

**EXPERIENCES OF CRITICAL CARE NURSES OF DEATH AND DYING IN AN
INTENSIVE CARE UNIT: A PHENOMENOLOGICAL STUDY**

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Declaration

This is to certify that the work is entirely my own and not of any other person, unless explicitly acknowledged (including citation of published and unpublished sources). The work has not previously been submitted in any form to the Durban University of Technology or to any other institution for assessment or for any other purpose.

Signature of student

Date

Approved for final submission

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Abstract

Background

Working in the intensive care unit can be traumatic for nursing personnel. Critical care nurses are faced with repeated exposure to death and dying as they are involved in caring for patients who are actively dying or who have been told that they have a terminal illness and are faced with the possibility of impending death. Critical care nurses relate in different ways to the phenomena of death and dying within their nursing profession and their scope of practice. These nurses often have a difficult time coping with the stress that comes with caring for those who are dying or relating to loved ones of those that are dying.

Aim of the study

The aim of the study was to explore the critical care nurse's experiences of death and dying.

Methodology

A qualitative, descriptive phenomenological approach was used to guide the study. Four nurses were recruited and rich descriptions of their experiences were gained through individual face-to-face interviews. One broad question was asked: *'What are your experiences regarding death and dying of your patients in ICU?'*

Results

The findings of this study revealed that issues such as communication, multicultural diversity, education and coping mechanisms relating to caring for the critically ill and dying patient are essential in nursing education and practice. Critical care nurses need to have support networks in place, not only to assist in providing care, but also for their own emotional support

Dedication

I dedicate this dissertation to my family for their patience, love, motivation, support and encouragement during this long and challenging but wonderfully overwhelming process of learning.

Acknowledgements

This project and its entire journey, has been a very humbling experience. I could not have completed this work without the help of many people who have offered their support, guidance and academic assistance along the way.

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Thank you to my husband, Mickey and children, Shivaan, Veantha and my dearest mother Ruby. To the loved ones that I have lost, my dad Saygaren and sister Pearl, you have given me firsthand experience of dealing with grief, death and dying, through the eyes of an ICU nurse.

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Acronyms

| Acronym | Full word |
|---------|--|
| AACN | American Association of Critical Care Nurses |
| CNA | Canadian Nurses Association |
| DOH | Department of Health |
| ICU | Intensive Care Unit |
| KZN | KwaZulu-Natal |
| SANC | South African Nursing Council |

CHAPTER 1

OVERVIEW OF THE STUDY

*"Nursing is an art: and if it is to be made an art,
It requires an exclusive devotion as hard a preparation,
as any painter's or sculptor's work; for what is the having to do with
dead canvas or dead marble, compared with having to do with the living body,
the temple of God's spirit. It is one of the Fine Arts:
I had almost said the finest of Fine Arts."
- Florence Nightingale*

1.1 INTRODUCTION AND BACKGROUND TO THE STUDY

The environment of an intensive care unit has been recognized as a very stressful, high-tech, fast paced and emotionally charged atmosphere. According to Prompahakul, Nilmanat, and Kongsuwan (2011: 15) who conducted a study relating to nurses' caring behaviours for dying patients, it was noted that the most important aspect of nursing is caring and this is even more so in an intensive care unit (ICU). However, it was also noted in the same study that nursing in an ICU can influence a critical care nurses' experiences with a dying patient or the end-of-life care. Significant factors such as working in a highly technological environment and lack of nurse education on death and dying raised concerns about the quality of the end-of-life care rendered. These concerns obviously seemed to stem from a critical care nurses' experiences with death and dying.

Apart from providing vigilant care to their patients and interacting on a daily basis with distraught families, critical care nurses confront death and dying, end-of-life decisions and ethical dilemmas very frequently. Furthermore, conflicting

values, moral and ethical codes of conduct which exist amongst the multidisciplinary health team; namely, doctors, nurses, physicians and medical technicians, can create additional tensions in the critical care unit. In general, the very nature of nursing is stressful and a nurse's attitude about death and dying can be extremely complex to understand. This is often related to his or her own experiences with death and dying. According to Urden, Stacy and Lough (2010: 2) critical care nurses fulfil speciality roles that require their clinical teaching, leadership, research and consultative abilities. The caring aspect is fundamental to the nurse-patient relationship and to the health care experience. Thus, keeping the 'care' in nursing is one of the biggest challenges of critical care nursing and this is especially the case when dealing with grief, death and dying. Not only must the critical care nurse be able to deliver high quality medical care skilfully, using all appropriate technologies, she must also be able to apply psychosocial and other holistic approaches when planning and delivering care (Thelan, Davie Urden, and Lough, 1994: 4).

Patients are often nursed in a critical care unit for long periods of time and this allows the nurse to bond with the patient and the family. Patients enter the acute care setting in physiologic crisis and treatment can be aggressive in order for it to be lifesaving. Interventions are sometimes effective in treating and stabilizing these ill patients but it is estimated that as many as one in five patients dies in critical care. Critical care nursing practice occurs centrally to the nurse with the patient and family in an environment that requires humanism and compassion. Providing quality care to a dying patient or the grieving family members can be both emotionally rewarding and draining. In the terms of the grand nursing theorist, Sister Calista Roy, critical illness causes a disruption in life (George, 2011: 294). The disruption requires a period of adjustment called the compensatory process that results in adaptation to the event. Adaptation can

be positive or negative, complete or incomplete, depending on what happens during the adjustment period. The process repeats itself, and as a patient's condition changes, the critical care nurse must adapt to these changes. Prompahakul, Nilmanat and Kongsuwan (2011: 15) maintain that caring for patients at the end-of-life becomes an indicator of the quality of care in a hospital. The management of critical illness and dying in the setting of the intensive care unit presents new evidence about the way the end-of-life is shaped, and managed in highly technological healthcare environments. They further maintain that intensive care practitioners, including critical care nurses, are often deeply concerned with issues of human dignity and with 'good' death and dying in intensive care unit.

Critical care deaths represent the majority of hospital deaths and for many nurses, the loss of a patient can create intense feelings of grief, while for others, the reminder of their own personal tragedies creates a very trying and stressful situation Carlson (2009: 1507). Nurses suffering from such stress may lose their capacity to perform well in their jobs and this can result in job dissatisfaction and burnout. According to a study that was conducted by Klein and Alexander (2003: 269), it was found that medical personnel have a twofold responsibility in understanding grief, dying and death reactions. One is to help the bereaved to develop their own ways of coping and the other is to ensure that their own difficulties, needs and attitudes relating to death and dying of their patients do not compromise their psychological well-being. It was noted by the same author that the psychological impact and after events prevalent in a critical care nurses' working environment remains relatively unexplored. Michell (2010: 34) also felt that repetitive exposure to resuscitative measures, end-of-life care needs, prolonging life by pharmacological and mechanical means and the continuous adjustment of these critical care nurses to this hostile environment, results in psychological disorders such as post-traumatic stress disorder. Despite

aggressive technology, the challenge to create an environment where healing can occur, has historically been difficult. ICUs were established for the close monitoring of the sickest patients within the hospital walls. According to Hov, Hedelin and Athlin (2005: 206), in many ways, 'intensive care' represents, in a symbolic and real sense, the modern preoccupation with the mastery of disease, the eradication of 'untimely death' and the prolongation of life. It is the place to which clinicians may refer a patient when that individual stands at the brink of death and is beyond the reach of conventional therapies. ICU admission, has become a routine part of the post-operative management of patients undergoing complex surgical procedures. It has even begun to play a role in the palliative management of patients suffering from AIDS and invasive cancer. The goal of these intensive care units or critical care units has long been viewed as assisting the individual to survive a life-threatening physiological process. Integral to that survival is the critical care nurse who, with the assistance of advanced assessment modalities, multiple pharmacological agents, and sophisticated technology, directs the care of the patient and the family (Carlson, 2009: 7).

As human beings, the control that nurses have over death and dying issues stems from how they have developed ways to cope with the causes of death and dying as well as their ability to control physical body functions, slow down the dying process, or prolong the natural progression of a disease. For many people, death remains a reality. Even the most widely acclaimed medical personnel, who are expertly trained in curing disease and handling disabilities, must still face death. Death is part of the cycle of life and death and dying are phenomena that are unavoidable (Hov, Hedelin and Athlin, 2005: 203). Nurses in intensive care units regularly face critically ill patients. Some patients do not benefit from the treatment they undergo and die after days or months of apparent pain and suffering. Research articles have shown that there is a mounting trend towards withdrawal of treatment in intensive care units.

Physicians are responsible for decisions concerning medical treatment, but as critical care nurses, it is within their scope of practice to carry out physicians' decisions. Sometimes the consequences of end-of-life pain, suffering and dying can be quite detrimental to the nurse.

Acute grief following the death of a loved one or a patient in ICU is often intensely painful but diminishes over time as the loss becomes integrated into ongoing life and the general nursing routine (Liebert, 2011: 207). The study further states that, adjusting to a loved one's death requires that both parties acknowledge the reality of the death. Medical technology has created new ethical dilemmas for medical professionals. Technological advances have allowed critical care medical and nursing interventions to heal impaired body functions. Technology also allows the medical profession to prolong life, in the critical care unit, often at great cost, both financially and emotionally, to both the dying and the living. Even with such advanced medical technology worldwide, studies show, that there is a need for protocols, guidelines, and support services to be instituted to help the critical care nurse as she experiences death and dying in the ICU (Carlson, 2009: 1507).

1.2 PROBLEM STATEMENT

Working in ICU can be traumatic for nursing personnel. Critical care nurses are faced with the repeated exposure to death and dying. Often they are involved in caring for patients who have a terminal illness, are actively dying or those who are faced with the possibility of impending death. Critical care nurses often have a difficult time coping with the stress that comes with caring for those who are dying. Brenner (2000:11) states that having had the opportunity to work in an end-of-life unit added to her knowledge and experiences in critical care nursing. Working with experts in the care of the dying enabled her to increase her knowledge and skills in listening and talking. According to Alspach (2006: 849),

the scope of practice for acute and critical care nursing is defined by the dynamic interaction with the acutely and critically ill patient and therefore providing care for the dying may evoke strong emotions such as anger, frustration or dislike in caregivers. The author further states that death and the dying process can evoke complicated psychological states stemming from critical care nurses' experiences with such situations. Part of the challenges of being a nurse are, dealing with morbid and distressing issues such as patients' deaths and critical illnesses. Even though a nurse can celebrate the positive effects that nursing care has on a patient, there may still be no closure when death, dying and despair are witnessed. Sometimes there is no time for nurses to recognise and proceed through the stages of grief. Therefore, understanding critical care nurses' experiences of death and dying can help the health care delivery system prepare and educate these nurses on issues relating to the needs of the dying or terminally ill patient and also teach them how to effectively deal with such issues (Urden, Stacy and Lough, 2010: 2). Death is like a mystery which evokes feelings of fear, sadness and doom whenever it is spoken or heard of. The way one relates to the concept of death is what makes a difference in coping with it. For many, the failure to accept the ultimate reality and certainty of death may result in mental distress.

1.3 AIM OF THE STUDY

Critical care nurses relate to the phenomena of death and dying in different ways within their nursing profession and their scope of practice. It is a common tendency of critical care nurses to portray a cavalier attitude and to relate the reality of death and dying in an ICU as being 'all in a day's work'.

The aim of this study was to explore the critical care nurse's experiences with death and dying.

1.4 RESEARCH QUESTION

There was only one central research question that was posed to all the participants which guided the study, "What are the critical care nurses' experiences of death and dying in an ICU?" Further probing questions were based on the responses from the central research question. (See Appendix E).

1.5 SIGNIFICANCE OF THE STUDY

Understanding critical care nurses' experiences of death and dying can help the health care delivery system prepare and educate these nurses more fully on issues relating to the needs of the dying or terminally ill patient as well as how to deal effectively with the stress that these situations cause. According to Hay and Oken (1972: 109), the quality of a patient's care and hence the outcome of their treatment greatly depends on the people providing that care. The effectiveness of the care that these nurses are able to give is a function of their psychological state, as much as it is of their technical expertise. This has special meaning for the ICU patient, as his or her very life depends upon the care provided by the ICU nurses. Hay and Oken (1972: 109) further argue that the psychological burdens placed on critical care nurses are extraordinary and very often the situation of these nurses face on a regular basis can be likened to that of a soldier serving with a combat group, because the quality of a patient's care and hence, the outcome, depends greatly upon the people providing that care, and the effectiveness of the latter is a function of their psychological state as well as of their technical expertise.

The above-mentioned research study also emphasised that, a critical care nurse who is not stressed and is coping well in her workplace will thus be more productive because she will be able to function as is expected of a person in her position. This has special meaning for the ICU patient, whose very life depends upon the care provided by the nursing staff. Yet, in this special environment, the psychological burdens imposed upon the nurse are extraordinary. A patient's experience in an intensive care unit has lasting meaning for the patient as well as for his or her family members and any significant others. Even though actual painful memories are blurred by drugs and the mind's need to forget, attitudes that are highly charged with feelings about the nature of the patient's experience do survive. These attitudes not only shape the person's beliefs about nurses, physicians and health care, but also shape the nurses' experiences when caring for the critically ill patient.

The researcher therefore, hopes that the findings of this study will assist ICU nurses in two ways. It will not only show that nurses can advocate for improving the care given to dying ICU patients by becoming proactive and involved agents of change within their own organizations; that is if one does not already exist within their organization, but also the development of a multidisciplinary end-of-life care committee may be the first step toward assuming a proactive position to enhance end-of-life care for patients dying in the ICU and their families. According to Kirchhoff and Beckstrand (2000: 5), the collaboration between ICU caregivers and member of the multidisciplinary team can result in timelier decisions regarding life-sustaining treatments. The researcher also hopes to emphasise that during data collection in this study, the emergence of certain prevalent themes such as; thoughts and feelings of a critical care nurse, communication and experiences of a critical care nurse with death and dying as well as support systems to cope with death and dying in a critical care unit,

actually influences the type of experiences a critical care nurse has with death and dying in an ICU.

Specific measures that nurses use to support patients and their families through the stress of crisis and adaptation to illness, death, or a return to health sometimes go unnoticed. An understanding and appreciation of the intricate relationships among mind, body, spirit, and the healing process enables the critical care nurse to provide emotional support to the patient and family. It is the caring and emotional support given by the nurse that is often remembered and valued. In the contemporary world, nursing care is an essential component of providing end-of-life care. Various factors appear to influence end-of-life decision making and care planning for critically ill patients. Therefore, if a critical care nurse is adequately equipped to deal with terminal illnesses or is able to anticipate a critical event in her patient, this will assist her in promoting quality end-of-life care in an ICU.

1.6 DEFINITION OF TERMS

1.6.1 Critical Care Nurse

A critical care nurse is a knowledgeable, highly skilled professional nurse and one whose nursing excellence goes beyond the bedside skills required, to take care of the sickest and most vulnerable patients and their families (Morton et al., 2005: 115).

1.6.2 Death

Niederriter (2009: 13) defines death as the cessation of respiration (breathing) and circulation (blood flow) of the body.

1.6.3 Dying

Dying relates to a process where the patient's body systems start shutting down. It is also known as multiple organ dysfunction syndrome. The patient may become unconscious and the body is no longer able to function normally (Niederriter 2009: 13).

1.7 CONCLUSION

What the researcher hoped to emphasise, was an understanding that life and death were part of the critical care nursing profession. Even though nurses were fully aware and committed to a nursing philosophy, paradoxical situations such as life-saving interventions and promotion of a peaceful death state are just some of the experiences that critical care nurses are faced with. Recognition of the death and dying processes in an ICU and utilization of the effective and appropriate coping skills could ensure the essential well-being of both nurse and patient alike.

Critical care nurses often felt that they had a hand in making decisions in letting someone die when, in truth, there was no decision to make. Both critical care nurses and the general public needed to accept death as an inevitable life event rather than an undesirable medical outcome and that death was and still is a critical point of illness and should be treated with the dignity it deserves (Kirchhoff and Beckstrand, 2000: 4).

Chapter two gives detailed information from extensive research literature and articles that give insight into the research topic.

