for family regardless of age, gender etc. Findings confirm prx studies: Everything done Feeling support relative Reducing family anxiety/fear Easing their bereavement Fear of disruption of CPR was found to be unfounded as all providers judged families behaviour to be appropriate Differences between nurses/phys FP programs should focus on educating staff Studies show that providers initially opposing FWR have striking shifts in opinion when their experiences with FWR do not confirm their concerns and the benefits to families become apparent</th>
<th>FWR is slowly overcoming resistance low % would never allow FWR during trauma (50%) compared to studies done by Helmer et al (2000) which showed 97.8% would not support FWR Previous studies support the idea that female are more receptive to FWR than their male counterparts The presence of an integrated FWR prevents the concept becoming an additional stressor for the team Increase in stress is supported by Helmer et al who suggested that FWR would turn the resus into a more stressful task for team members – an opposite opinion is given by Hanson and Strawser who showed during their 9yr retrospective study not a single case of interference Helmer et al also state that the fear of lawsuits is a good reason to exclude family from the resus however experts in medical malpractice feel that FWR actually decreases the likelihood of lawsuit by strengthening the bond between staff and family Up to date there have been no medical malpractice lawsuits involving FWR Trauma resuscitation may be not be suitable for FWR due to traumatic injury Many family members are first responders, know what to expect from TV medical dramas so therefore its an event from which the general public need not be shielded anymore</th>
</tr>
</thead>
<tbody>
<tr>
<td>Limitations</td>
<td>Generalisability of family responses is limited because only those members assessed as suitable FP candidates who accepted the visitation option were included. Those who declined were not studied – therefore we do not know how representative these families are of the universe of those with a loved one requiring CPR/IP Interviews were conducted with family members 2mths after event which may be prone to recall error Physicians who did not support FWR were not surveyed Again recall error may be a limitation for HCP’s as questionnaires were returned more than 2wks after the event</td>
<td>Postal questionnaires not very reliable Study focuses on trauma surgeons – may not be generalized to other professions Male/female divide may not be transferable Method approach does not allow for participants to expand on their replies – so it is difficult to understand why the replies are as such</td>
</tr>
<tr>
<td>Recommendations</td>
<td>Further research should focus on outcomes with different populations in different settings. Further studies should determine whether FWR alters the activities, length and cost of IP/CPR.</td>
<td>A FWR protocol will have to address physicians objections to be successful. Protocol should designate a specially trained staff member to offer support. Explanation prior to involving family in resuscitation.</td>
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</tr>
<tr>
<td>Relevance /10</td>
<td>5/10</td>
<td>6/10</td>
</tr>
<tr>
<td>Article Title</td>
<td>Paediatric critical care nurses attitudes and experiences of parental presence during cardiopulmonary resuscitation: A European study</td>
<td></td>
</tr>
<tr>
<td>--------------</td>
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<td></td>
</tr>
<tr>
<td>Purpose</td>
<td>To determine the experiences and attitudes of European paediatric critical care nurses about parental presence during a resuscitation of a child</td>
<td></td>
</tr>
<tr>
<td>Research Design</td>
<td>Quantitative Survey design Structured attitudinal questionnaire Likert scale</td>
<td></td>
</tr>
<tr>
<td>Sample</td>
<td>Convenience sample 158 paediatric critical care nurses Response rate = 103 (65.2%) Female 91.6% v Male 8.4% ICU nurse = 93.9% &gt;10yrs exp. = 79.2%</td>
<td></td>
</tr>
<tr>
<td>Data Collection</td>
<td>Descriptive statistics SPSS analysis p&lt;0.05 Questionnaire 3 sections: Biographical info. Experience of FWR 30 statements Likert scale</td>
<td></td>
</tr>
<tr>
<td>Results</td>
<td>Nurses experiences Experienced FWR – 70.1% Invited family in – 36.2% Positive exp. – 73.5% Negative exp. – 41.2% Decision making Family should always be offered opportunity – 63.3% Family should not be offered opportunity – 30.6% Doctor responsible for decision – 37.8% Nurse responsible for decision – 32.7% Joint decision – 70.4% Problems with confidentiality – 35.7% Parents would be more likely to</td>
<td></td>
</tr>
</tbody>
</table>

