VIEWS OF EMERGENCY AND INTENSIVE CARE UNIT NURSES REGARDING FAMILY PRESENCE DURING EMERGENCY PROCEDURES AT THE HOSPITALS IN WALVIS BAY, ERONGO REGION, NAMIBIA

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ABSTRACT

The purpose of the study was to explore and describe the views of emergency and intensive care unit nurses regarding family presence during emergency procedures at the hospitals in Walvis Bay, Erongo Region, Namibia. Moreover, the significance of this study was mainly to understand the challenges faced by nurses when family members were present during emergency procedures and encouraging the creation and implementation of policies regarding family presence during emergency procedures with the aim of caring for the patient holistically using a patient-and family-centred approach.

The main objectives of this study were to explore and describe the views of emergency and intensive care unit nurses regarding family presence during emergency procedures at the studied hospitals in Walvis Bay, Namibia. The study employed a qualitative approach utilizing exploratory, descriptive, and contextual research design to determine the views of emergency and intensive care unit nurses regarding family presence during emergency procedures at the two hospitals in Walvis Bay, Namibia.

The population of this study comprised of thirty-five (35) nurses who provide nursing care in emergency rooms and intensive care units, including high-care units at the Walvis Bay State Hospital and a private hospital specializing in emergency and critical care. The sample size consisted of thirty-one (31) participants. Rich data on the views of nurses working in the ER and ICU regarding family presence was collected using an interview guide until data saturation was reached.

The three (3) fundamental ethical principles guided the researcher namely: principle of respect for persons, principle of beneficence and principle of justice which were adhered to during the study. After gaining consent, the researcher physically interviewed the participants using an interview guide, voice recorder and field notes.

Data were analysed using Tesch's eight steps of data analysis and content analysis. Four (4) themes emerged, and (9) sub themes emerged from nine predetermined questions to each interviewee and formed part of the study's results. The findings of the study reveal that nurses hold varyingly strong views regarding family presence during emergency procedures and that both the family and nurses are affected by this practice, Intensive Care Unit nurses were more receptive to FPDEP and many nurses felt that a formal evidenced based policy would encourage best practices. The study's findings may help identify potential benefits of family presence during emergency procedures and encourage understanding of the challenges faced with the drafting and implementation of policies and procedures regarding family presence during emergency procedures. Thus, it is intended that the study findings may provide information contributing to the body of knowledge.

It is recommended that the study's findings be used to develop policies for family presence during an emergency procedure and incorporate such policy with a patient and family-centred approach to health care, training 'nurse counsellors by a tertiary institution in conjunction with health services that are empowered to facilitate the activities of family member presence. Further studies on the of patient's and family members views regarding being present during emergency procedures would further add to the profession's body of knowledge.

KEY TERMS*: View, emergency unit, intensive care unit, nurse, family, emergency procedures, hospital.*

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LIST OF ABBREVIATIONS

AACN:	American Association of Critical Care Nurse
ACEP:	American College of Emergency Physicians
AHA:	American Heart Association's
AICU:	Adult Intensive Care Unit
ANA:	American Nurses Association
ANC:	Ante-Natal Care
BLS:	Basic Life Support
CCN:	Critical Care Nurse
CICU:	Covid-19 Intensive Care Unit
CPR:	Cardiopulmonary Resuscitation
EC:	Emergency Centre
ECN:	Emergency Care Nurse
ED:	Emergency Department
EN:	Enrolled Nurse
ENA:	Emergency Nurses Association of America
ENPC:	Emergency Nursing Paediatric Course
ER:	Emergency Room
FPDEP:	Family Presence during Emergency Procedure
FPDR:	Family Presence during Resuscitation
FWR:	Family Witness Resuscitation
HPCNA:	Health Professional Council of Namibia

ICU:	Intensive Care Unit
NICU:	Neonatal Intensive Care Unit
OPD:	Out-Patient Department
PALS:	Paediatrics Advanced Life Support
RBC:	Relationship Based Care
RN:	Registered Nurse
TNCC:	Trauma Nursing Core Course
UK:	United Kingdom (Great Britain)
USA:	United States of America

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DECLARATION

DECLARATIONS

I, Benjamin Sebulon Klaas Manetti, hereby declare that this study is my own work and is a true reflection of my research, and that this work, or any part thereof has not been submitted for a degree at any other institution. No part of this thesis/dissertation may be reproduced, stored in any retrieval system, or transmitted in any form, or by means (e.g. electronic, mechanical, photocopying, recording or otherwise) without the prior permission of the author, or The University of Namibia in that behalf. I, Benjamin Sebulon Klaas Manetti, grant The University of Namibia the right to reproduce this thesis in whole or in part, in any manner or format, which The University of Namibia may deem fit.