CHAPTER 2

LITERATURE REVIEW

“We have to ask ourselves whether medicine is to remain a humanitarian and respected profession or a new but depersonalized science in the service of prolonging life rather than diminishing human suffering”

Elizabeth Kubler-Ross

2.1 INTRODUCTION

This chapter reviews factors relating to critical care nurses' experiences regarding their critically ill and dying patients or patients that have died. A review of the literature was conducted to determine the existing body of knowledge on the research topic and to identify any possible commonalities or differences that exist in the searched literature. This enabled the researcher to provide a framework for the study by placing it in the context of current knowledge about critical care nurses, critical care as a discipline, the phenomena of death and dying and the tensions, and challenges critical care nurses experience as a result of their roles in their daily work life. Although South African researchers focus on the challenges faced by critical care nurses, little research has been done on the experiences of critical care nurses in ICU; hence this study focuses on their experiences with death and dying. Whether it is the challenges faced by their dying patients or the challenges ICU nurses face caring for these dying patients, the necessary attention, skills, and competency in dealing with death and dying are integral to the health and life of each and every human being in this universe. Even though death is inevitable, professionals, such as nurses, encounter death and dying more often than other

people. Dying patients often turn to these nurses for guidance, support and assistance, expecting and trusting that these nurses have been trained and are skilled in handling such matters.

A study done by Kirchhoff and Beckstrand (2005: 396) revealed that most patients, whether by intent or need, rely on medical professionals to be both a source of comfort and information during times of death and dying. The author also debated that, if death and dying is an essential component of the medical and profession, which includes the nursing fraternity, and then training within these professions should include how to deal with end-of-life care and death of patients. According to Berg (2004: 1), factors such as technology and socio-economic factors have greatly impacted on a critical care nurse's experiences with death and dying. The author further argued that this could be viewed in a positive light as it serves as a valuable database that could be utilized in critical care nursing practice, education and research. The capacity to provide more complicated care has brought both rewards and challenges for nurses. The close working relationships between critical care nurses and their patients and patients' families, some being over extended periods of time, bring both rewards and strain to the nurses. Continuously monitoring the ill patient at the bedside, ICU nurses sometimes see the small gains, and sometimes deterioration, that occur during the patient's life journey. The calm voice of a nurse, the gentle touch, the reassurance of someone who cares, become even more significant when difficult and risky decisions are being made: ones that may have life-altering effects on a patient (Carlson, 2009: 1507).

It is often in the critical care environment that ethical decisions such as; death with dignity, withdrawal of life support, organ transplantation issues, and quality

of life issues concerning allocation of resources, are made. Nurses occupy an important role in these decisions, as they usually have the most complete understanding of the patient's and family's wishes based on their sustained contact at the bedside. Human lives include a steady existential questioning and search for meaning in which death is an inevitable and natural phenomenon. The world is rapidly becoming a global community, which creates a need to further understand the universal phenomena of death and professional caring for dying persons. Nursing activities in an ICU create a compassionate, supportive and therapeutic environment for patients and staff, with the main aim being promoting comfort and healing and preventing unnecessary suffering. However, death and dying are inevitable processes in an ICU environment. Patients admitted to an ICU can die from various diagnoses or complications thereof. Death in an ICU can sometimes be unexpected, when patients die suddenly after injury, after a longstanding illness, after the withdrawal of life support or as a result of brain death. The experiences of critical care nurses in such situations can be greatly influenced by the circumstances that surround the patient's death (Alspach, 2006: 9). A study that was conducted by Dracup and Bryan-Brown (2005: 2) on death and dying in an ICU revealed that end-of-life issues in the ICU were among the most serious problems that faced the nursing and medical professions. While much attention was focused on the critical care nurse's role to assist others in the end-of-life or dying process, little attention was paid to the critical care nurse's psychological, cultural, and spiritual well-being when dealing with death and dying or end-of-life issues. Research data in a study done by (Kirchhoff and Beckstrand, 2005: 396) revealed that, despite adequate documentation of the difficulties that critical care nurses are faced with, whilst providing end-of-life care, very limited focus appears to be placed on the obstacles or stumbling blocks that actually give rise to these challenges. The author further suggests that it is these challenges that nurses endure that are associated with negative consequences such as burnout, fatigue, and

emotional distress. End-of-life issues related to ICU nurses' experiences of death and dying include terminal or palliative care, communication skills, advanced directives, caring for grieving family members, cultural issues, nurse ethics, spirituality, psychological issues, nurse training on end-of-life issues and its inclusion in the curriculum, death education, nurse-patient relationships, attitudes and beliefs and research information (Khader, Jarrah and Alasad, 2010: 2). The death and dying of patients in an ICU is a universal phenomenon. This literature search was therefore, firstly expanded globally, to encompass perspectives on critical care nursing and pertinent dying, death or other end-of-life issues that arise from nursing in an ICU environment. The researcher then reviewed similar literature, but from a South African perspective. This study was done in South Africa and reviewing South African viewpoints, enabled the researcher to provide more insight, depth and meaning to the topic.

2.2 HISTORY OF CRITICAL CARE AND ITS EVOLUTION

As health care delivery systems of our world continue to evolve, so too does nursing and critical care. Significant technological advances have occurred, accompanied by a knowledge explosion in critical care nursing. This has been accomplished by integrating sophisticated technology with the psychosocial challenges and ethical conflicts associated with critical illness, while at the same time addressing the needs of the people in the patient's life (Hudak, Morton, Fontaine, and Gallo 2008: 3). In response to the evolution of critical care nursing, the authors further state that critical care nurses are continuously championing the needs of the critically ill patient, the family or significant others. According to Alspach (2006: 34) during the last several decades, critical care nurses have experienced first-hand what nurse researchers have consistently

demonstrated: that, critical illness is not only a physiological alteration, but a psychosocial, developmental, and spiritual process.

Research on the evolution and history of critical care show that in the nineteenth century, Florence Nightingale had realized the advantages of nursing acutely ill post-operative patients away from other ill patients. Critical care then evolved from the realization that the needs of patients with life-threatening illness or injury could be better met if patients were organized in separate or distinct areas of a hospital (Urden, Stacy and Lough 2010: 3). A nationwide nursing shortage occurred immediately after World War II as many nurses left the workforce and returned home. There were fewer nurses and, in order to ensure safe care to postoperative patients, the patients were grouped in recovery rooms according to their health condition. This not only proved efficient, but also improved patient outcomes. The result was that by 1960 nearly all hospitals had recovery rooms (Berg 2004: 1). According to the Society of Critical Care Medicine, mechanical ventilation of patients, who were critically ill, was becoming possible, and the care and monitoring of ventilator-dependent patients was more effective and efficient when those patients were grouped in a single location. This became the standard of care, and by the late 1950s, 25% of community hospitals with more than 300 beds had an ICU (Hudak et al., 2008: 3).

However, the technologies and the combat experiences of the wars of the twentieth century revealed a strong need for specialized medical and nursing care. Critical care nursing was organized as a special field in nursing about forty years ago. Previous to that, critical care nursing was just practiced on an *ad hoc* basis whenever there were critically ill patients (Hudak et al., 2008: 3). Advanced medical technology and interventions paved the way for recognizing the importance of nurses' roles in monitoring and observing the critically ill patient. Here again, it was noted that in a physician's absence, it was the nurse

who initiated emergency medical treatment. With the introduction of advanced medical technology, hospitals began to separate units and make more efficient use of equipment and specially trained staff. Medical and surgical intensive care units segregated the most critically ill patients in locations where they could be cared for by nurses who had specialized knowledge in those areas of care (Urden, Stacy and Lough, 2010:4).

2.3 MODERN CRITICAL CARE

Since the 1950's, medicine has seen continued growth of critical care units. Many hospitals today have several ICUs, with patients grouped by both age and diagnosis. Specialization within the nursing profession has followed suit, and nurses in all settings have developed in-depth knowledge and skills. Nursing care in an ICU today reflects an integration of the knowledge, skills, and experience that are necessary to meet the needs of patients and their families. In a study done by Farrell (1989: 39), which focused on dying and bereavement in an ICU, it was noted that critical care units of today are totally dedicated to saving lives by offering specific and specialized disease and surgical management to many patients. It was also shown in this study that while a high level of clinical competency is required of a critical care nurse for effective patient care, they also have the very important responsibility to offer caring and compassion to the dying and critically ill patient. Alspach (2006: 2) maintained that although each patient is unique, all patients in an ICU have similar needs and the more compromised these patients are, the more complex are their needs.

Today, modern critical care is provided world-wide by health care professionals who have in-depth education in the field of critical care. This multidisciplinary

team of health care professionals comprises anaesthetists, speciality physicians, advanced practice nurses, critical care nurses and other speciality nurse clinicians, pharmacists, respiratory technicians, social workers, dieticians and others Alspach (2006: 3). Critical care is provided in specialized units or departments and emphasis is placed on the continuum of care with effective and efficient transition of care from one setting to another. Critical care patients, being high risk for actual or potential life-threatening health problems, need constant, and more vigilant nursing care (Urden, Stacy and Lough, 2010: 4).

2.4 CRITICAL CARE NURSING IN SOUTH AFRICA TODAY

South Africa is a new and rapidly changing democracy with first class and first world medical and nursing standards. The American Association of Critical Care Nurses (AACN) has established nursing standards that provide a framework for South African critical care nurses. These standards are authoritative statements that guide and prescribe the level of care and performance by which the quality of critical care nursing can be judged (Thelan, Davie and Urden, 1994: 3).

Role responsibilities for the South African critical care nurses have been delineated by the AACN and according to (Urden, Stacy and Lough, 2010: 5) are explained as follows:

- to respect and support the rights of the patient or patients' surrogate in informed decision-making
- to intervene when the best interest of the patient is in question
- to help the patient obtain the necessary care

- to respect the values, beliefs and rights of the patient
- to provide education, support and help to the patient or the patients' surrogate to make decisions
- to represent the patient in accordance with patients' choices
- to support the decisions of the patient or the patients' designated surrogate or to transfer care to an equally qualified critical care nurse
- to intercede for patients who cannot speak for themselves in situations that require immediate attention
- to monitor and safeguard the quality of care that the patient receives
- to act as a liaison between the patient and the patients' family and other health care professionals.

2.5 CULTURAL ISSUES IN CRITICAL CARE NURSING

According to (Urden, Stacy and Lough, 2010:4) the critical care nurse needs to 'know the patient' in order to individualize and humanize nursing care. Beliefs about health and illness are deeply rooted in a person's culture. The response of a patient or family member to the diagnosis or treatment may be strongly influenced by his or her values and culture. Nursing literature acknowledges the importance of providing culturally sensitive patient care, however there is little evidence of cultural awareness in the critical care nurse's daily assessments and interactions with patients and families. According to Lee, Anderson and Hill (2006: 138), sometimes culture plays a vital part in end-of- life decision-making. An individual sometimes cannot make an independent decision because the family as a whole is considered to be the smallest decision-making unit. Transcultural nursing refers to a formal area of study and practice that focuses

on providing care that is compatible with the cultural beliefs, values, and lifestyles of individuals. A cultural assessment includes the patient's usual response to illness as well as his or her cultural norms, beliefs, and world views (Hudak et al., 2008: 17). They highly recommended that critical care nurses must recognize their own individual biases and examine their personal values and beliefs about health and nursing care. Many health beliefs and values are based on commonly held European and American values that have influenced nursing. Some of these beliefs are; beliefs in individualism, informed consent, orientation toward clock time, and belief in God as being the most powerful being. There are other shared beliefs, such as the belief that modern technology and scientific measures will improve a person's overall ill-health. The influence of such values on other cultures may negatively impact on nursing care (Hudak et al., 2008: 18).

2.5.1 Cultural awareness in critical care nursing

For a long time critical care nursing has been a dynamic and evolving entity. Another recent trend that has influenced critical care considerably in these times is the consumer mandate for culturally competent care in an increasingly diverse and multicultural ICU. According to Flowers (2004: 42), cultural awareness involves the self-examination and exploration of a critical care nurse's own professional and cultural background. Flowers further argued that the term cultural competence refers to the ability to work effectively with individuals from backgrounds or in settings where different cultures coexist. In order to become culturally competent, the ICU nurse must become familiar with other cultures so that she is well positioned to deliver effective health care. This is a development process and is also a process of learning and practicing over time. A study done by Singer and Bowman (2002: 7) revealed that culture is one aspect that determines how an individual sees the world and any effort by the health care

provider to improve the quality of life of a dying patient must be sensitive to cultural considerations. It was also noted in the same study that the attitude of a nurse towards end-of life care is relative to particular cultures, societies, and times. When health care providers like critical care nurses and recipients of health care like the ill or dying patient come from different cultural backgrounds, interaction between them takes place under the influence of unspoken assumptions and there is often a communication breakdown.

Cultural awareness should begin with a deep insight into one's own health care values and beliefs. Merely having a basic knowledge of another's culture is not adequate to equip one to cope with the stresses of ICU patient care. In another study done by Lee, Anderson and Hill (2006: 138), their findings revealed that nurses in general use their own backgrounds and cultures to determine what is 'normal' and 'acceptable' even if they are aware that every patient is from a different culture. The authors further stated that critical care nurses should understand their own biases and prejudices and only then will they be able to accept and respect cultural differences amongst their patients and adapt their care to coincide with their patient's culture. Experiences of death and dying and critical illness are influenced by the religion and cultural views of both patient and care giver alike. Most nations in the world are very diverse and cultural sensitivity has become increasingly important in nursing and dealing with issues of death and dying.

There are many religious and cultural beliefs that affect a person in the dying process. Cultural spiritual and religious attitudes affect how illness is perceived and experienced. A study done by (Niederriter 2009: 22) revealed that in certain parts of the world, culture, spirituality and religion are intertwined and religious

beliefs have a strong bearing on the believer's way of life. In cultures such as Indian, Iranian or American, the subject of death is avoided as it appears to create a feeling of hopelessness. Certain sectors of Hispanic Americans prefer to die at home to prevent the soul from getting lost. Throughout the world there is controversy relating to giving patients bad news about a terminal illness. The principle of veracity or 'truth-telling' is avoided for fear of burdening or creating feelings of hopelessness in an ill patient. End-of-life rituals and practices are governed by religion and culture. The same study also noted that in the United States, families are often made up of a variety of cultures and religions, so it becomes important for nurses to understand which practices are being followed in order to provide quality care to the patient and his/her family.

Dietary habits that are part of a person's culture also affect the patient's view, even in the terminal stages of his life. Certain foods are forbidden or have strict requirements about how the food must be prepared, namely kosher foods that are essential for those of the Jewish faith. Even during times of death and grief and when the family is being taken care of, careful consideration should be given to different cultural preferences (Hudak et al.; 2008: 17). Therefore it is important that critical care nurses are culturally informed and competent when working with those that are ill or dying as it affects their care.

Americans' practices and attitudes are very different from other cultures regarding death. Glaser and Strauss (2004: 3) state that Americans generally are unwilling to 'talk openly' about the process of dying and they prefer to avoid telling a dying person that he is dying. Their study also found that there was controversy about giving patients bad news about a terminal illness. In Western cultures, there is the belief that the patient has a right to know their diagnosis in

order to make an informed decision about their care. This 'truth telling' may conflict with other cultures who believe that it is in the best interest of the patient not to 'burden them' and destroy their feelings of hope.

In some cultures like amongst the Muslims, the dying person is kept at home to die and the family does the after care. The body is then prepared for burial. Persons belonging to the Hindu faith believe that life after death is a place free of pain and suffering, a place where there are no hardships. They also believe in a reunification with loved ones (Mani, 2003: 7). A study done by Elliot and McKinley (2008: 15) in North America provided evidence that end-of-life care which is patient-centred and one which maintains active multidisciplinary team and family involvement in death and dying decision-making has better patient outcomes. In the Indian context, quality of life is more important than quantity, an attitude possibly based on their belief in reincarnation. Death is seen as merely a separation of the body and soul (Manghrani and Kapadia 2005: 34). The same study highlighted the problem of the increasing number of terminally ill patients in India and the Indian reluctance to place dying patients in palliative care facilities. It is fervently believed that death marks the beginning of a new life. For example, whenever death occurs at home, the body is washed and wrapped in clean white sheets and coins or jewellery are placed in the deceased's mouth. This is believed to help the soul with its encounter with God and the devil. The body is then buried in a coffin in the ground. In another study on the East-Asian countries' views on death and dying and cultural considerations, it was noted that after death, the Hindu priest pours water into the deceased's mouth. Hindus may prefer only family members touch the body and do the entire post-mortem procedure themselves. Blood transfusions, organ transplants, and autopsies are all allowed and cremation is preferred as reincarnation is a Hindu belief (Mani, 2003: 8). The same study discussed

Chinese beliefs and it was found that the Chinese have an aversion to death. Autopsy and burial are the choice each individual. Euthanasia is allowed and the donation of body parts is encouraged. In India they respect the dying person's need for a clear head when approaching his/ her death. They believe in God's will, and feel that they will be unsure of this will if they are under the influence of any types of medication that alter their minds. Providing a time and place for the family to pray is necessary, this helps them deal with stress and conflict (Mani, 2003: 9).