135
<table>
<thead>
<tr>
<th>Processes</th>
<th>Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Parental presence should be seen as normal practice – 58.2%</td>
<td></td>
</tr>
<tr>
<td>Beneficial to the child – 35.7%</td>
<td></td>
</tr>
<tr>
<td>Not beneficial to child – 30.6%</td>
<td></td>
</tr>
<tr>
<td>Difficult to concentrate for HCP’s during FWR – 33.7%</td>
<td></td>
</tr>
<tr>
<td>Likelihood to interfere – 21.4%</td>
<td></td>
</tr>
<tr>
<td>Say things that would upset parents – 69.4%</td>
<td></td>
</tr>
<tr>
<td>Find CPR too distressing – 65.3%</td>
<td></td>
</tr>
<tr>
<td>Not enough staff to provide support – 49%</td>
<td></td>
</tr>
<tr>
<td>Space constraints – 41.8%</td>
<td></td>
</tr>
<tr>
<td>Everything is being done – 89.8%</td>
<td></td>
</tr>
<tr>
<td>Legal action – 22.4%</td>
<td></td>
</tr>
<tr>
<td>CPR may be prolonged – 28.6%</td>
<td></td>
</tr>
<tr>
<td>Long-term emotional effects – 12.2%</td>
<td></td>
</tr>
<tr>
<td>Strengthen nurse/relative bonds – 59.2%</td>
<td></td>
</tr>
<tr>
<td>Important for parent to share child’s last moments – 71.4%</td>
<td></td>
</tr>
<tr>
<td>Helped the grieving process – 71.4%</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Discussion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nurses experiences</td>
</tr>
<tr>
<td>Incidence of FWR much lower in adult than paed arena</td>
</tr>
<tr>
<td>Staff who had previous exp. of FWR they were more likely to favour it</td>
</tr>
<tr>
<td>More nurses have been approached requesting to be present than adult counterparts</td>
</tr>
<tr>
<td>One of the reasons that staff may not approach family members is the lack of written policies</td>
</tr>
<tr>
<td>More written policies in paed arena (12%) versus adult (5%)</td>
</tr>
<tr>
<td>Nurses rely on their physician colleagues to make decisions</td>
</tr>
<tr>
<td>Paed nurses are more confident in approaching relatives than their adult counterparts</td>
</tr>
<tr>
<td>Decision making</td>
</tr>
<tr>
<td>Majority of nurses supported the idea of FWR (63%)</td>
</tr>
<tr>
<td>66% of nurses agreed that physicians do not want relatives to be present during resus – these perceptions may not be an accurate reflection of physicians own views although studies do show marked difference in support of FWR between both professions</td>
</tr>
<tr>
<td>Majority of nurses support the idea of joint decision making but are</td>
</tr>
</tbody>
</table>
reluctant to involve the parent in that decision making with only 33% supporting this idea. The idea of the resus being interrupted by family members is unfounded and unsupported by previous studies. Not all relatives want to be present and that each family member should be assessed individually.

Processes
Parents might become distressed but majority of nurses (65%) felt this was not good enough reason to deny them access. A vast majority (87%) of nurses believe that there should not be a dedicated nurse to support the parents – this is in contrast with other studies that show the importance of having a dedicated nurse – this role is crucial to the success of FP (Aldridge and Clark 2005) – the authors of this study is unable to explain this 87% but suggests that staffing levels/space may not permit FWR and that other patients care may be compromised.

Outcomes
Large % (90%) believe that by allowing parents to be present they would see everything is being done. Not allowing FP out of concern may not necessarily reduce distress but on the contrary may exacerbate/intensify it. 22% were weary of legal wrangling when FWR was performed but this is unfounded – nurses should recognize that the parents decision to stay is not an attempt to detect mistakes or assess the nurses competence in CPR skills, rather it is indicative of their need to remain with their loved one (Meyers et 2000).
| Limitations                                                                 | Sample not representative of the paediatric critical care nursing population  
|                                                                          | Only those with an interest in FWR would complete the questionnaire  
|                                                                          | The findings are not representative of all critical care nurses experiences or attitudes as the majority of the respondents are based in paediatric setting - ?transferable to adult arena |
| Recommendations                                                           | Further qualitative research is recommended to improve understanding in the area  
|                                                                          | Studies that examine the decision-making and performance of HCP during resus attempts when relatives are present are needed |
| Relevance /10                                                            | 5/10 |
APPENDIX II

Information sheet/letter for participants

Dear colleague,

I am undertaking a research thesis to examine emergency nurses experiences of family witnessed resuscitation in an Irish general hospital setting.