Benjamin SK Manetti	*BSKManetti*	October 2023
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Name of Student	Signature	Date

DEDICATION

I dedicate this dissertation to my beloved Mother, Sr. Magritha Hilde Manetti, who is a registered nurse on the frontline, and to all the nurses of Namibia, who I believe remain the underdogs of the health profession yet continue to save lives and take the responsibility for caring for the communities they serve. Your service during the COVID-19 Pandemic will never be forgotten. I pray that this thesis demonstrates how invaluable you all are and that you are appreciated.

My dear mother, you have been my biggest inspiration and supporter. I love you very much.

CHAPTER 1

OVERVIEW OF THE STUDY

1.1 INTRODUCTION AND RATIONALE

Worldwide, nurses in emergency and intensive care units are entrusted with critically ill patients and are considered the first line for patient treatment and intervention, including initiation of oxygen therapy, intravenous access or nurse-initiated cardiopulmonary resuscitation (Ervin, Kahn, Cohen, & Weingart, 2019). According to Omoding (2011), the most common diseases that critically ill patients suffer from are acute respiratory failure, acute myocardial infarction, cardiac arrhythmias, heart block, cardiac tamponade, severe shock, unconsciousness, acute renal failure, multiple organ dysfunction syndromes and severe burns, which may result into hypovolemic shock (Anjum, 2018). A loved one, overwhelmed by anxiety, would bring in the patient to the ER. The problems encountered while nursing these patients include life-threatening crises, such as sudden cardiac arrest or complications from chronic illnesses which necessitates emergency procedures which may include cardiopulmonary resuscitation, ventilation, administration of emergency medications, and any other emergent and lifesaving procedures. Omoding (2011) furthermore discusses the process of the emergency intervention that occurs while various stakeholders are present, including the nurses, doctors, health care supporters, porters, as well as the relatives of the patient and, of course, the patient undergoing the emergency procedure.

Typically, the patient's relatives would have been asked to remain in the waiting area outside of the resuscitation room and not given the option to be present during the emergency

procedure. The assumption has been that families are not permitted to be present when the said lifesaving interventions are implemented while awaiting the doctor's arrival. Notwithstanding the above, in some countries, the notion and practice of Family Presence during Resuscitation (FPDR) is not an entirely new concept. A report published by the Resuscitation Council in 2016 found that given the opportunity, the patient's family member(s) would want to opt in being present during the emergency procedure (Resuscitation Council UK, 2016). Similar studies have been conducted amongst families who witnessed the resuscitation of their relative in Europe, Saudi Arabia and the United States of America, which led to various responses (Motsepe, 2016).

A study by Bashayreh, Saifan, Batiha, and Abu Ruz (2015) revealed that both healthcare professionals and family members held positive views of family presence during resuscitation policies, advocating for the continuation of such a policy. Over the past forty (40) years, demands for patient autonomy and attention to consumer preferences have caused the global healthcare community to rethink many traditional practices, including those that exclude families from participating in patient care. Settings such as emergency departments and neonatal, paediatric and adult intensive care units have been the venues for these interactions between the health care workers and relatives of patients. This practice has been researched in several countries, including Kenya, South Africa, Turkey, Saudi Arabia and England (Motsepe, 2016; Ward, 2011; Wirthwein, 2011). However, the lack of established policies concerning the presence of family members during emergency procedures, such as resuscitation, has led to various responses by nurses. Healthcare teams worldwide are considering the risks and benefits of having family present in the room during a life-threatening resuscitation attempt (Ward, 2011).