American Indians believe that the spirit does not leave the body for at least 72 hours. They place the body above the ground in the open and allow the spirit time to leave the deceased, at which time the body is disposed of. Different religions and cultures vary in their practices at the end-of-life times. The Catholic religion believes in performing the last rites and it is very important to assist a dying person who feels a need for last rites and to have a priest anoint them. This ritual is performed close to a patient's death. A request for the Sacrament of Reconciliation allows the dying patient to have a priest grant them forgiveness from God is also practiced in the Catholic faith. In some faiths, prayer, scripture reading or hymns are a comfort to the dying patient (Niederriter, 1998: 26). The same study discussed Catholic patients' need to repent all of their sins through the priest before they can enter into heaven. Many people of the Christian faith believe there will be punishment and suffering for earthly sin after death. Others believe there is no after life; rather, they believe death is the end.

There are also different beliefs about the body itself. Some religions believe the body keeps its physical form while many others believe the spirit and soul leave

the body and go on. Reincarnation is the belief that the spirit and or soul return to earth in another body, or life form (Hudak et al, 2008: 15).

According to Niederriter (2009: 25) frequent problems encountered in an ICU are the use of other remedies by other cultures. Not all cultures or religions for that matter, believe in Western medicine as the only way to cure or comfort someone. Many cultures practice other types of cures or non-pharmacological methods for critically ill patients such as Reiki treatments and herbal concoctions. Traditional medicine and the use of traditional healers have been passed down from generation to generation and are very commonly used in South Africa. When nurses are working with patients, families may want to continue the use of these remedies. Nurses in an ICU will need to be sensitive and understand how these work in relation to other medical treatments which are being used.

The above author also found in that certain cultures believe in religious or spiritual objects that they feel need to remain with the patient. For example Zulu patients may tie a piece of animal skin, which is considered sacred to them, around their wrists. People of the Hindu faiths will wear a symbol of a religious deity as a pendant around their necks so that no harm befalls them. Understanding how these practices, symbols and rituals fit into the beliefs of the family and patient is important for the nurse and will promote a harmonious nurse-patient relationship in the ICU. Many people strengthen their spiritual beliefs when they are dying, even people who have had little or no beliefs, find comfort in spirituality when the end is near. Many religions have rites and rituals that are practiced during the dying process and at the time of death. Prayers, blessings and scriptures are often read. Whatever the culture or religious beliefs

a dying patient may have, it is important that the critical care nurse is tolerant and accommodating of the dying patient's culture (Carlson, 2009: 1514).

2.5.2 Cultural competency in critical care nursing

Culturally competent nursing care is defined as being sensitive to issues related to culture, race, gender, sexual orientation, social class, and economic situation (Hudak et al., 2008: 34). Culturally competent nursing also involves the family structure and gender role as it relates to the patient. For example, in the Indian culture, it is vital that important health care decisions be discussed with the family. According to Lee, Anderson and Hill (2006: 137) cultural competence is an essential skill for the critical care nurse and is an important factor to consider for the deliverance of quality patient care. It also means listening to the patients in the ICU with the objective of learning about the patient's perceptions of health, illness, death and dying. Cultural competence is about providing care to ICU patients, whilst also adhering to the needs of the family and significant others. It should also be noted that a critical care nurse who is considered culturally competent is not expected to have specialist knowledge about the different cultures, but rather is sensitive and aware of his or her patient's needs and demonstrates this in his or her practice (Lee, Anderson and Hill, 2006: 139).

2.5.3 Cultural sensitivity in critical care nursing

Sometimes a nurse will be introduced to multicultural awareness early in his/her training. However, cultural sensitivity will be dictated by the nurse's own cultural biases, and values. Hudak et al. (2008: 34) stated that to be truly sensitive, one has to possess the ability to look at one's own perceptions and recognize the limitations and threats they can pose to oneself. Differences in race, gender and

ethnicity are some of the many multicultural issues a critical care nurse is faced with. Patients' personal preferences and cultural background and values should always be considered when nursing care is rendered.

2.6 MORAL AND ETHICAL OBLIGATIONS IN CRITICAL CARE NURSING

In critical care, the appropriate use of technology and information in patient care can be useful yet very crucial. The ICU is run on complicated technology and is a place where critical decisions about life and health are made. Patients in the ICU are acutely ill and although nurses and other health care providers make moral choices and are faced constantly with ethical dilemmas in everyday practice, choices are sometimes difficult and create feelings of uncertainty, conflict, or distress (Zomorodi and Lyn, 2010: 90). ICU nurses view their role as consisting of multiple goals, with patient care being only one aspect of their daily routine. The same study showed that the nurses' role in the ICU is currently focused on the curative model, and nurses feel ill-prepared to focus on a palliative, patient-centred role. In today's society, however, it was found that death is no longer an everyday thought and is difficult to predict and this has resulted in frustration about the nurses' role at the time of death.

Ethics is an integral part of the foundation of nursing. According to Searle (2000: 100), ethics refers to the study of those standards and values that helps a critical care nurse answer questions about what is right or good. Morals are personal or codes of conduct that define the critical care nurses expected behaviour. Not only are they the standards of behaviour and values to which critical care nurses are committed as members of society and of a practicing profession, but ethics and moral obligations characterize a critical care nursing profession (Hudack et al. 2008:17). A study done by Klein and Alexander (2003: 269) regarding issues that cause moral distress to ICU nurses states that

anything that interferes with a nurse's ability to provide optimal patient care has the potential to create moral distress in an ICU. The writer argues that issues such as difficulty acting according to rules and regulations, lack of support structures, rendering of poor quality care, incompetent colleagues and lack of medical resources such as medical equipment are as some of the moral and ethical conflicts facing an ICU nurse. In another study done by Langley and Schmollgruber (2006: 58), it was noted that at the end-of-life, the patient, the family, doctors and nurses are the primary persons involved in the actual ethical decision-making process and they are the human face of care. Decision-making is frequently a frustrating process which can sometimes be disadvantageous to the patient.

2.7 WORLD VIEWS ON DEATH AND DYING IN CRITICAL CARE UNITS AND ITS IMPACT ON CRITICAL CARE NURSES

In a study done by Wingate and Wiegand (2008: 84), it was reported that most deaths in a hospital, occur in a critical care unit and that American views on death and dying are very much influenced by Western medicine. It was noted in this study that the Western culture of medicine is diverse and constantly evolving. Critical care medicine and nursing tend to view topics like disease, health, death and dying in a broader context. Statistics reflected in this study show that most deaths in the United States occur in the critical care settings of hospitals. However, Western medicine remains based on scientific, rational and objective principles. The American Association of Critical Care Nurses has maintained that critical illnesses should never become an ordinary experience for nurses (Morton et al., 2005:3). These authors argue that knowledge and care go hand in hand: one without the other does not translate into quality care. Therefore, the specialty of critical care requires high levels of preparation and in-depth knowledge to enable the critical care nurse to cope with death and dying. When patients and families hear diagnoses and end results, it can be

devastating if the critical care nurse has limited or no knowledge in how to deal with the patient and his or her significant others. The nurse and patient can feel lost, helpless, and powerless and may handle grief poorly and with fear. Wingate and Wiegand (2008: 91) also stated that even though Advanced Directives are used in America to assist the families of critically ill patients in making decisions regarding the patient's death and dying or in treatment decisions, most patients admitted to critical care do not have Advanced Directives.

According to Niederriter(2009: 20), surveys done by the Canadian Nurses Association (CNA) revealed that the essential value of providing compassionate and appropriate care to all individuals facing a life-threatening illness should always be upheld and that quality end-of-life care for a dying patient can be best provided if there is collaboration amongst the multidisciplinary team. CNA also suggests that nurses are probably one of the most important role-players in an ICU because they assist and provide direction to the dying patient. Nurses were part of a complex process that was a physically, psychologically, emotionally and a spiritually intimate one which allowed the nurse to develop a therapeutic relationship with the dying patient.

Research studies that were conducted in Eastern and Middle Eastern countries reveal a different perspective on dying. For example in India, studies discussing issues relating to coping and dealing with terminally ill patients noted that death and dying was an emotive and sensitive issue that could not be talked about casually by health care workers. There is no cultural acceptance of withdrawing life support or treatment. However, the spiritual tradition of the Indian subcontinent glorifies and welcomes a dignified acceptance of death. It has also

been found in this study that since Hindus believe in reincarnation and transmigration of the soul, they tend to sometimes approach death without fear (Mani, 2003: 7). Another study done in Saudi Arabia surveyed people of the Islamic faith and the way death was perceived by them. According to this study, there were no standardized nursing plans or strategies that helped nurses care for a terminally ill or dying patient. It was however; very important that nurses acknowledged and respected Islamic religious beliefs and rituals to make the dying process smooth. It was also noted in this study that Islam prohibits assisted suicide, mercy killing and euthanasia. The issue of organ donation is still under debate and is surrounded by a lot of religious controversy (Salman and Zouha, 2010: 157).

A Swedish study done by Fridh, Forsberg and Bergbom (2007: 395) reported that there was a significant role that the family played in making death and dying decisions for the patient in an ICU. It was also noted that the critical care nurse's knowledge of the Swedish culture of death and dying and family presence in an ICU at the time of death was seen as effective end-of-life care. In countries such as Belgium, end-of-life decisions are made every day (Vincent, 2006: 1908). What was noteworthy in this study was that Belgium practises euthanasia and very often in their ICUs, life supporting treatment is withdrawn or withheld prior to death in the critically ill patient. The study does make note that controversy still surrounds this legislation as doctors and nurses working in an ICU are faced with many moral and ethical obligations of their practice, as many feel that their role function is to ensure well-being and maintain life rather than to assist in ending it.

The findings of a study that was conducted in Australia reports that critical care nurses can sometimes feel powerless to change events that affect dying patients and intensive care practitioners are often deeply concerned with issues of human dignity, and with death and dying issues in intensive care units (Kirchhoff and Beckstrand, 2005: 397).

Dying and death has a different connotation for people of Africa. Many Africans believe that the spirit of the deceased remains in the world and that the dead person can come back embodied in another person. It is believed by many Africans that death stands between the world of human beings and the world of spirits (Searle, Human and Mogotlane, 2009: 121). In a study done by Eyetsemitan (2002: 4) on the cultural views of death and dying in Nigeria, it was found that the loved one had time to prepare both emotionally and cognitively for death before it occurred. The author suggested that this made coping after a death much easier for significant others to handle. Similar to other African perspectives on death, this study also found that religious beliefs and personality characteristics were important aspects that helped the individual cope with the dying or death of a loved one

2.8 DEATH AND DYING IN SOUTH AFRICAN CRITICAL CARE UNITS AND ITS IMPACT ON CRITICAL CARE NURSES

A South African study that was conducted by Langley and Schmolgruber (2006: 63) highlighted the problems faced in South African ICU's on the issue of the death and dying of ICU patients. This study exposed the problem of attending doctors postponing palliative care for intensive care patients until death is obviously imminent. Integration of palliative care in comprehensive intensive care units was seen as appropriate care for all critically ill patients. The same

study also maintained that the current shortage of trained and experienced staff in all South African hospitals means that units are frequently staffed by agency nurses or inadequately experienced and even unqualified staff. This in itself places a burden on the experienced and specialist practitioners and leads to frustration and burnout.

Statistics in a study done by de Beer, Brysiewicz, and Bhengu, (2011: 6) showed that the actual mortality rate for patients in ICUs in South Africa was 31,5%, with the predicted mortality rate being 30%. It was found that the HIV/AIDS pandemic has also compounded the problem of death and dying in South African ICUs, taking into account that the process of dying can take minutes or it may take weeks. HIV patients often required prolonged stays in ICUs and this increased the strain on the services and further impacted on the limited resources.

The quality of care the patient and the family received in the critical care unit will have a major impact on their lives, not only at the time of the death but also for many years afterwards. Taking into consideration, the circumstances, critical care nurses should ensure that the whole death and dying experience of both patient and family is as compassionate as possible (Fouche, 2006a: 67). In another study done by the same author, it was found that there was a tendency for South African intensivists, namely anaesthetists and other attending doctors caring for patients in ICU's, to prolong life. It was noted, that this resulted in moral distress for all parties concerned and therefore, in order to prevent such stressful situations, intensivists needed to understand that death is a natural process and not a direct reflection of the failure of their skills. It was also suggested in this study, that care and treatment for dying patients should be stopped earlier (Fouche, 2006b: 46).

Multiple traumas resulting from high levels of violence, motor vehicle accidents and suicide in all populations are increasing, impacting on the acuity of patients in ICUs. All these factors increase the likelihood that palliative care will be necessary, and decisions about when and how to withhold or withdraw treatment are becoming increasingly important in South African ICUs (Langley and Schmollgruber, 2006: 59).

2.9 COMMUNICATION ISSUES IN A CRITICAL CARE UNIT RELATING TO DEATH AND DYING

Good communication in an ICU is a matter of insight and self-awareness, not just language skills (Langley and Schmollgruber, 2006: 58). There will always be inherent difficulties with the ICU environment because of its unpredictability and lack of quality time for critical care nurses to care for dying patients and the patients' families. Other problems include communication between doctors, nurses, and patient's families in an ICU. It is said that end-of-life care or care of the dying can be improved if communication measures ensure that all members of the multidisciplinary team are working towards the same goals for the patients and their families (Fouche, 2006a: 68). According to Urden, Stacy and Lough (2010: 3) the critical care nurse needs to 'know the patient' in order to individualize, humanize and communicate nursing care. Life experiences and value systems can influence the way a critical care nurse perceives death and dying. Events such as the death of a family member or friend, religious upbringing, spirituality, near death experiences and personal attitudes can determine nurses' thought processes related to grief, death and dying. Experience with death or caring for the dying is emotionally draining. In a study by Dracup and Bryan-Brown (2005: 456), it was argued that developing communication skills amongst the different staff in an ICU was just as important as developing other clinical skills. It was also noted that communication between the multidisciplinary team and the dying patient can be tiresome and daunting.

Critical care nurses become frustrated and have reported that they are uncertain if their role is to postpone death or extend life. The same study highlighted end-of-life communication has being a specialized type of therapeutic communication that requires specialized education. Having communication skills and family centred communication, are seen as subjective approaches in medical science, and are considered key components of implementing end-of -life care in an ICU (Curtis 2001a: 364).

A study carried out by Elliot and McKinley (2008: 11) suggested that even though patients in critical care units are too ill to participate in decision making, significant others should be involved in patient care and treatment. According to the same study, critical care nurses can assist by providing physical and emotional comfort to both the patient and the relatives. According to Dracup and Bryan-Brown (2005: 457), communication amongst the health care team, the patient and the family is essential to devising an adequate care plan for the patient. Patients' responses must be reviewed and communicated each day. The authors of this article also stated that intensive communication, between healthcare providers and families in an ICU, led to either continued support for patients with the potential to survive or allowed for early withdrawal of life support if it was deemed ineffective. It should be noted that frequent and respectful communication among caregivers about short and long term goals regarding death and dying issues, will not only help patients and families adjust their expectations about what is able to be achieved by ICU care, but will also make difficult decisions and discussions less difficult. Zomorodi and Lyn (2010: 89) stated that although the traditional role of the ICU nurse was high technology curative care, the increased incidence of disease, death and dying amongst populations has made it clear that ICU nurses felt ill-equipped or unable to communicate with regards to handling end-of-life or palliative care. Critical care nurses have reported not being adequately equipped to communicate with the

dying patient or the grieving relative. Nurses often appeared to express a sense of helplessness, frustration, uselessness and guilt when working with patients and families in death and dying situations. Some nurses also appeared to draw from their own life experiences when relating to dying patients or grieving relatives, whilst others became so distressed by the situation that they shied away from any discussion on the topic.

In the critical care unit, death is no longer treated as a natural outcome of life but rather seen as a medical failure. Often the critical care staff is so focused on saving a life that they ignore that the quality of the life saved and the pain and suffering inflicted to save the life are ignored. The findings of the study that was done by Zomorodi and Lyn (2010: 90) revealed that nurses lacked preparedness when dealing with end-of-life care in a critical care environment. Prolonged exposure to the stress and trauma that accompanies patients death and dying, can compromise the critical care nurse's ability to cope, both at home and at work. The study also suggested that emotionally disturbing experiences with death led to ICU nurses presenting with hyperactivity, aggressive outbursts, sleep disturbances and impaired concentration which led to withdrawal, emotional instability and pessimism.