The aim of this research is to explore emergency nurses experiences of family witnessed resuscitation who are working within an Irish general hospital setting. The proposed aim is to enable the development and introduction of guidelines and policies in relation to family witnessed resuscitation. A semi-structured interview with clear and unambiguous open-ended questions will be utilised. The interview will be audio-recorded and last approximately 30-45minutes.

You have the right to:

• Decide voluntarily whether or not to participate
• Cease participation at any stage, with no impact for you personally or professionally
• Make contact with myself regarding any questions relating to the study

The information that you provide in this study will:

• Never be used against you in any way
• Be securely stored and treated in the strictest confidence

Complete anonymity will be guaranteed.

If you have any concerns or questions please do not hesitate to contact me on the number below.

I would appreciate your participation in this study.

Yours sincerely

_________________________________

Mobile Number
APPENDIX III

Consent to Participate in Research Study

A research thesis to examine:

Emergency Nurses Experiences of Family Witnessed Resuscitation in an Irish General Hospital Setting: A Qualitative Study

I agree to take part in the above research study. The study has been explained to me, and I have read the participant information sheet, which I can keep for my records.

I understand that agreeing to take part means that I am willing to participate in an audio recorded interview.

I understand that any information I provide is anonymous and confidential. I also understand that no information that could lead to the identification of any individual will be disclosed in the study. No identifiable personal data will be published.

I understand that my participation is voluntary and as such I can decide not to participate in part or all of the project. I can withdraw at any stage of the study without being penalised or disadvantaged in any way.

Name of participant: ____________________________________________ (please print)
Name of researcher: _______________________________________________
Signature of participant: ___________________________________________
Signature of researcher: ___________________________________________
Date: ______________________
APPENDIX IV

Letter seeking permission for study from the Director of Nursing.

Emergency Department
Hospital Address
Date

Dear Sir,

I am currently undertaking a Masters programme in Waterford Institute of Technology. I am writing to seek permission to carry out the following study.

“Emergency Nurses Experiences of Family Witnessed Resuscitation in an Irish General Hospital Setting: A Qualitative Study”

The proposed study will involve interviewing seven nurses from the emergency department to discover their experiences of family witnessed resuscitation. These interviews will last approximately 30-45 minutes. I have applied to the HSE and WIT ethics committee and am awaiting response.

I am willing to meet with you to discuss any questions you may have in regards to the study. Please find enclosed a copy of my research proposal.

Yours sincerely,

__________________________

Mobile Number
APPENDIX V

Letter outlining study sent to Counsellor covering HSE-South Area

Emergency Department
Hospital Address
Date

Dear Ms.

I am currently undertaking a Masters programme in Waterford Institute of Technology. I am writing to inform you of the following study.

“Emergency Nurses Experiences of Family Witnessed Resuscitation in an Irish General Hospital Setting: A Qualitative Study”

The study will involve interviewing seven nurses from the emergency department to discover their experiences of family witnessed resuscitation. These interviews will last approximately 30-45 minutes. I have applied to the HSE and WIT ethics committee and am awaiting response.

Due to the sensitive nature of the study, I intend to offer information on counselling services provided by the HSE.

Do not hesitate to contact me if you have any queries. I am willing to meet with you to discuss any questions you may have in regards to the study.

Please find enclosed a copy of my research proposal.