In a study by Giles (2015) in two of the South African hospitals in different areas of Gauteng Province revealed lack of policies for family presence during resuscitation procedures. The policies in the Gauteng hospital required family members to remain in the waiting area until the procedures were completed, denying relatives access to the procedure or resuscitation room. It is unknown what the views of nurses in these emergency and intensive care units at the state and private hospitals were towards family presence during emergency procedures (Motsepe, 2016).

According to this researcher's observations made at the two hospitals in Walvis Bay, family presence during emergency procedures were either rarely practised or not practised at all. This is in stark contrast to the approach taken by the Swedish hospital, Vrinnevisjukhuset, in the City of Norrkoping, where family presence during emergency procedures is advocated (Waldemar & Thylen, 2018). The researcher was a foreign exchange student and was present during resuscitations at this hospital.

Not allowing the family to be present at the bedside of the patient during healthcare interventions would be against the guidelines set out in the Patient Charter and thus inconsistent with the patient-and family-centred care approach. The Patient Charter states that the patient and family should be involved in a shared decision about the patient's healthcare, and the relatives preferences and values should be considered, (Ministry of Health and Social Services, 2016). The proponents for excluding family members in patient care put forward various arguments and thus question the reasons for the changes. One of the reasons that may be considered is the lack of family presence during emergency procedures guidelines or due to a perception that patient relatives may question the abilities or competence of health care practitioners during emergency procedures.

1.2 BACKGROUND TO THE STUDY

Generally, many health care professionals have continued to resist the practice despite advocacy for family presence during emergency procedures from professional organisations such as the American Association of Critical-Care Nurses, American Heart Association and Emergency Nurses Association to move towards family-centred care. In the African context, there have been similar studies on family presence during resuscitation which revealed FPDEP policies not adopted by professional organisations and their stance were not declared. FPDR was not adopted by medical and nursing associations in South Africa at the time of publication and did not have such policies (Gordon, Kramer, Couper, & Brysiewicz, 2011; Motsepe, 2016; Omoding, 2011). The researcher believes that adopting guidelines for family presence is likely to be greater if healthcare providers are presented with evidence and ethical reasoning that address common healthcare provider concerns about having patients' relatives witnessing emergency procedures. The views and beliefs of nurses working in adult, paediatric and neonatal intensive care units and emergency care units have been reported in numerous quantitative studies. However, qualitative studies investigating these views and beliefs are lacking.

Furthermore, FPDEP allows nurses to gain a new perspective on patient care or validate a proper course of action. The research approach endeavours to explain unique and complicated information that quantitative studies cannot provide. Thus, it may reveal healthcare obstacles and enlighten nurses on how patients perceive the quality of their care (Gishu, Weldetsadik, & Tekleab, 2019). In Namibia, specifically at the Walvis Bay state and private hospitals, the norm is for patients' relatives to stay in the waiting rooms until the emergency procedures are completed. While international studies have been conducted on

family presence during emergency procedure, none have been conducted in Namibia. Currently, the two hospitals do not have policies with regards to family presence during emergency procedures. FPDEP was the prerogative of the Registered nurse in charge/Registered Nurse shift leader. This caused differing views among EU, ICU and NICU nurses. Believing that patient-and family-centred approach may bring a sense of closure or comfort to patients' relatives, the researcher decided to conduct this study. The researcher was thus motivated to examine this aspect of patient care using qualitative research to understand the nurses' views from their standpoint as participants as well as their lived experiences (Hammarberg, Kirkman, & De Lacey, 2016).

1.3 STATEMENT OF THE PROBLEM

According to the state hospital matron's monthly statistics report at the Walvis Bay district hospital, it is estimated that at least a total number of twenty (20) cases of severe medical and traumatic emergencies are being attended per month. About 2-3 cases result in cardiopulmonary resuscitations. The Motor Vehicle Accident Fund of Namibia has reported 424 casualties and 28 fatalities due to motor vehicle and pedestrian accidents in Erongo region of which mostly occurred in Walvis Bay (MVA Fund Road Crash & Claims Report, 2020). During the period of working in the ER, ICU and NICU of a private hospital in Walvis Bay, as a registered nurse, the researcher observed with concern the inconsistencies whereby some nurses were more open and accepting having family members present during emergency procedures while others were entirely against the presence of family members. Walvis Bay hospitals were not allowing family to be present during emergency procedures, for them to provide the necessary support to their sick relatives. Nurses argued that allowing family members to be present during emergency procedures may be used to hold them