2.10 SPIRITUALITY ISSUES IN A CRITICAL CARE UNIT RELATING TO DEATH AND DYING

Morton et al. (2005: 24) maintain that caring in nursing includes the recognition and support of the spiritual nature of human beings and this recognition not only includes, but goes beyond religious beliefs. These elements also may be viewed as benefits of spirituality. Spirituality, they believe includes one's system of beliefs and values. Sulmasy (2006: 1385) believes that spirituality encompasses factors such as religion, beliefs and values, a sense of connection

with the universe and personal empowerment. Nursing goals related to spirituality include the recognition and promotion of patients' spiritual sources of strength. The author also believes that by supporting patients and allowing them to share their beliefs about the universe without disagreement, ICU nurses help patients recognize and draw on their own sources of spiritual courage.

Spirituality is recognized as a factor that contributes to health in many persons and the concept of spirituality is found in all cultures and societies. In a critical care unit, the core issues for a person who is dying, would probably not be whether he or she would be put on a ventilator, or whether they would receive artificial feeding, but rather how to face death, how to bring their lives to a close and how to help their family go on without them (Urden, Stacy and Lough , 2010:3). Critical care nurses face dilemmas in their everyday lives. Ethical decisions about whether to withdraw or withhold treatment can be the order of the day, but these dilemmas are not the ones that trouble patients that are dying and their families the most. What does concern them is that the end-of-life is a spiritual crisis. According to Hardwig (2000: 28) the word 'spiritual' can sometimes be ambiguous. Not only can it refer to one's meaning and values in life, it can also have religious connotations. Spirituality tends to offer solace and comfort to a patient during times of grief. The author also states that spiritual factors impact on how the dying patient feels about the end-of-life care issues. Sometimes, the importance of spirituality is omitted from end-of-life discussions due to a lack of knowledge about various religions or one's own spiritual beliefs. People facing death battle to find a spiritual sense of being in the hope of having a better after-life. In the same study, it was noted that death and dying issues are rarely spoken of by religious affiliations, religious persons, ministers, pastors or priests, who offer prayers for the dying. The focus is generally on what comes after death and often there are strong social and religious pressures to

suppress doubts or questions regarding death because it could be seen as a sign of weak faith.

Spirituality is broader than religion and whilst not all dying persons may belong to a religion, questions surrounding spirituality do cross a dying person's mind at the end-of-life (Sulmasy, 2006: 1386). This author further argues that the spirituality aspect of caring for the dying in medical settings has been neglected. It seemed that so much emphasis is placed on the physical care of the dying that spirituality is often overlooked and healthcare providers, who are untrained in the subject of spirituality, do not recognize that special efforts are needed to respect the cultural traditions of the dying.

2.11 PSYCHOSOCIAL ISSUES IN A CRITICAL CARE UNIT RELATING TO DEATH AND DYING THAT CONCERNS THE PATIENT, NURSE AND THE GRIEVING FAMILY

People facing death tend to suffer from an inability to find meaning. In this last chapter of their lives, lots of issues affect these critically ill patients, ranging from:

- the inability to be able to deal with family and loved ones;
- a total dependence on others;
- a loss of capabilities;
- the change from being sole breadwinner into a burden on others;
- being unable to perform the daily activities of living;
- being cast out of the world of the living;

- guilt;
- a sense of abandonment; and
- from anger about all of this (Hardwig, 2000: 29).

It was noted in a study done by Klein and Alexander (2003: 262) that health care professionals are not impervious to the emotional impact of the demise of those under their care and even though most nurses are taught Kubler-Ross's grieving process, some of them even go through this process (namely denial anger, bargaining, depression and acceptance) when working with dying patients (Hudak et al. 2008:17). For the critical care nurse, negotiating these steps of grief and coping with the psychosocial demands of the dying patient and their loved ones may be experienced as being more stressful than the complex medical management of patients. One-third of ICU nurses experience burn-out syndrome and this was especially true when the goals of the health care team were at odds with critically ill patients and their families (Niederriter, 2009: 21).

Findings from a study done by Glaser and Strauss (2004: 155) suggested that the relationship between the nurse and family members of the dying patient is an important factor in a nurse's ability to cope. This study revealed that the coping abilities of nurses were positively influenced by those family members who understood and responded to the needs of the dying patient and adhered to ICU policy. The authors further argued that it is within this profound, reciprocal, emotional, and interdependent relationship between nurses and relatives that the nurse caring for the dying patient or one who has died can continue to provide care despite their experiences of overwhelming emotional and physical strain. The ICU can be an unnatural and threatening environment for the

patient, and their families as well as the nurse. As much as each one has their own role to play, they are all dependent on each other. The need to finalize or part with emotionally complex information to the relatives or patient, can be very emotionally taxing on the critical care nurse. Information such as the poor progress, poor clinical outcomes, or poor prognosis of a patient can lead to vital and important decision-making. According to Brysiewicz (2006: 224), family members are often unable to comprehend the loss of their loved one and that unexpected deaths can compound the impact of grief on family members. The same study revealed that family members also needed to be included and involved in the decision making process and care of their loved one. Hudak et al. (2002: 39) stated that there are still gaps between nurses and families of the dying patient. With modern technology and the state of the art care provided by an intensive care unit, critically ill patients can now be kept indefinitely alive. However, emotionally overwhelmed and confused families can create great distress in even the most committed and dedicated health care worker. In this study it was further revealed that the greatest challenge to humane and appropriate care for critically ill patients is related to the psychosocial adjustment of the family. One needs to understand that, being confronted with the possibility of death is an emotional experience and not a technological one and is an experience that will have a life altering implication for the family concerned. The authors also stated that the emotional features of an ICU, namely the symptoms evoked by ICU stays are just as threatening, as the physical elements such as, life support machines and the sound of alarms beeping. These tend to create a sense of vulnerability because of the emotional and physical dependency of the patient in ICU.

2.12 NURSING CURRICULUM AND OTHER SUPPORT STRUCTURES RELATING TO COPING WITH DEATH AND DYING IN A CRITICAL CARE UNIT

Caring for a person facing death is not an easy undertaking, but many, it is a privilege (Fouche, 2006b: 46). It has been found in the same study that no amount of nursing experience can prepare a nurse to face the death of a patient. Accumulated nursing experience can never be enough to enable a critical care nurse to deal with the fears and insecurities related to death and dying experiences of patients in critical care units. In fact in the study done by Fouche (2006c: 92), there are indications that the opposite holds true. There is a certain amount of uneasiness experienced by the critical care nurse, associated with his/her interaction with the dying. According to the same study, this increased with nursing experience. The critical question then is how can critical care nurse educators or the critical care nurse curriculum assist students to face death-related fears before they come to work in intensive care units?

Thanatology or the study of death education has evolved through various caregiver and theological programmes since the 1970s. Studies of death education in the nursing curricula involved evaluating the effects it had on the student. Despite interest in end-of-life educational efforts, there are still barriers that hamper the integration of this kind of education into medical and nursing school curricula. Fins and Nilson (2000: 662). Nursing schools in the United Kingdom spend about a day teaching death education using traditional methods, and nursing education institutions in South Africa include a day's workshop in their post basic curriculum to deal with the psychosocial aspects of death and dying in an ICU (de Beer, Brysiewicz, and Bhengu, 2011: 6). The findings of the study that was conducted by Fins and Nilson (2000: 663) recommended that nurse educators may need to be creative in order to guide curricular changes.

In a study done by Gillespie, Kyriacos, and Mayers (2006:50), it was stated that whilst nurses played a major role in death and dying of their patient they still needed to have more participation in the end-of-life decision making. According to Brosche (2003: 176), attempting to suppress feelings associated with the death of a patient can take a heavy toll on the nurse. Therefore, critical care nurses have a responsibility to ensure that they equip themselves adequately to cope with stress and stressful events like death in their units. Employers also have a responsibility to ensure that their staff knows how to deal with such issues as well as have the necessary competencies, equipment and support to assist them in coping with these stressors.

According to Manghrani and Kapadia (2006:72), health care workers, including critical care nurses could help terminally ill-patients prepare by informing them in a tactful manner about their condition and could thereby make the process of dying more peaceful, easier, happier, painless, and less mysterious. The authors went on to state that a review of the existing curriculum of medical and nursing colleges in India had identified gaps in sensitive patient and care giver handling procedures particularly in issues such as death, grief and bereavement. It was therefore felt that nursing students stood to benefit by increasing their emotional understanding of the patients. Such an approach could be included in planned in-service courses. This would complement nurses' sense of objectivity in consideration of death and dying making them emotionally strong as deaths and impending psychological pain is a part of their daily routine. In a study done by Brysiewicz (2006: 230) that explored experiences of losing loved ones to death in KwaZulu-Natal, it was noted that health professionals are faced with large volumes of patients with life threatening conditions. This impacts negatively on nurses working in such fast-paced and high-tech areas and can lead to burnout. The researcher recommends that people that act in the interest of staff development should

ensure that structures like bereavement counsellors and workshops should be put in place as this would assist staff in managing deaths in their units appropriately.

2.13 CONCLUSION

This chapter presented literature incorporating the various world views on death and dying. It also reviewed factors such as spirituality, communication, psychosocial issues and support structures that are related to the topic under discussion. According to Fouche (2006b: 46), the goal of a critical care nurse who is caring for dying patients is to enable these patients to experience a dignified death and maintain personal comfort and control as their end-of-life approaches. Unfortunately in an ICU, such deaths are not always possible. The author further maintains that deaths in a critical care unit are far from the dramatics that we see in movies or read in novels. If it is understood that death is a natural process and not a direct reflection of failure of their skills or care, a lesser degree of stress will be experienced by all those involved in this trying period. The next chapter will discuss the research methodology used to obtain and analyze the findings of this study.

CHAPTER 3

RESEARCH METHODOLOGY

“The caterpillar dies so the butterfly could be born. And, yet, the caterpillar lives in the butterfly and they are but one. So, when I die, it will be that I have been transformed from the caterpillar of earth to the butterfly of the universe”.

Rita Mae Brown

3.1 INTRODUCTION

The purpose of this study is to explore the experiences of critical care nurses with death and dying in an ICU. Chapter three describes and discusses the phenomena. This chapter also presents the research design, researcher bias and impact, as well as the study population, sample size and method and the selection criteria. An overview of type of approach used for this qualitative study, interview sites, and interview techniques, will be described. Data collection methods and data analysis methods are also included for discussion in this chapter.

3.2 RESEARCH DESIGN

According to Polit and Beck (2008: 17) qualitative research is a type of scientific research and investigation that seeks to understand a given research problem or topic from the perspectives of the local population it involves. Qualitative research is especially effective in obtaining culturally specific information about the values, opinions, behaviours, and social contexts of particular populations. The strength of qualitative research is its ability to provide descriptions of how

people experience a given research issue and it provides information about the 'human' side of an issue. Qualitative methods are also effective in identifying intangible factors such as social norms, socioeconomic status, gender roles, ethnicity, and religion. This type of data can be acquired by in-depth interviews.

In order to explore the experiences of the participants with death and dying, a qualitative study using a descriptive phenomenological approach was used to guide the study. This type of approach is useful when the focus is on describing the subjective experiences of the participants and in examining the beliefs and cultures that impact on the death and dying experiences of the subjects. A phenomenon is a fact or occurrence that appears or is perceived. A phenomenological paradigm is concerned with understanding human behaviour from the participant's own frame of reference (Polit and Hungler, 2004: 246).

Phenomenology was founded by Edmund Husserl in 1962 and emerged as a branch of philosophy but was refined by other philosophers such as Martin Heidegger and Maurice Merleau-Ponty (Polit and Hungler, 2004: 246). These writers discuss further that in philosophical terms, phenomenology means 'to let that which shows itself, be seen'. Therefore, phenomenology is the uncovering and showing of things as they truly are. The four major philosophical concepts of phenomenology that provide a foundation for phenomenology as a research methodology in the context of this study are intentionality, life world, intersubjectivity, and embodied consciousness (Gibson and Hanes. 2003: 183). Intentionality is human consciousness or awareness that is directed outward into the world. This consciousness then allows the individual to see a clearer picture of the concept or object and looks at it as a whole or its entirety. An awareness of the wholeness of life is critical to gaining an understanding of the complexity of issues and topics that are explored by phenomenological researchers

(Aspers, 2004: 12). Phenomenology is situated in the lifeworld and this methodology can assist researchers in gaining an understanding of the complexities of human life and the fullness of our experience in it. The philosophical concept of intentionality is important to phenomenology, as a research methodology because the purpose of phenomenological research is to understand how humans experience and perceive certain objects or phenomena in the world. The life world is the place where humans are in the world or with the world, and therefore, it is the starting point for research in the human sciences (Gibson and Hanes, 2003: 185). Phenomenology seeks to understand how a person constructs meaning of the said phenomena. In other words, how the individual makes sense of the phenomena and what it means to them. An important concept to note in phenomenology is intersubjectivity. Polit and Hungler (2004: 246) believe that our experiences of the world, upon which our thoughts about the world are based, are inter-subjective because we experience the world with and through others. It is also believed that whatever meaning we create has its roots in human activity.

3.3 PHILOSOPHICAL UNDERPINNING OF A PHENOMENOLOGICAL STUDY

Phenomenology, which examines subjective human experience, has evolved as a philosophical context for nursing science inquiry and as a research method. A primary assumption underlying phenomenology is that humans seek meaning from their experiences and from the experiences of others. This meaning is interpreted through language and thus leads to a reality that is socially constructed rather than the reality that exists outside these meanings. The relationship between the researcher and research participant is seen as a 'subject to subject' interaction in which values and facts reside within each individual and cannot be separated (Gibson and Hanes, 2003: 182).

The structure of phenomena is the major finding of any descriptive phenomenological inquiry. This structure is based upon the essential meanings that are present in the descriptions of the participants and is determined both by analysis and also by intuition (Kleiman, 2004: 8).

There are two main types of phenomenological frameworks used in nursing literature: the descriptive type which is also known as the Husserlian type of phenomenology and the interpretive type, which is also known as the Heideggerian type of phenomenology (Polit and Beck, 2004: 521). Each of these approaches adds insight to the meaning of the phenomena under study but differ in their aim. Phenomenological studies begin with a question about the meaning of the participants' experiences of a phenomenon for which the researcher has a serious interest and commitment.

It should also be noted that the researcher is critical care trained and a nurse educator, who is still very much involved through nurse education and training, in caring for the critically ill and dying patient in an ICU. As an educator, and working with registered nurses as ICU students in the clinical setting, the researcher has had discussions with them about their patients and how to approach the topic of death and dying. It was noted how these students were affected by dying patients and their grieving families and how they tried to cope with the different situations that arose.

In a study that debated the use of phenomenology in research Kleiman (2004: 9) also revealed that by using phenomenological research, the researcher seeks to find the essence of the experience of a phenomenon. Therefore, the goal of the

phenomenological researcher in this study is to uncover these essences or underlying themes of the meaning of these shared experiences of death and dying in an ICU. In the context of this study, a descriptive phenomenological approach was used which involved a search for the meaning of the experience of the participants and thus provided a foundation from which to build an understanding of what it is like to be an ICU nurse caring for a dying patient or one who has died. The researcher also contends that using a descriptive approach of phenomenological methodology has the potential to augment and expand what is known about death and dying in an ICU.

The interviewees and the descriptions of their experiences should therefore be instantly recognizable, expanding and enriching the store of knowledge about the life world. It must be noted, however, that researchers can never totally step out of their own implicit pre-understandings and interpretations of the phenomenon. Therefore, pure description and knowledge, free of the researcher's own perspective and involvement in the life world, are impossible (Gibson and Hanes, 2003:186). Polit and Beck (2004: 521) asserted that humans have intentionality and will see something as something when it presents itself. However, the researcher should acknowledge and consciously set aside or bracket their own pre-understandings and focus on description of the experience from the perspective of the participants in their own voices rather than via interpretation (Aspers, 2004:11). In this study, this was done by ensuring that the four steps of a descriptive phenomenological study were maintained as follows:

3.3.1 Bracketing

The researcher brackets out any pre-conceptions and opinions they might have about the phenomena under study. This is done to avoid any researcher bias.

This aspect is sometimes called phenomenological reduction (Polit and Hungler, 2008: 247). In the context of this research, despite having countless experiences with death and dying in an ICU as a critical care nurse, the researcher ensured that each interview was entered into with a clear and open mindset, so that due consideration was given to interviewees' experiences without any prejudices or pre-conceived opinions (Polit and Beck, 2008: 228).