Yours sincerely,

__________________________

Mobile Number
# APPENDIX VI

## Participant Demographic Data/Interview Questions

**Interview Number:** ____________

### Demographic Data

<table>
<thead>
<tr>
<th>Sex</th>
<th>Age: ________</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Male</td>
<td></td>
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<tr>
<td>□ Female</td>
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<table>
<thead>
<tr>
<th>Professional Grade</th>
<th>Professional Qualification:</th>
</tr>
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<tbody>
<tr>
<td>□ Staff Nurse</td>
<td>□ RGN</td>
</tr>
<tr>
<td>□ CNM1</td>
<td>□ RSCN</td>
</tr>
<tr>
<td>□ CNM2</td>
<td>□ RPN</td>
</tr>
<tr>
<td>□ CNM3</td>
<td>□ RM</td>
</tr>
<tr>
<td></td>
<td>□ Other</td>
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</table>

<table>
<thead>
<tr>
<th>Working Pattern</th>
<th>Educational Qualification:</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Full-time</td>
<td>□ MSc</td>
</tr>
<tr>
<td>□ Part-time</td>
<td>□ BSc</td>
</tr>
<tr>
<td></td>
<td>□ HDip</td>
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<tr>
<td></td>
<td>□ Diploma</td>
</tr>
<tr>
<td></td>
<td>□ Other</td>
</tr>
</tbody>
</table>

| Years of nursing experience: ________ | Years of nursing experience (emergency): ________ |

### Interview Questions

- What do you believe family witnessed resuscitation to mean?
- Do you support the idea of family witnessed resuscitation?
- Could you tell me of your experiences involving family witnessed resuscitation?
- What was the experience like? Would you repeat the experience? Would you have done anything differently? Why/why not?
- When would you allow/not allow family witnessed resuscitation?
- What were your greatest concerns with having family members present? How did their presence make you feel?
- Has the experience had any effect on you or your nursing?
- Was the experience what you expected?
APPENDIX VII

Ethics Approval from Waterford Institute of Technology

23rd April, 2008

Dear

Thank you for bringing your project ‘Emergency Nurses Experience of Family Witnessed Resuscitation in an Irish General Hospital Setting: A Qualitative Study?’ to the attention of the Department of Nursing Ethics Committee. I am pleased to inform you that we are satisfied that you have considered all the ethical implications of your research and we will convey to Academic Council that the project has been approved.

We wish you well both in the work ahead and the completion of your Masters programme.

Yours sincerely,

Dr. John Wells
Chairperson,
Department of Nursing Ethics Committee.
Appendix VIII

Ethics Approval from Health Service Executive

Waterford Regional Hospital,
Dunmore Road,
Waterford,
Ireland.

Telephone 051 848000
Fax 051 848572

Research Ethics Committee
HSE South Eastern Area
Old School of Nursing
Waterford Regional Hospital

Title of Application:
“Emergency Nurses Experiences of Family Witnessed Resuscitation in an Irish General
Hospital Setting: A Qualitative Study”

Date: 30th January 2008

Dear

The Ethics Coordinator for the Research Ethics Committee, HSE, South Eastern Area has
reviewed the above application and can grant expedited approval for this study.

The expedited approval has been given following review of:

Application Form ✓
Research Proposal ✓
Literature Review ✓
Questionnaire/ Interview Schedule ✓
Other supporting documentation ✓

The above application will also be reviewed by the Research Ethics Committee, HSE, South
Eastern Area at their next meeting on 18th February 2008, any comments made at this
meeting shall be communicated to you in writing.

Yours sincerely

Caroline Lamb, Ethics Coordinator
Research Ethics Committee, Old School of Nursing, Waterford Regional Hospital
Tel: 051 842026 E-Mail: Caroline.Lamb2@maila.hse.ie
APPENDIX IX

Data analysis framework utilised within the study

Colaizzi’s (1978) framework as cited by Parahoo (1997):

1. All interviews are transcribed verbatim and read in order to get a feel for them

2. Significant statements and phrases that pertain to the experience under investigation are extracted

3. Meanings are formulated from these significant statements

4. Significant statements are organised into clusters of themes

5. The themes are used to provide a full description of the experience

6. Researcher returns the description to its original source for confirmation of validity
APPENDIX X

Contents of recordable disc enclosed

- Interviews 1-7 (Word 97-2003 Document)
- Interview broken into themes (Word 97-2003 Document)
- Interview analysis 1-7 (Word 97-2003 Document)
- Demographic data analysis (Excel 97-2003 Workbook)