accountable. There were numerous complaints from patients' relatives that nurses at the Walvis Bay hospitals are not allowing them to be present during emergency procedures in order to provide the necessary support to their relatives. This may be due to the unpredictability of the general public, patients, their family members, and visitors as a possible sources of violence. Literature reveals that nurses deployed in the Emergency Units and the ICUs have been subjected to instances whereby patients' relatives demand to be present during emergency procedures, sometimes escalating into verbal or physical confrontations with the healthcare team, which may require the intervention of security or police officers (Halm, 2017).

An investigation in Canada by Brophy et al. (2018) found that nurses were hesitant to allow family members to be present during procedures due to difficulties with family members blocking them from executing life-saving procedures. Several healthcare personnel described violence as a "daily" occurrence. Healthcare employees reported regular incidence of violent occurrences. Yet, the potential for violence existed in every aspect of patient care, including acute and chronic care. Aggressive behaviours can be triggered by fear, suffering, trauma, and care for the sufferers. A few studies have been conducted regarding family presence during resuscitation and invasive procedures with most being quantitative in nature (Hammarberg, Kirkman, & De Lacey, 2016). Limited studies regarding family presence during emergency procedures. This is indicative of methodological gaps and thus leading to knowledge gaps. This prompted the researcher to explore and describe the views of emergency and intensive care unit nurses regarding family presence during emergency procedures in Walvis Bay hospitals.

1.4 PURPOSE OF THE STUDY

The purpose of the study is to explore and describe the views of the emergency and intensive care unit nurses regarding family presence during emergency procedures at the hospitals in Walvis Bay, Erongo Region, Namibia.

1.5 RESEARCH QUESTIONS

Research questions:

- What are the views of the emergency and intensive care unit nurses regarding family presence during emergency procedures at the hospitals in Walvis Bay, Namibia?

Sub-Research question:

- How has your performance been affected by family members being present during emergency procedure?
- How comfortable or uncomfortable would you feel with family presence during an emergency procedure?

1.6 OBJECTIVES OF THE STUDY

Main Objective of the Study:

- To explore the views of the emergency and intensive care unit nurses regarding family presence during emergency procedures at the hospitals in Walvis Bay, Namibia

Sub-objectives of the study are to:

- Describe the emergency and intensive care unit nurses' views regarding family presence during emergency procedures at the studied hospitals in Walvis Bay, Namibia.

1.7 SIGNIFICANCE OF THE STUDY

Sharing this study's findings may contribute Understanding the challenges faced with the drafting and implementation of policies and procedures. Identify potential benefits of family presence during emergency procedures. The multi-faceted approach from the study findings may enable the creation or improvement of policies. May provide information contributing to the body of knowledge.

1.8 LIMITATIONS OF THE STUDY

Limitations of this study include factors such as data being collected from one geographical area. The findings of this study thus cannot be generalised outside of the Walvis Bay area as the sample of participants was taken only from Walvis Bay state and private hospitals and, therefore, not representative of nurses in other hospitals in the country or elsewhere.

1.9 PARADIGMATIC PERSPECTIVES OF THE RESEARCH

The paradigmatic perspective investigates natural phenomena, encompasses philosophical assumptions, and guides the researcher's investigative approach (Polit & Beck, 2012). A paradigm is viewed as a set of *fundamental beliefs* (or metaphysics) that deals with first principles and represents a *worldview* that defines for its holder the nature of the world, the individual's place in it, and the range of possible relationships to that world, and its parts have (Creswell & Clark, 2017).

According to Polit and Beck (2012), assumptions are fundamental ideas accepted accurately based on logic or reasoning but are not supported by evidence or verification. Burns and Grove (2017) define an assumption as a claim or assertion that is either true or self-evident. A researcher does not examine the actual value of assumptions or subject them to empirical verification because they are regarded as axioms or proverbs. The assumptions which underlie this study are assumed to be correct. According to Babbie (2012), assumptions serve as underlying beliefs or claims that support whatever research judgments a researcher makes and include meta-theoretical, ontological, epistemological, axiological, and methodological assumptions.