3.3.2 Intuiting

This occurs when researchers remain open to the meanings attributed to the phenomena by those who have experienced it, resulting in a common understanding of the phenomena under study. In this study, the researcher ensured that only responses from participants were taken into consideration. No personal viewpoints of the researcher were put forward to the interviewee (Polit and Beck, 2008: 228).

3.3.3 Analysing

This occurs when the gathered data is coded or categorized to make sense of the essential meanings of the phenomenon, at the same time allowing common themes to emerge. With this thematic approach, the researcher was able to sift out the common ideas or concepts that emerged from the respondents and thereafter develop them into major theme and then sub-themes (Polit and Beck, 2008: 228).

3.3.4 Describing

This is the final phase, where the researcher comes to understand and define the phenomenon. The aims here are to communicate and to offer distinct, critical descriptions in both written and verbal form. The researcher was able to

correlate literature searches with a discussion of the findings after an analysis of findings (Polit and Beck, 2008: 228).

3.4 CRITERIA FOR CONDUCTING PHENOMENOLOGICAL RESEARCH

Qualitative research is an inductive research approach and gives attention to the social context in which the research takes place. It tries to discover, describe and understand the social reality from the perspective of the participants. Thus the data gathering is flexible and may be constantly revised during the data gathering process (Penner and McClemment, 2008: 2). Any researcher undertaking a study of this nature must be open to and truly want to know the answer to the question, not merely to confirm their preconceptions about the phenomenon, but to allow the phenomenon to reveal itself as it is. Gibson and Hanes (2003: 186), argue that five concepts are critical to conducting phenomenological research and, in uncovering the essences of lived experience, namely; openness, encounter, immediacy, uniqueness, and meaning. These concepts are explained as follows:

3.4.1 Openness

Openness refers to the researcher's ability to be receptive, sensitive, and willing to understand how the phenomenon reveals itself. The researcher must be able to ask true phenomenological questions but at the same time withhold their own assumptions of the answers.

3.4.2 Encounter

The goal within the encounter is intersubjectivity or being with the participant throughout the research interview. The encounter is the balance between the researcher's goals of developing new knowledge and an ethical concern for the research participant. As a result of this coming together or 'being with' of the

researcher and interviewee in the research interview, the interviewee feels more comfortable in describing the experience, leading to more concrete and accurate descriptions of the phenomenon under investigation.

3.4.3 Immediacy

This concept was described as being present and engaging with the participant throughout the research relationship, which establishes a level of trust and intimacy. Immediacy reflects the immersion of the researcher in the phenomenon being studied while maintaining enough distance to be aware of one self and of the interview's purposes and process.

3.4.4 Uniqueness

Uniqueness refers to the researcher's acknowledgment and acceptance of the individuality of each participant while simultaneously looking for the essences that are common to all. As a research methodology, phenomenology focuses on finding the essence of the phenomenon rather than the essence of a singular experience. While interviewing, therefore, it is important to take the uniqueness of each interviewee into consideration as well as his or her unique experience of the phenomenon while searching for the underlying themes of meaning that flow through the experience of all of the interviewees.

3.4.5 Meaning

The fifth concept lies within the individual. The researcher must create an atmosphere in which the individual can reflect on a concrete experience and assign meaning to that experience. The researcher then must uncover the essence of the meaning in the experience being studied.

3.5 RATIONALE FOR USING PHENOMENOLOGICAL METHOD FOR ENQUIRY AND ANALYSIS

The flexibility of phenomenological research and the adaptability of its methods of inquiry is one of its greatest strengths. A phenomenological analysis does not aim to explain or discover causes. Instead, its goal is to clarify the meanings of phenomena from lived experiences. Phenomenology, when practiced within a human science perspective, can thus result in valuable knowledge about individuals' experiences (Penner and McClemment, 2008: 2). Phenomenology differs from other approaches due to its emphasis on the participants' experienced meaning rather than just on a description of their observed behaviours or actions. This highlights the subjective aspect of human activity by focusing on the meaning rather than the measurement of the social phenomena. The descriptive phenomenological research method used in this study, therefore, attempted to uncover the underlying essences and meanings of experience to arrive at a deeper understanding. Polit and Hungler (2004: 246) define this concept by simply stating that it is an approach to thinking about what the life experiences of people are like.

3.6 SETTING AND PERMISSION TO CONDUCT INTERVIEWS

The study was only commenced after the study design, and procedures had been approved by Durban University of Technology Faculty Research Committee and only when the KwaZulu-Natal [KZN] Department of Health-eThekweni District Health Research Unit had approved that the study be conducted in their facilities. Permission was granted and approved in principle (See Appendix A and C). The interviews were scheduled so that they were conducted at the time and convenience of the health care service and the participant.

This study was conducted in the intensive care unit of a large 543 bedded provincial hospital in the Chatsworth area in the eThekweni District in the province of KZN (KZN Department of Health, 2011). Chatsworth is a suburb located in the southern eThekweni region with a population of approximately 192 000 thousand citizens. The selected hospital in this study is a health care service provider to areas in and around Chatsworth and serves a very diverse and multicultural population as well as mixed income groups namely, the upper, middle and lower class groups. The ICU is a general ICU and admits patients from various disciplines such as medical, surgical and orthopaedic emergencies. This unit very often accepts patient overflows from 'sister' hospitals' critical care units when there is a shortage of patient beds at those facilities.

3.7 SAMPLING PROCESS

A purposive sampling of all consenting professional nurses employed in the ICU of the participating hospital took part in the study. The hospital has a total population of 15 staff members in the ICU. Of these 15, ten are professional nurses of whom only six are ICU trained. Other categories included four enrolled nurses and one enrolled nursing assistant. There are four shifts or teams that run concurrently at any given time. The two-day duty nursing shifts that work on alternate days to each other have only two ICU trained or qualified professional nurses on each shift or team. The two-night duty nursing teams that also work on opposite shifts are only staffed with one ICU trained or qualified professional nurse on each team. Participants in this study were selected on day duty. However all participants were allocated to a period of working four to five months of compulsory night duty per year in an ICU.

The inclusion criteria that was used for this study was as follows;

- Critical care trained/ ICU trained professional nurses
- Critical care experienced/ ICU experienced professional nurses, who had been working in an ICU for one year and above.
- The participant should be a permanent employee of the participating hospital.

The exclusion criteria that was used for this study was as follows;

- Non critical care trained/ Non-ICU trained professional nurses
- Critical care experienced/ ICU experienced professional nurses, who had been working in an ICU for less than twelve months.
- Participants who were not permanent employees of the participating hospital.

3.8 PILOT STUDY

A pilot study was conducted with two ICU nurses from the same hospital. These two nurses that participated in the pilot study were not included in the main study. The results of the pilot study were that the interviewing skills of the researcher and the data analysis approach were acceptable. No changes were made after the pilot study. The pilot study turned out to be a reassuring experience for the researcher.

3.9 DATA COLLECTION

To gain a full understanding of the lived experiences of ICU nurses with death and dying, a method of qualitative data gathering was employed. Informed consent included an explanation of the handling of all interview materials, confidentiality issues and anonymity procedures for participants, and the option to withdraw at any time. Once informed consent was obtained, all interviews were recorded by audiotape to provide an unobtrusive and accurate record of the participant's comment.

The in-depth interviews were conducted with the use of an interview guide containing a demographic section as well as a central question to focus the discussion. The initial question that was asked was "What are the critical care nurses' experiences of death and dying in an ICU?" Probing questions were then used to elicit more information (See Appendix E). Probing is eliciting more useful information from a respondent in an interview that was volunteered in the first reply with the goal being to ask questions that give the respondent an opportunity to provide rich, detailed information about the phenomenon under study (Polit and Beck 2008:394). The purpose of interviewing was also to understand the essences, meaning, and values, that participants attributed to the phenomena under study. Interviews were scheduled for forty-five minutes, for each participant. If no common themes emerged in the initial set of scheduled interviews, additional interviews would have been conducted until saturation of key themes occurred. However, during the four interviews similar information and common themes emerged. Data saturation was reached after interviewing four nurses as no new information emerged. So, no additional interviews were arranged.

Transcribed recordings of interviews and written notes will be kept safe for a period of five years and thereafter will be destroyed. As noted before, the interview was the method of data collection and for the purposes of this research; one face-to-face interview was conducted with the critical care nurse

3.10 DATA ANALYSIS

Giorgi's four steps for data analysis were used to identify themes regarding experiences of death and dying. The aim of data analysis in this study was to identify commonalities and differences in the individual experiences of all participants. The goal was to keep the richness of the experience that each participant had with the patients that they cared for whilst exploring the descriptive meanings of such experiences, through identification of essential themes (Polit and Beck, 2008: 519).

The first step in using Giorgi's method in this research was to read and re-read the entire set of participants' experiences in order to familiarize oneself and get a sense of the whole picture of the phenomena under discussion. This method helped the researcher to understand the meaning of the experience from the participants' viewpoints and not in terms of the researcher's theory about the topic under study. This first step also served as grounding for the next step.

The second step involved reading each successive transcript thoroughly and breaking each down into distinct meaning units. Meaning units consisted of words, phrases, sentences or passages and were then coded by the researcher to ensure accuracy and completeness. After the whole description of the phenomena that was being studied had been broken down and divided into meaningful units, the researcher then reflected on these units in the context of

the whole experience or phenomena under study. This was done so that the true essence and meaning of the critical care nurses' experiences with death and dying would not be lost during the data analysis process.

The third step using Giorgi's analytical method was to transform participants' words into scientific terms. This was done by re-describing the meaning units into psychological language and this was accomplished by searching for essential or dominating meanings in each unit. The researcher then related each meaning unit to the topic under study. This again was done so that the meaning of the participants' experience was not changed, but at the same time unimportant meanings in the participants' experience or situation were discarded.

The final step was to involve the synthesis of the transformed meaning units into an overall description of death and dying as experienced by the critical care nurse. This the researcher did by consistently describing this phenomena and adding a psycho-analytical to the obtained data. The researcher then attempted a general analysis by focusing on the essential aspects and characteristics of the phenomena under study. By providing descriptions and then analyzing these meaning units, the researcher was able to draw individual and subjective meanings of all participants, relating to their experiences of death and dying.

3.11 TRUSTWORTHINESS

According to Polit and Beck (2008: 195), researchers want their findings to reflect the truth. Research that is inaccurate or holds a biased viewpoint cannot be of any benefit to nursing practice. Due to the nature of this study being a

qualitative one, methods of enhancing trustworthiness were utilized and the following four principles outlined by Guba's strategies of credibility, transferability, dependability and confirmability were applied (Lincoln and Guba, 1985).

3.11.1 Credibility

Credibility was achieved through the accuracy of the description of the parameters of the study (who, where and when). Participants were purposively sampled. The information was probed until data was saturated to ensure credibility of the study. This also ensured that there would be confidence that there was truth in the collected data and truth in the way the data was interpreted by the researcher, so that all research results were reflected in a believable way. Peer-debriefing was done to exclude researcher bias.

3.11.2 Transferability

Transferability refers to the generalization of the data or the extent to which this data can be applied to other settings or sample populations (Polit and Beck, 2008: 202). In this study, this was achieved through thick description of data and purposive sampling. Transferability was also promoted in this study by ensuring that there was an adequate amount of data collected to provide evidence of research findings in this study.

3.11.3 Dependability

Dependability refers to evidence that is consistent and stable (Polit and Beck, 2008: 196). In this study, this was achieved by a description of the method of data gathering, data analysis and interpretation. In order to enhance consistency, the researcher conducted a pre-test with one participant prior to the study. This participant did not participate in the main study.

3.11.4 Confirmability

Polit and Beck (2008: 196) maintain that confirmability is similar to objectivity, in that the study results are derived from participation information related to the context of the study. Researcher biases do not have a place in the study. Within the context of this study, tape recordings as well as field notes increased the confirmability of the research. The tape recordings, transcriptions and field notes were preserved for future auditing.

3.12 ETHICAL CONSIDERATION

Before commencement of the study, ethical clearance was obtained from the Durban University of Technology Faculty Research Committee (See Appendix A). Written consent was obtained from Nursing Service Manager of the participating hospital (See Appendix B) and eThekweni District Health Research Unit (See Appendix C). All the participants made an informed, voluntary decision to participate in the study. The nature of the study, the right to refuse to participate, the risks as well as the benefits was fully described to them (See Appendix D). The researcher personally approached professional nurses who were either trained in ICU nursing or experienced in ICU nursing, in order to get written and informed consent from them.

3.12.1 Beneficence

Polit and Beck (2008: 170) maintain that beneficence basically stresses that the researcher has to minimize any harm to subjects or society as a whole. Instead, the researcher and research findings should benefit the participants or individuals that are part of a study. The aim in this study was to ensure that the findings create awareness for the need for ongoing nurse support and education in the area of coping with the death and dying issues of a patient and the importance of informed policy making on death and dying in a critical care unit.

One of the consequences of participating in a study of this nature was the sensitivity of the concepts discussed under the topic i.e. death and dying. For example, participants were asked questions about their personal views and weaknesses. The very use of probing by the researcher in order to get the participant to elaborate on certain aspects did at times mean that the participant became highly emotional. During the interviews and discussion with participants, a certain amount of distress was evoked concerning issues of death and dying and as a result a lot of mental anguish and deep-seated anger seemed to arise from the pent up emotions that participants appeared to harbour when they related their work experiences of death and dying to their own personal experiences of the same situations. The personal losses of loved ones seemed to trigger emotional outbursts and episodes of crying whilst being interviewed. This resulted in debriefing sessions being held after the interviews by the interviewer.

3.12.2 Respect for Human Dignity

This principle involves the right to self-determination and the right to full disclosure (Polit and Beck, 2008: 171). In this study, this meant that participants could choose to participate or not. They had the right to ask questions, to refuse to give information or to withdraw from the study at any time. None of the participants were asked to perform any acts or make statements which would cause discomfort, compromise them, diminish their self-esteem or cause them to experience embarrassment. There was also no risk of damage to their financial or social standing.

3.12.3 Justice

This principle included the participants' right to fair treatment and their right to privacy (Polit and Beck, 2008: 173). The researcher ensured that the study participants met with all the inclusion criteria or research requirements. All due respect was shown to participants beliefs, values, morals, culture, lifestyle and opinions. A courteous, tactful and careful line of questioning was used by the researcher at all times during data collection. Privacy was maintained throughout the study and participants were assured that the data they provided was going to be kept in strictest confidence. Neither the names of the hospitals or the participants were disclosed. Interview data would be kept for 5 years and thereafter would be destroyed.

3.13 STRENGTHS AND LIMITATIONS

This study focused on a fundamental phenomenon (death and dying) in critical care nursing. The views of the participants concerning the thoughts and feelings of an ICU nurse coping in an ICU in the constant face of grief with an apparent

lack of knowledge or support structures were documented and made known to the sciences and the profession (See Appendix D).

The fact that the researcher was a critical care trained professional nurse with vast amounts of experience with death and dying issues in an ICU would influence the research process, content and findings. It was hoped that the researcher's integrity, honesty and commitment would influence the policy makers of the sciences and the profession to take steps to focus on and alleviate the stumbling blocks that promote ineffective coping skills of an ICU nurse with death and dying of a patient.

3.14 CONCLUSION

Using this research methodology, the researcher was unable to anticipate how the study was going to evolve. Much of the research design appeared to come about during the data collection and analysis process. It was also found that using the phenomenological approach in this study, helped the researcher examine the human experience based on the descriptions provided by the persons involved and what meanings these descriptions held for them for them alone. Polit and Beck (2008: 520) argue that qualitative analysis of data can be both challenging and labour intensive at times. However, if it is guided by the researcher's approach to phenomenological data analysis, common patterns or themes of experiences emerge. Penner and McClemment (2008: 2), state that themes are recurring patterns of meaning and are likely to identify both a matter that concerned the participant and the meaning that this matter of concern conveyed to the participant. Such themes did appear to emerge in this study and provided rich insight into participants' experiences and highlighted similarities and contrasts amongst the viewpoints of the different participants.

This chapter described and discussed the research methodology used in this study .The next chapter will therefore present the results of the study in question and highlight the common themes, as they were identified from participants' responses and summarized by the researcher. Evidence will also be presented to back up the generated themes and will be underpinned by quotes from the transcribed data of the actual interviews.

CHAPTER FOUR

PRESENTATION OF THE RESULTS

“To do what nobody else will do, a way that nobody else can do, in spite of all we go through; is to be a nurse “

Rawsie Williams

4.1 INTRODUCTION

This chapter will present the results of the study. The purpose of the study was to explore the experiences of critical care nurses with death and dying in an ICU. All participants had had many experiences with death and dying, both in the workplace and in their personal lives. Therefore, after analysis of the in depth interviews with the critical care nurses, a thematic framework was used to categorize findings as they emerged and then organize them into themes. The researcher was able to get both objective and subjective responses from the participants that provided both their professional and personal reflections on death and dying. In order to adhere to the principles of phenomenology, the researcher set aside any preconceived expectations or experiences and allowed the participants to tell their stories. This meant that interview discussion was not subjected to researcher bias or influence.

An interview guide (See Appendix E) was used to guide the interview discussion taking into consideration the participants 'demographic information as per Table 1 below.

Research findings

Table 1: Participants' demographic profile

The sample in the study comprised of four participants. The participants' demographic information is illustrated in following table.

| Criterion | Number of years | Frequency | Percentage |
|----------------|-----------------|-----------|------------|
| Age | 20-25 | 0 | 0% |
| | 26-31 | 0 | 0% |
| | 32-37 | 1 | 25% |
| | 38 and above | 3 | 75% |
| ICU Experience | 1-3 | 0 | 0% |
| | 4-7 | 2 | 50% |
| | 8 and above | 2 | 50% |

Of the four participants, only 1(25%) was within the 20-25 years age group and 3(75%) fell into 38 years and above age group. With regards to the duration of the experience in ICU, 2(50%) had 4-7 years' experience and the remaining 2(50%) had above eight years' experience in ICU.

4.2 IDENTIFIED THEMES

THEME 1

4.2.1 Thoughts about caring for a dying patient

It was apparent from the participants' responses that the thoughts on death of an elderly or aged patient often crossed a critical care nurse's mind. For some of the participants, it helped shift the focus from one of deep sorrow and grief to one of reality. The concept of death being inevitable or real seemed to provide some measure of comfort to the nurse caring for the patient. This is supported by the following statements.

"I think that adult patients have seen life" Participant 1

"With the older people, you think somewhat differently and you tend to accept that death is a reality." Participant 2

"With the aged, you actually think that they shouldn't suffer for long and when you look at them, you realize that death and dying is a process of life." Participant 4

When youngsters or children die, it becomes very sad and unmanageable at times for all staff in an ICU. Very often a youngster's death is unpredictable and unexpected namely, if he was involved in a car accident. The fact that it was a young person involved tends to make the whole situation highly emotional and this was strongly evident from the responses below:

“We look at a child dying and think of our own kids and become emotional”. Participant 3

“My experiences of having children dying in my hands, has a huge negative impact on me”. Participant 1

“When I look at young people dying it really makes me sad to see that they have been robbed of such a long life ahead of them.” Participant 4

Another very pertinent theme that emerged relating to thoughts of caring for the dying or dead patient the way his or her death was perceived by the younger inexperienced staff in an ICU. The age of the nurse caring for such a patient seemed to have a bearing on the way the nurse copes with the event. In this study it emerged that it impacted negatively on the patient if the nurse was young. Younger nurses were found to be task orientated, and lacked the empathy, respect and psychosocial aspect of patient care. The following statements were made by the participants who were interviewed, confirm this:

“Young nurses seem to be totally unaffected by the impact of a dying patient on his or her family”. Participant 2

“Some young nurses don’t have a husband or children and therefore cannot relate to the death of a child’. Participant 1

“Some nurses have not had much exposure to death or dying of patients”.
Participant 4

Older nurses were considered to be the most suitable candidates to deal with death and dying issues in the unit. This common response from participants in this study seemed to support the fact that the older nurse was more mature and showed more understanding. There was the perception that the older nurse may have more 'humane attributes and qualities stemming from her life's experiences as well as having sound technical and theoretical skills'.

The following statements made by participants during the interviews verify this:

"But to us that has come from the old school, we can still shed a tear, still can mourn with the relatives and put our arms around them and comfort them". Participant 3

"Most of the nurses now are in their forties and fifties in an ICU, and have a caring mature personality". Participant 1

"Being older and having a more mature level of understanding plays a very important part when your patient dies in ICU". Participant 4

THEME 2

4.2.2 Feelings about caring for a dying patient

The pain of watching a loved one die or caring for a loved one throughout the dying process can evoke feelings of despair, anger and even denial. Apart from playing the important role of being a patient advocate, the findings of this study revealed that the critical care nurse felt ethically responsible to do his or her best. Participants in this study have illustrated this finding as follows:

“You become so attached to your patients and their relatives that you actually feel quite sad when they die.” Participant 2

“I don’t feel that death is easy to accept whether it was a long term patient or a short term patient.” Participant 1

“But, you know, as long as the family members come, you bond with them. You update them and when a person dies, you feel as though it was your own” Participant 3

“You feel that you have to do your best and wonder if it was your loved one, what you would do” Participant 4

“We must be able to form a relationship with family and with the patient and feel what they are going through and think of them as your own”.
Participant 4

Being exposed to death is acknowledged to be stressful, and there is a need to understand the nature of the nurse that is exposed to this event. The participants in this study reported that they had been exposed to the many deaths and critically ill patients in an ICU. As much as there were feelings of sadness and pain, it prepared them to expect the unexpected. These feelings of preparedness allowed the nurse to foresee or predict, using their nursing knowledge, the prognosis of a critically ill patient in their care. This helped them prepare themselves and others for what to expect. Actual excerpts from conversations with participants below are testament to this:

“The mortality rate is quite high and it really is so sad to see people die all the time...but we are so used to it”. Participant 1

“We have a mixture of ICU admissions and lots of patients die despite being resuscitated, like your, gun shots and stabs...which can still be very traumatizing to us nurses even though you know what the outcome is going to be” Participant 2

“There's often a sense of hopelessness in ICU because you know your patient is dying and you can do nothing but accept that it was going to happen”. Participant 3

“You find working in an ICU can be very painful especially if you are faced with deaths continuously or on a daily basis and you just try and cope”
Participant 4

THEME 3

4.2.3 Communication with a dying patient

The findings of this study also revealed that the nurse who provided verbal and non-verbal communication with her patients, allowed her to become more in tune with the needs of the patient and their desires as they neared death. The following statements made by participants confirm this:

“Dying people have the sense of fear so just being around them and holding their hand and saying some soothing words, helps the dying process”. Participant 2

“Well, there are no words that can offer comfort but if you just hold that person, give them a tissue to wipe the tears, stand there with them. It a kind of silent communication”. Participant 1

“Communication with your patient helps you to know your patient needs”
Participant 4

“Critical care nurses are sometimes the only people that communicate love and comfort to the ill patient”. Participant 3

“We have to have good communication skills as nurses to be able to know our patients’ needs”. Participant 3

Another very important theme emerged relating to interpersonal relationships and communication skills between the nurse and the patient in an ICU. This was the ability of the nurse to be culturally sensitive to the dying patient's needs. Responses from participants demonstrated that a critical care nurse needed to be aware of cultural attitudes, behaviours and traits of patients to enhance the caring component in critical care nursing. Actual responses below, from the interviews conducted provide substantiation:

"We very often allow African people to come into ICU soon after the patient's death to pray to 'take' the spirit away". Participant 1

"But lots of patients have pastors and priests from all different religious groups praying for them and very often we join in prayer". Participant 2

"We have to have a respect for the different cultures". Participant 3

"We always advise our relatives to come and do any last rites that they want such as Holy Communion". Participant 4

"If anyone comes to pray for our patients irrespective of whatever religious background, we do not turn them away". Participant 4

THEME 4

4.2.4 Experiences with death and dying and the impact it has on the critical care nurse

All the participants that were interviewed felt that a critical care nurse's personal experiences with death and dying impacted on the way she communicated or related to her patients and their loved ones. This sometimes prepared them to cope better and accept eventual death when it occurred. Participants further stated that the knowledge and skills gained from their personal experiences of caring for a dying family member or any other person that they were associated with was extremely beneficial to their professional nursing experiences. This past experience impacted on the way they communicated verbally and non-verbally with their patients and the family of their patients. It was also evident from this study that whenever critical care nurses encountered death or dying they either empathized with the situation or person. The following excerpts from the actual interview responses confirm this.

"Because it hurts me when a patient dies as I lost both my parents"

Participant 4

"Every time I nurse a patient I always think like, you're nursing your own".

Participant 2

"As much as I'm an ICU nurse, I feel hopeless when a family member dies and I cannot do anything". Participant 1

“My brother committed suicide so when other patients die of suicide attempts I am moved”. Participant 3

THEME 5

4.2.5 Support systems that enable the critical care nurse to cope with the trauma of death and dying

All participants agreed that it was very important to have the whole multidisciplinary team work as one ICU team. The findings of this study also showed that the ICU nurse experiences death in a critical care environment as a series of inter-relationships between patients, nurses, doctors and other members of the multidisciplinary team. This will enable them not only to support the dying patient or the patients’ family, but also to support each other in the face of grief. The statements below support this notion:

“Doctors definitely need to play a bigger role in keeping relatives informed”. Participant 1

“The doctor, for example, the attending physician and the surgeon has to be forthright in preparing the family in accepting whether the prognosis is good or poor”. Participant 2

It was also evident that experiences of the dying process, as well as the demise of a patient are a major source of psychological conflict for nurses in an ICU. It is apparent from the participants’ reports that if the psychological well-being of the nurse is not taken into consideration, patient care can be ultimately affected. Interviewees aired their views as follows:

“We should employ specific people to help colleagues and nursing personnel to deal with stressful issues in an ICU”. Participant 4

“Strategies should be implemented to help ICU nurses with coping mechanisms”. Participant 2

“Professional help, counselling, and interaction with other colleagues that experience traumatic experiences, helps them to cope”. Participant 1

The findings also verify that responses to death and dying of nurses working in an ICU are shaped by their spirituality and religious philosophies in life. Spirituality provided guidance and support during trying times and periods of stress in an ICU. The following statements made by interviewees verify this:

“Sometimes as an ICU sister you tend to believe that God is ultimately in control” Participant 1

“We have to let our patients know that God strengthens us with His grace”. Participant 4

“And sometimes I even whisper a prayer for them while I'm nursing them. I'll say 'Lord, let your will be done’”. Participant 3

“We encourage the family to follow their spirituality” Participant 2

“Spirituality tends to help prepare family members for impending death”.

Participant 1

4.3 CONCLUSION

In this chapter the researcher was able to analyze the information derived from the interviews with the selected participants so that certain themes could be identified. Table 2 below provides a summary of themes and sub-themes. The overall themes that emerged from the interviews were that a critical care nurse will always experience a degree of pain when dealing with dying and death and that abstract issues such as a nurse’s thoughts and feelings relating to the ill patient in her care shaped this experience.

Despite advances in the healthcare sector, the critical care nurse is not being sufficiently equipped with skills to deal with death and dying in their professional practice, especially if the nurse had little or no exposure dealing with death and dying issues. The ages of both the patient and the nurse determined what ICU nurses thought of them. The knowledge and skills deficit of recently qualified ICU nurses dealing with death and dying issues was another feeling shared by all those interviewed. There were also strong viewpoints regarding the active participation of the patient’s attending doctor in the end-of -life care of their patients, as well as in keeping the patient and relatives fully informed of the patient’s progress. Participants felt that the skills that had been acquired by them were learned through their personal and life’s experiences. It was also felt that other resources such as social workers, counsellors and designated grieving areas were needs that were still outstanding in the hospital ICU set-up. Chapter 5 will elaborate further by discussing these findings.

Table 2: Summary of themes and sub-themes

| Main Themes Identified | Sub-themes Identified |
|--|---|
| 4.2.1 Thoughts of a critical care nurse | <ul style="list-style-type: none"> • Age of patient and its role in death acceptance • Age of nurse and its role in determining maturity and understanding. |
| 4.2.2 Feelings of a critical care nurse | <ul style="list-style-type: none"> • Feelings of grief when coping with the dying or dead patient. • Feelings of knowing when to prepare for inevitable death of a patient |
| 4.2.3 Communication of a critical care nurse | <ul style="list-style-type: none"> • Communication with dying patient • Communication with loved ones of dying patient • Communication of cultural awareness • Non-verbal communication |
| 4.2.4 Experiences of a critical care nurse with death and dying | <ul style="list-style-type: none"> • The personal impact of death and dying on the critical care nurse • Exposure of critical care nurse to death and dying and the role it plays in coping. |
| 4.2.5 Support Systems to cope with death and dying in a critical care unit | <ul style="list-style-type: none"> • lack of workplace structures • use of spirituality as support and guidance • lack of nurse education on death and dying issues |

CHAPTER 5

DISCUSSION OF FINDINGS

“Death and dying will remain as being one of life’s greatest challenges. This is probably because of the fact that the most important part of being human is the relationship we build with those around us.”

Author Unknown.

5.1 INTRODUCTION

Whilst death is a very personal event for any patient, it rarely happens in isolation. Death, as a phenomenon, encompasses cultural, ethnic, spiritual, social and physical elements and very often when critically ill patients are dying or die in an ICU environment, the critical care nurse is present. The previous chapter presented the findings of the study. This chapter will discuss these findings in relation to the aim and themes mentioned in Chapter One. The main aim was to explore the critical care nurse’s experiences with death and dying. The identified themes of the study were:

- Thoughts about caring for a dying patient
- Feelings about caring for a dying patient
- Communication with a dying patient
- Experiences with death and dying and the impact it had on the critical care nurse
- Support systems that enable the critical care nurse to cope with the trauma of death and dying

5.2 DISCUSSION OF THEMES

5.2.1 Critical care nurses' thoughts about caring for a dying patient

According to the findings of this study, the above theme relates to the thoughts that enter a critical care nurse's mind whilst caring for the dying patient. Thoughts are considered to be images, memories, beliefs, judgments and reflections that float through a person's mind. These thoughts can either be related to person, concept, object or a situation (Everson, 1998:20). The author also feels that thoughts are more logical and rational and lack emotion. After the analysis of the data, this study indicated that nurses working with ill patients in an ICU had various thoughts about working with dying patients and their families including the fact that it can be frustrating and emotionally draining for all concerned parties. This suggests that the many difficulties that arise when working with such patients, such as communication difficulties and ethical dilemmas only make the critical care nurses more determined to function in the capacity of a patient advocate and assist the patient with all his or her daily activities of living, despite the somewhat painful and stressful job of an ICU sister (Kirchhoff and Beckstrand, 2005: 395).

Sigmund Freud, the psycho- analyst, once said; *"Our own death is indeed quite unimaginable, and whenever we make the attempt to imagine it we really survive as spectators. Nobody believes in his own death, or to put the same thing in a different way, in the unconscious every one of us is convinced of his own immortality"* Stoodley (1959: 179).

It was further evident that, like everyone else, critical care nurses have thoughts about their work, who they are working with and their social contacts etc. There are many thoughts that go through their heads as they nurse difficult and

challenging patients, learn new things, work with different members of the health team and encounter different situations. Similarly, it was noted by Bester, van der Walt and Greef (2006: 13), that working with dying patients and their families can cause these nurses to have a lot of thoughts about issues that they may not have thought about before. One of these is to question their own lives and spiritual values. This study also revealed the conflicting thoughts that arise from caring for the dying related to the different age groups of the patient and the nurse caring for the patient. These findings were consistent with a study done by Glaser and Strauss (2004: 174) who examined the impact of younger patients' death on nurses. These authors found that when younger patients died, every possible thought that entered a critical care nurse's mind focused on helping this patient onto the road to recovery. With older patients, however it was thought that they had experienced their lives. Even though nursing care is aimed at promotion of health, the loss of a patient is easier to cope with when faced with the death of terminally ill older patients. In such cases, nurses can sometimes demonstrate thoughts of relief at their passing seeing it as an end to all their suffering.

The participants in this study thought that the age of a nurse caring for the dying patient played a significant role in the actual end-of-life care of the patient. Khader, Jarrah and Alasad (2010: 1) also made note of this issue in a study that looked at nurses' attitudes towards death and dying and revealed that younger nurses showed a very immature attitude when handling death issues in an ICU. This same study agreed with the participants' views that older nurses were more comfortable, even when talking about end-of-life issues to the patient and family. They described the relationship between the thoughts and the clinical outcomes of critical care nursing and felt that it reflected on the nurse's attitude towards the dying patient. This was also consistent with the study findings of the study that was conducted by Press, Thorn and Kline (2009: 955) which revealed that

any admission to a critical care unit may be seen as a threat to the life and well-being of the patient who is admitted and his or her family. Critical care nurses themselves tend to perceive the ICU as a place where fragile lives are carefully assessed, cared for, and sent off on the road to recovery. Research findings indicated that patients and their families frequently perceived admission to critical care unit or intensive care unit as a sign of impending death and doom.

A critical care nurses' perceptions of self and relations with others as well as his or her spirituality affects how he or she responds to stress, illness or dying in an ICU. This sentiment is shared by Press, Thorn and Kline (2009: 956) in their study which noted that age, years of experience and personal values of a nurse affected the way death and dying was coped with in an ICU. Respondents in this study emphasized that understanding what critical care means to patients may help nurses care for their patients but this can be often difficult if there is a clash of ideals between nurse and patient. Khader, Jarrah and Alasad, (2010:5) also maintain this in their study, stating that the nurse patient relationship then becomes more challenging and frustrating. Challenges may relate to any aspect of critical care nursing and even includes the caring for the patient whilst he is on his death-bed.

5.2.2 Critical care nurses' feelings about caring for a dying patient

This study highlighted the feelings of the participants whilst caring for dying patients. Some of the types of feelings that surfaced were fear, sadness, compassion, humility, nervousness, joy, guilt, frustration and satisfaction. Feelings occur as a set of recognizable sensations in a person's body such as a tension in the shoulder when a person feels angry or heaviness in the chest when a person feels sad (Everson, 1998: 20). The author further argues that "feelings" are formed by the 'emotional' mind and can sometimes be devoid of logic and reason. The way that nurses in an ICU sometimes perceive the death

of their patients can be very confusing to them. The evidence relating to the confusion was found in a study done by Wolf, Dy, Frick and Casper (2007: 44) who examined the feelings of end-of-life caregivers. They stated that despite the challenges and the intensity related to providing assistance to the dying patient, their job allowed them to appreciate life more and made them feel good about themselves. Even though the findings of this study have shown that any experience with death or caring for the dying was emotionally draining, it was in keeping with the literature review that critical care nurses became frustrated and were uncertain whether their role was to postpone death or extend life. Zomorodi and Lyn (2010: 89-96) state that, although the traditional role of the ICU nurse was focused on high-tech curative care, the increased incidence of disease, death and dying amongst populations has made it clear that ICU nurses need to feel just as equipped and motivated to handle end-of-life or palliative care.

Fear was something all critically ill patients faced. Nursing a critically ill patient was just as daunting and fearful to the nurse, especially when death was inevitable. Many respondents in this study agreed that ICU nurses became angry with the whole situation when a patient died as they felt that all their efforts had been in vain or that "life was just unfair". To some nurses, there was still a feeling of guilt that more should have been done to help the patient. Findings from the study done by Khader, Jarrah and Alasad., (2010:15) coincides with the discussion on supportive measures implemented at institutional or unit level that assist and support an employee in coping with feelings of grief and death in the workplace. This study also indicated that critical care nurses felt it was important to be attentive to all ICU patients, irrespective of their reason for admission to an ICU, but were affected by their conflicting feelings regarding the death of a young person as opposed to the death of an elderly person or

terminally ill person. Feelings of grief were another over whelming feeling that affected all respondents, more especially if the patient was a youngster. Literature findings agree that there is probably no emptiness that compares to that of grief from the loss of a child and comforting a grieving parent made the tasks of ICU nursing even more painful (Glaser and Strauss, 2004: 126). In another study done by Shorter and Stayt (2009: 159), it was revealed that sometimes critical care nurses prefer to distance and disassociate themselves from the dying patient in an attempt to cope with the impact of grief and trauma that death brings. These findings were synonymous with the feelings that arose from the participants' views in this research study. Sometimes participants felt that they had to literally 'drag' themselves away from the dying patient so that the emotion that surrounded the pain and sadness did not impact on their ability to nurse the patient objectively.

Feelings of both satisfaction and relief were revealed in the respondents' views as they care for the ill and dying. Even though they had feelings of sadness when a terminally ill patient or an elderly patient died, they also saw it as that the patient 'had gone to a better place' or 'lived a good age'. Klein and Alexander (2003: 261) agree and add that medicine is associated with many kinds of losses, for example disfigurement and amputations. But the most painful and problematic deaths in an ICU and those that evoke lots of emotional and conflicting feelings in a nurse, are the deaths of children and known persons.

This research study has showed that all respondents, regardless of spiritual or cultural denomination are affected by trauma of death and dying and the feelings that surfaced in response to grief were in keeping with the literature. The nurse, as in the case of the patient or loved one, will go through denial, anger,

bargaining, and depression and eventually acceptance. Denial is a refusal to accept one's loss. It is a natural defence mechanism. Anger experienced by the patient or relatives can be directed towards themselves or to those around them. The stage of bargaining is to negotiate with God. Following that are feelings of depression and then acceptance (Hudak et al. 2008:18). The authors further agree with the findings of the respondents because they state that the threat of illness precipitates coping behaviours associated with loss. Dying patients must adapt to the loss of life. So too the critical care nurse. Regardless of the nature of the loss, the dynamics of grief present themselves in some form. The response to loss can be described in the following three phases namely feelings of shock and disbelief, feelings of awareness and eventual resolution. By recognizing the behaviours and understanding of their underlying dynamics, the nurse can plan interventions to support the healing process.

5.2.3 Critical care nurses' communication with dying patients

Despite the challenges of proper communication with dying patients, this study revealed that critical care providers wish to avoid the problems associated with communication breakdowns. These health care providers consider sensitive communication a priority and make time to integrate communication into caring for a critically ill patient. A study done by Brenner (2000: 11) supports this assertion as the findings showed that even though many critical care professionals are skilled at talking about treatment options, they lack training in listening and talking about psychosocial issues such as impending death or dying. The authors are also emphatic in their study about a skilled nurse being an essential component in the successful death and dying process of a patient in ICU.

Inter-professional and ethical dilemmas in ICU nursing have been documented since the time of Florence Nightingale as critical care nurses often harbour ethical dilemmas when it comes to the facilitating of medical and nursing management of the dying patient (Thelan, Davie, Urden and Lough, 1994:6). This dying process of the patient can create a barrier to effective interpersonal skills between nurse and patient. On the other hand, the personal experiences of the nurse provide a learning curve, allowing the nurse to communicate better and become more in tune to the needs of her patient and their desires as they near death. Similarly, it was noted in another study that problems like pain, discomfort and depression caused by the dying process can be adequately addressed with better communication patterns in an ICU (Antonelli, 2004: 786).

For many patients, the thought of dying evokes as much or more fear and apprehension as does the thought of death itself. Consequently, discussing the dying process, as well as thinking about how one's last days, weeks, and months might be spent, can be very beneficial. If this does not occur, the process of dying becomes a forbidden topic. Hudack et al (2006: 23) state that knowledge and understanding among the family clinicians and nurses in an ICU of a patient's life support preferences is poor and this may be compounded by misunderstandings related to the cultural, spiritual and religious needs of the family. It is in this context of fear, apprehension, and denial that dying persons are often viewed as persons whom one might feel sorry for, yet as individuals whose very presence makes caretakers and family members feel uneasy and whose feelings, attitudes, and behaviours are hard to relate to. Generally end-of-life discussions related to goals, processes and discussions about the dying patient are poorly documented (Antonelli, 2004: 786).

It is possible that there may be several reasons for the difficulty that many critical care nurses experience in communicating with dying persons: not wanting to face the reality of one's own death, not having the time to become involved, and not feeling emotionally able to handle the intensity of the situation are just some of them. Brenner (2000: 11) agrees and maintains that this could be possible as deaths in an ICU are sometimes perceived as failures for ICU staff. For some ICU nurses the grief that they experience in anticipation of a patient's death may help to explain their difficulty in interacting with terminally ill individuals. For others, dying may have 'gone on too long' and thus the dying person experiences the pain of being isolated from those whose love he or she needs most. Likewise, critical care nurses' beliefs about whether they could have somehow prevented the death or not, may evoke more guilt in themselves, causing them to avoid interacting with a dying loved one (Urden, Stacy and Lough, 2010: 4).

It is the task of the nurse practitioner, however, to ensure that in nursing practice, both direct and indirect communications are conducive to sound practice (Searle, 2000: 254). The author also maintains that communication is the bond of humanness in the health care system. However, critical care nurses have reported not being adequately equipped to communicate with the dying patient or the grieving relative. The findings of this study were in agreement with literature from Curtis (2001a: 363) which stated that discussing end-of-life care and death with patients and their families was an extremely important part of providing a good quality care in the intensive care unit. Nurses often appear to express a sense of helplessness, frustration, uselessness and guilt when working with patients and families in death and dying situations. In keeping with the findings of this study, it was noted by Kirchhoff and Beckstrand (2005: 395), that some nurses also appear to draw from their own life experiences when

relating to dying patients or grieving relatives, whilst others are so distressed by the situation that they shy away from any discussion on the topic. It was also noted that the biggest obstacles to the death and dying of patients in an ICU are the behaviours of patients' families that seem to hamper the interpersonal communication between nurses, doctors and patients in ICU. Studies conducted by Patrick and Shannon (2001: 26) share the same viewpoints, and add that difficulties between families and caregivers in an ICU arise because families face unexpected poor prognoses situations associated with acute illnesses. This study agrees with the research findings that ICU is very often perceived as a unit whose purpose is saving lives.

Characteristics of dying individuals also may affect the critical nurse's apprehension about communicating with such patients. Pain frequently accompanies terminal illness and its presence often affects simple communication like non-verbal communication. In their study on professional nurses dealing with the death of a terminally ill patient, agree with the present findings of this research and state that patients who are terminally ill, appeared to be calmed by physical contact. Findings of research done by Press, Thorn and Kline (2009: 959) was of the same notion as this study, that terminally ill ICU patients often deny any verification of impending death that is conveyed to them.

Dying patients can become often non-productive, unattractive and not in control of themselves. The benefits of open communication are clear as stated by the respondents of this study. However Alspach (2006: 877) feels that relationships between the ill patient and the ICU nurse that allow for communication about

death, often precede healthy adjustment. The emotional impact of being labelled as 'dying' is directly related to quality and openness of the communication between the dying patient and the care giver.

5.2.4 Experiences with death and dying and the impact it had on the critical care nurse

Whereas an illness may be approached clinically and dealt with scientifically, death is a human event, an emotional activity that may involve moral or ethical decisions. Even if the attending doctor is able to remain detached emotionally, critical care nurses are driven by their own emotions and humane feelings that surround end-of-life and dying issues of their patients. Respondents showed that past experiences with death and dying still had an impact on the way they carried out their duties. Khader, Jarrah and Alasad, (2010:7) agree that there is a relationship between recalling first death experience, death anxiety and death attitude of nurses. This research also reflected that even though ICU nurses are very committed to life and health, the dying patient was thought to be a contradiction to a nurse's commitment. Occasionally people in the medical field react to the dying person as if they represent a failure in their care, or their skills (Curtis 2001b: 26). Although there is really nothing a human being can do to stop the destiny process of another human being, we can help the dying patient and their families in their final hours with our education and compassion. It was also evident that events such as the death of a family member or friend, one's religious upbringing, near death experiences and personal attitudes can determine a patient's thought processes related to grief, death and dying (Press, Thorn and Kline, 2001: 959).

Many study participants have noted the difficulty that physicians experience in communicating with the dying and their families. This was also evidenced in a study done by Kirchhoff and Beckstrand (2005: 395) who found that discomfort in broaching the topic of advance directives, death, and symptom control may stem from a lack of confidence in providing palliative care or a lack of understanding regarding the ethical and legal aspects of end-of-life decision making. Reluctance to discuss end-of-life issues with patients may also be caused by a fear of damaging their hope, based on a perception that the role of the physician is only to heal and preserve life. It is therefore very often the critical care nurse who has the unpleasant task of imparting or communicating news of a terminal event to families. The nurse experiences a sense of loss but does not have a socially recognized right, role, or capacity to grieve. Experiencing the death of patients can be considered an occupational hazard of being a nurse. For these reasons, nurses seldom talk about their grief following the death of a patient and do not get the opportunity to mourn publicly (Kirchhoff and Beckstrand, 2005: 396).

In this study respondents appeared to assume some degree of remorse and guilt for death of their ICU patient. Studies show that this perception is particularly true in a critical care unit. Death is no longer treated as a natural outcome of life but rather is seen as a medical failure (Khader, Jarrah and Alasad, 2010:8). Often critical care staff is so focused on saving a life that they overlook the quality of the life saved and the pain and suffering inflicted on loved ones. The findings of a study that was done by Zomorodi and Lyn (2010: 89-96) revealed that nurses lack preparedness when dealing with end-of-life care in a critical care environment. Prolonged exposure to the stress and trauma that accompanies a patient's death and dying, can compromise the critical care nurse's ability to cope, both at home and at work. This can lead to hyperactivity,

aggressive outbursts, sleep disturbances and impaired concentration. Emotionally disturbing experiences with death can lead to withdrawal, emotional instability and pessimism. According to a study by Brosche (2003: 174), death is a natural progression from life. Most nurses will be exposed to the physical and emotional effects of this experience as they care for a dying patient. The nurse is taught how to provide support for the patient and family as they proceed through the stages of grief. Often, however the nurse may not realize his or her own need to grieve. The nurse also needs to be prepared to deal with his or her own grief. Attempting to suppress the feelings associated with the death of a patient can take a heavy toll. When nurses care for dying patients, they must be prepared to assist the family of the dying patient with the grieving process.

The participants also felt that dying patients and their families' feelings of being overwhelmed or the feeling of vulnerability directly affected their behaviour and communication towards them. What was once open, friendly conversation one day suddenly changed when the families were informed of the patient's terminal status. Morton et al., (2006) agreed with this as it was noted that patients react differently to grief, death or dying. They may feel angry, rejected, or totally ignored because they are affected physiologically and psychologically. Much of this anger and feelings of hopelessness and despair will be directed towards the critical care nurse. It should also be noted that on other days, this same patient may be very open or psychologically dependent on the professional caregiver. Fears, hopes, or secrets may be willingly shared. Remembering that a person's response to death will be shaped by culture and spirituality, it should be noted that such fluctuations are to be expected and are characteristic of the 'ups and downs' of the dying process (Urden, Stacy and Lough, 2006:6).

5.2.4 Support systems that enable the critical care nurse to cope with the trauma of death and dying

The literature search regarding the available support structures for critical care nurses shows that there are many concerns related to nurses working in the nursing field and being faced frequently with death and dying of patients. One very important factor to note was the lack of education about death and dying for nurses (Nelson, 2006: 2547). The respondents in this research study were also of the same viewpoint. Research recommendations derived from studies done by Patrick and Shannon (2001: 29) also conclude that helping loved ones through a period of grief and bereavement can encourage critical care nurses themselves to identify and express their uncertainties and feelings and help them adjust to the fact that the dying patient may never recover. Nelson (2006: 2547) agrees with this finding and adds that these facts need to be clearly explained to the nurse by a trained professional i.e. social worker or grief counselor. It was evident in the same study that privacy and confidentiality and having a grief or trauma counselor employed at the institution, plays an important role in helping the dying person to a peaceful death or helping the family come to terms with a hopeless situation. This view was another one that was voiced by almost all the respondents. It was noted by the interview responses that the present day ICUs, in their daily hustle and bustle, tend to overlook crucial ethical principles such as confidentiality and veracity.

Critical care nurses should work within their scope of practice and that which allows them to perform medical interventions and is not under the direct and immediate supervision of a delegating physician or superior. All critical care nursing activities and interventions must be based on established protocols and policies. These protocols and policies should be devised by nursing governing bodies and sanctioned by the medical and nursing departments. They should be reviewed for compliance in accordance with the laws of the country (Alspach,

2006: 877). The findings of the study that was conducted by Iranmanesh, Axelsson, Häggström and Sävenstedt (2010: 51) revealed that nurse education should incorporate death education. The curriculum must be reviewed frequently so that health care professionals can determine whether it reflects current medical and nursing standards of care. In the event of a malpractice suit, the critical care protocols and procedures can be introduced as evidence to help establish the applicable standard of care. It is important to note that protocols and policies provide direction and guides the critical care nurse in her everyday practice (Hudak et al., 2005: 8).

Iranmanesh, Axelsson, Häggström and Sävenstedt (2010: 51) also suggest that the physical and organizational context must be supportive and should enable nurses to cope with the demands of close relationships that end with the death and dying of a patient. The participants' stated that in the South African critical care curriculum, a maximum of eight to ten hours of theory is focused on psychosocial support of the nurse, patient and significant others all together. Clearly, this amount of time spent on such an important aspect of critical care nursing, is not enough. Practical and theoretical support in this vital area should have a greater focus, especially as critical care students embark on an intense course that is loaded with scientific, medical and surgical management principles on coping with trauma and surgery.

Evidence in a study done by Kirchhoff and Beckstrand (2005: 402) suggest that one of the reasons serious deficiencies continue to exist in end-of-life care in an ICU is due to the fact that not enough emphasis is given to thanatology or death education in nursing or medical schools. Iranmanesh, Sävenstedt and Abbaszadeh (2010: 51) agree with the views of the responses of the interviewees in this study that a lot more attention needs to be paid to the

teaching of end-of -life issues and that death and dying education needs to be incorporated into every nursing curriculum. They also state that in Iran, the overall national curriculum for registered nursing education includes two to four hours of theoretical education about death and how to care for a dead body. They had no special education or training however, in the care for dying persons. Kirchhoff and Beckstrand (2005: 402) agree with the present research findings that nursing can be an emotional experience and it becomes important for critical care nurses to identify ways to cope with their feelings while working with dying patients. There is a need to support ICU nurses in difficult intensive care situations. This can be achieved by mentoring them in the grieving process, just a small step towards coping with the impact of death and dying in ICU.

Participants in this study also mentioned that, the lack of timely debriefing leads to inadequate adaptation of the critical care nurse to the grieving process of his or her patients. This view is shared by Schaffer and Norlander (2009: 3). Death, dying and end-of life issues are not simple or straightforward and they should be approached from different angles, for example, medical, ethical, spiritual, cultural, social, and psychological angles. Although death is inevitable, human beings have forced it to be shadowed, removed from the daily existence, and look at it as something to be feared instead of acknowledged as a natural process.

The general response by all participants regarding ICU admissions was in keeping with review done by Schaffer and Norlander (2009: 3) who criticized the apparent lack of policies on the issue. However, despite advanced technology and intensive nursing care, many patients do not survive their critical illness.

The subsequent grief can be traumatic to a critical care nurse and can have serious emotional and physical repercussions for them. If a critical care nurse is adequately equipped to deal with terminal illnesses or is able to anticipate a critical event in her patient, he or she will assist in promoting quality end-of-life care in an ICU (Carlson, 2009: 1521).

The issue of critical care nurses being unprepared to take an active role in caring for patients who are dying or are terminally ill was another fact that surfaced during the data collection process of this research. This could be because they have a difficult time coping with the stress that comes with caring for those who are dying, but do not have the necessary institutional and management support to cope with such grief and negativity that surrounds death. This view was supported by Khader, Jarrah and Alasad (2010: 7) who found that attitudes can be changed through education and experiences and that caring for the most seriously ill patient requires special knowledge and training for all healthcare professionals even at ward level. Understanding critical care nurses' experiences of death and dying can help the employer or the healthcare service delivery system to prepare these nurses for such events by using available research to implement training and development.

The psychosocial impact of grief and loss is briefly covered in the ICU nursing curriculum. This was a point that was raised up by almost all the respondents, who felt that nurses needed to be made aware of and to respect the grieving process of the patient and family and therefore more emphasis should be focused on such issues in the nursing curriculum.

5.3 CONCLUSION

Death and dying is a phenomenological experience and sometimes experience is the best teacher. Those nurses who were interviewed, reinforced the notion that ICU nursing curriculums still are not providing adequate end-of-life training and local and international studies have shown that comprehensive end-of-life care training is greatly needed. Participants believe that specific skills related to caring for the dying and the dead need to be incorporated in critical care nursing curriculums such as the current Diploma in Medical and Surgical Nursing Science-Critical Care course offered in South Africa. Communication skills are vital in all aspects of critical care nursing practice and are a vital component when dealing with the patient, the family or any other member of the health team. Very often critical care nurses tend to be emotionally affected by their patients' death especially if they have lost loved ones of their own.

Death takes an emotional toll on all persons caring for the dying and therefore, critical care nurses need to have support networks in place, not only to assist in providing care, but also for their own emotional wellbeing. Irrespective of religion, culture or race, spirituality plays a huge role when caring for the dying and provides a resource for coping with death and dying for participants in this study. A nurse's age and level of maturity, as well as past experiences with dying and death plays a key role in providing care at end-of-life.

5.4 RECOMMENDATIONS

As a result of this study, the following recommendations were made with special reference to nursing education, institutional management and practice, policy development and implementation and further research are based on the findings of the study.

5.4.1 Nursing Education

The major issue identified by respondents was the lack of educational preparation in working with dying patients and their families. They felt that not enough time was spent in the critical nursing programme to cover end-of-life situations and protocols. Therefore, nursing as an academic discipline can, and should be concerned with the generation of new research about nursing practice, but this will remain meaningless if not integrated into learning and teaching especially in the clinical practice and setting. End-of-life or death education should be emphasised in undergraduate nursing curriculum and continue to be integrated to post-graduate or post basic nurse training. This should include skills specifically related to end-of-life care or dying in an ICU. Learning areas and outcomes in such curricula should focus on pain assessment and management, ethics, physician-patient-nurse communication, physician-patient-family communication, end-of-life communication, including teaching skills in relaying bad news. Discussing do-not-resuscitate orders, treatment goals, hospice, psychosocial and palliative care were considered equally important.

It was also reported that formal support in the form of clinical supervision is considered an invaluable measure in assisting a critical care nursing student cope with the grief, dying and death experiences in an ICU (Shorter and Stayt 2009: 165). According to the findings of Khader, Jarrah and Alasad (2010: 8), nurses are not well prepared to care for the dying, and this leads to negative attitudes towards caring for the dying. The researcher therefore recommends that a standardized module like end-of-life care be included in the South African Diploma in Medical and Surgical Nursing Critical Care nursing curriculum. Considering that teaching and learning is an active process, nurse educators teaching the ICU course should integrate this knowledge, using interactive and different teaching and assessment techniques in end-of-life care courses or

should ensure that they think about workshops for continuing and ongoing nursing education. Rethinking the criteria, by which critical nursing is evaluated, is vital in promoting effective handling of psychosocial issues of grief, dying and death in an ICU by all working in a critical care environment.

5.4.2 Institutional management and practice

Critical care nurses, no matter how skilled at their jobs, are human beings who have their own fears and issues with death. Nursing as a profession needs to create a support network made up of the multidisciplinary team, which is given institutional time and to which all nurses are encouraged to participate to share their grief and get support to enable them to cope with the death or dying experience in an ICU.

Health care settings that have an ICU should have a separate grieving area that can facilitate the comfort needs of the family or loved ones of the deceased. Professional assistance and advice should be readily available to all ICU staff requiring debriefing from traumatic ICU events. Staff being orientated should also have in-service training by professionals, namely psychologists and counsellors on matters related to death and dying. It is hoped that this will improve the knowledge and skills levels of clinical nursing in an ICU. Studies done by Shorter and Stayt (2009: 164) that explored the grief experiences in an adult intensive care unit, also reported a high success rate in the implemented grief support structures that were put in place in the ICU. It was further reported that this measure assisted in shaping the nature of caring for the dying patient and the critical care nurse's subsequent grief experiences.

5.4.3 Policy development and implementation

All nursing staff allocated to work in an ICU environment should undergo an ICU orientation programme that includes orientation on the death and dying policies and protocols in an ICU. These policies should comply with the ethical and legal guidelines laid down by the laws of the country and should include the following:

- Critical care nurses' role in caring for the dying and the dead patient
- Critical care nurses' role in caring for the grieving family
- Multidisciplinary teams' role in caring for the dying and the dead patient
- Ward or unit debriefing information
- Support structures available to staff members, namely in-hospital counselling
- Do Not Resuscitate Orders (DNR) and their legal implications for the patient, nurse and institution.
- Information on termination of life support, namely brain stem death testing
- Information of organ donation
- Information on patients requiring post-mortems.
- Guidelines on completion of relevant documentation

5.4.4 Further research

Further research is therefore recommended to ascertain whether the present South African Diploma in Medical and Surgical Nursing-Critical Care nursing curriculum adequately addresses the issues of death and dying in an ICU. Research into the expectations of the grieving family and the dying patient from the ICU nurse will serve as useful sources for future research reference. The researcher hopes that the above recommendations will not only serve to bridge the gap between research, practice and education but will endeavour to meet the needs of all stakeholders, staff and students of the medical fraternity and ultimately the nursing profession itself.

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APPENDIX A: University Ethics Clearance Certificate



Faculty of Health Sciences

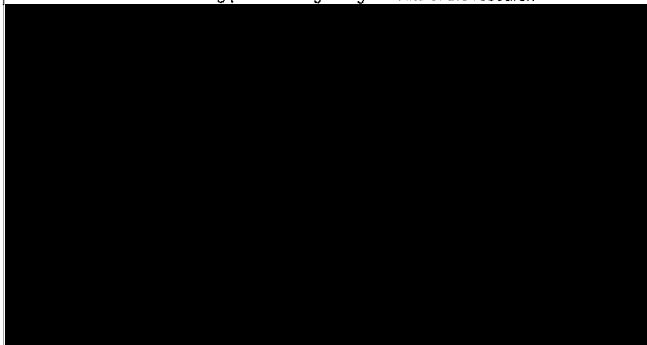
ETHICS CLEARANCE CERTIFICATE

| | | | |
|-------------------------|--|----------------------|----------------|
| Student Name | Vasanthrie Naidoo | Student No | 21032730 |
| Ethics Reference Number | FHSEC 039/10 | Date of FRC Approval | 4 October 2010 |
| Qualification | M Tech: Nursing | | |
| Research Title: | Experiences of critical care nurses with death and dying: A phenomenological study | | |

In terms of the ethical considerations for the conduct of research in the Faculty of Health Sciences, Durban University of Technology, this proposal meets with Institutional requirements and confirms the following ethical obligations:

1. The researcher has read and understood the research ethics policy and procedures as endorsed by the Durban University of Technology, has sufficiently answered all questions pertaining to ethics in the DUT 186 and agrees to comply with them.
2. The researcher will report any serious adverse events pertaining to the research to the Faculty of Health Sciences Research Ethics Committee.
3. The researcher will submit any major additions or changes to the research proposal after approval has been granted to the Faculty of Health Sciences Research Committee for consideration.
4. The researcher, with the supervisor and co-researchers will take full responsibility in ensuring that the protocol is adhered to.
5. *The following section must be completed if the research involves human participants:*

| | YES | NO | N/A |
|--|-----|----|-----|
| ❖ Provision has been made to obtain informed consent of the participants | X | | |
| ❖ Potential psychological and physical risks have been considered and minimised | X | | |
| ❖ Provision has been made to avoid undue intrusion with regard to participants and community | X | | |
| ❖ Rights of participants will be safe-guarded in relation to: | X | | |
| - Measures for the protection of anonymity and the maintenance of Confidentiality. | | | |
| - Access to research information and findings. | X | | |
| - Termination of involvement without compromise | X | | |
| - Misleading promises regarding benefits of the research | | | |



15/10/10
DATE

15/10/10
DATE

15/10/10
DATE

15/10/10
DATE

APPENDIX B: Permission to Nursing Services Manager to access study respondents



The Nursing Service Manager

Hospital

Durban

4000

Dear Madam

Re: **REQUEST FOR PERMISSION TO CONDUCT A STUDY**

I am presently registered as a Masters student at the Durban University of Technology in the Department of Health Sciences, Nursing Programme. The proposed title of my research project is: **Experiences of Critical Care Nurses with death and dying: A Phenomenological Study**

The aim of the study is will be to explore the critical care nurse's experiences with death and dying and to gain an understanding of critical care nurses'

- feelings about caring for a dying patient
- thoughts about caring for a dying patient
- communication with a dying patient
- experiences with death and dying and the impact it has on him/her
- support systems that enable him/her to cope with the trauma of death and dying

Data will be collected by two phases, namely non-participant observation and in depth interviews.

I hereby request your permission to conduct a research project at your institute. My research proposal has been attached for your perusal. Your support and permission to conduct the study at your facility will be appreciated

Yours sincerely

APPENDIX C: Letter of Approval from KwaZulu-Natal Department of Health



Health Research & Knowledge Management sub-component
10 – 103 Natalia Building, 330 Langalibalele Street
Private Bag x9051
Pietermaritzburg
3200
Tel.: 033 – 3953189
Fax.: 033 – 394 3782
Email.: hkrkm@kznhealth.gov.za
www.kznhealth.gov.za

Reference : HRKM189/10
Enquiries : Mrs G Khumalo
Telephone : 033 – 3953189

10 November 2010

Dear Mrs V Naidoo

Subject: Approval of a Research Proposal

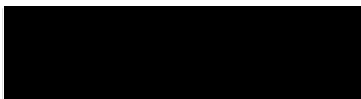
1. The research proposal titled '**Experiences of critical care nurses of death and dying in an intensive care unit: A phenomenological study**' was reviewed by the KwaZulu-Natal Department of Health.

The proposal is hereby **approved** for research to be undertaken at **RK Khan Hospital**.

2. You are requested to take note of the following:
 - a. Make the necessary arrangement with the identified facility before commencing with your research project.
 - b. Provide an interim progress report and final report (electronic and hard copies) when your research is complete.
3. Your final report must be posted to **HEALTH RESEARCH AND KNOWLEDGE MANAGEMENT, 10-102, PRIVATE BAG X9051, PIETERMARITZBURG, 3200** and e-mail an electronic copy to hkrkm@kznhealth.gov.za

For any additional information please contact Mrs G Khumalo on 033-3953189.

Yours Sincerely



Mrs E Snyman
Interim Chairperson, Health Research Committee
KwaZulu-Natal Department of Health
Date: 16/11/2010

uMnyango Wezempilo . Departement van Gesondheid

Fighting Disease, Fighting Poverty, Giving Hope

APPENDIX D: Letter of information and consent to respondents

Title of the Research Study: Experiences of critical care nurses of death and dying in an intensive care unit: A phenomenological study

Principle Investigator: Mrs. Vasanthrie Naidoo

Supervisor: Dr Nokuthula Sibiyi

Telephone Number: 031 3732032

Brief Introduction and Purpose of the Study: You need to be prepared to take an active role in caring for patients who are dying or are terminally ill, but often you may have a difficult time coping with the stress that comes with caring for those who are dying. Understanding your experiences of death and dying can help the employer or the health care service delivery system prepare you for such events by using available research to implement training and development strategies to aid you to cope with death and dying of a patient. Therefore the aim of this study will be to explore your experiences with death and dying.

Research Procedure: An in depth interview will be conducted with you in order to explore your experiences of death and dying. The interview will last for about 45 minutes to one hour. It will be conducted outside your working hours.

Risks or Discomforts to you: None

Benefits: The findings of this study may be used to conduct further studies on the awareness for the need for nurse support and education on coping with the death and dying in critical care units.

Reason/s why you may withdraw from the study: You are free to withdraw at anytime without any penalty.

Remuneration: None

Costs of the Study: None

Confidentiality: All data collected will be strictly private and confidential and will only be used for the purpose of the study. No information will be linked to your identity.

Research-related Injury: The study does not pose any risk of injury to you.

Persons to Contact in the Event of Any Problems or Queries:

Mrs. Vasanthrie Naidoo: 082 519 1550

Dr Nokuthula Sibiyi : 031 373 2606

Statement of Agreement to Participate in the Research Study: (Statement of Agreement to Participate in the Research Study:

I -----subject's full name, have read this document in its entirety and understand its contents. Where I have had any questions or queries, these have been explained to me to my satisfaction. Furthermore, I fully understand that I may withdraw from this study at any stage without any adverse consequences and my future health care will not be compromised. I, therefore, voluntarily agree to participate in this study.

Subject's Name-----Signature-----Date-----

Researcher's Name-----Signature-----Date-----

Witness.....Signature.....Date.....

APPENDIX E: Interview Guide

1. PARTICIPANT DETAILS

Age of participant in years

| | |
|--------------|--|
| 20-25 | |
| 26-31 | |
| 32-37 | |
| 38 and above | |

1.2 Duration of ICU experience in years

| | |
|-------------|--|
| 1-3 | |
| 4-7 | |
| 8 and above | |

2. QUESTIONS TO BE INCLUDED IN THE INTERVIEW

Central question

- “What are the critical care nurses’ experiences of death and dying in an ICU?”

Probing Questions

- “How does your personal experiences with death and dying impact on your daily work life?”
- “What form of support do you get from your institution assists you to cope with grief issues in your unit?”
- Any other question will be asked based on the responses of the participant to the above questions.