1.9.1 Meta-theoretical assumptions

Meta-theoretical assumptions refer to broad perspectives which make claims concerning the nature of reality. Meta-theories overarch numerous other theories, outstandingly mid-range speculations. Meta-theory addresses fundamental beliefs about the world that guide individuals' actions and can be paradigms or worldviews (Lor, 2019). According to Creswell

(2012), to understand the assumptions, the four fundamental interrelated questions should be asked, as indicated in the table below:

Table 1.1: Major assumptions of a naturalistic paradigm

Assumption	Naturalistic paradigm
Ontological What is the nature of reality in this study?	Realities of the lived experiences and views of nurses working in the Emergency and Intensive Care Units of Hospitals in Walvis Bay who had experienced the presence of patient relatives.
Epistemological What is the relationship between a researcher and the research phenomenon?	The researcher conducted semi-structured interviews. Subjective interaction was thus enabled, and knowledge was maximised in the findings.
Axiological What is the role of values in a research study?	Subjective interaction and values were unavoidable and important in this study.
Methodology How should a researcher obtain knowledge?	Qualitative, explorative, descriptive, and contextual research methods were used to conduct this study. The participants shared their views regarding family presence during emergency procedures.

(Sumpi, 2015)

1.9.2 Ontological assumption

Ontological assumptions deal with the nature of a research participant's world in all its dimensions; thus, ontological assumptions are ingrained in our understanding of human nature (Creswell & Creswell, 2018) “What are the views of nurses in the State and Private Hospitals regarding family presence during emergency procedures?” was the research question that needed to be answered. According to Creswell (2012), the individuals participating in the research setting form reality. The facts in this study are based on the views of nurses who had to deal with the presence of family members during an emergency procedure. Reality is generated because of an individual's perceptions and reactions to

external stimuli. Coady (2016), contend that truth is subjective and that each person's version of reality is distinct and formed individually. As a result, by reflecting on the views of the nurses' own experiences, humans construct an understanding of the phenomena surrounding the working environment. According to Edmonds and Kennedy (2013), reality originates from each individual's impression of their experience, such as nurses allowing patient families to accompany them during emergency treatments.

In terms of ontology, it is explained how the phenomenon is subjectively experienced and analysed by researchers and participants to extrapolate the universal truth about something. As a result, there is no single reality; instead, individuals construct numerous realities based on their perceptions and interpretations of a phenomenon (Edmonds & Kennedy, 2013).

Multiple realities in this study refer to numerous experiences, such as the researcher's, the participants', and the study's interpreters' realities. In supporting evidence, the researcher used verbatim quotes from interviews. The information gathered through observations and interactions during the interviews was organised into themes and summarised to provide precise meanings that reflected the views and lived experiences of nurses who experienced the presence of family members during emergency procedures (Creswell & Creswell, 2018). The responses were based on a diversity of study participants' viewpoints; the reality of this study was complex. This study assumes that data collected through semi-structured interviews with Emergency and Intensive Care Nurses enabled the researcher to gain knowledge regarding their views on family members during emergency procedures.

1.9.3 Epistemological assumption

The link between the knower and the known is epistemology, a technical term in philosophy (Creswell, 2012). Epistemology is the discipline of philosophy that investigates how one knows what is true and how one validates the truth (Repko, 2012).

"What is the relationship between the researcher and the participants?" is the question that needs to be answered to determine the epistemological presupposition of a study. The researcher guided and performed extensive subjective, semi-structured, face-to-face interviews in this study to understand the ideas and sentiments of nurses who had experienced the presence of a patient family during an emergency procedure. As a result, the researcher needed to conduct semi-structured interviews with such nurses to obtain answers. The truth was revealed in the reality that procedurally, relatives were denied access into the emergency procedure because they may distract the nurses and make the patient uncomfortable due to how they respond to the emotions. This fact was helpful to the researcher in learning about nurses' views on implementing policies that encouraged patient relatives during emergency procedures. The researcher's awareness of the value of the context was strengthened by the time spent with the participants during the interviews. The results of this study were the outcome of individual face-to-face interviews between the researcher and the participants. The researcher assumed that the information obtained from the interviews enhanced the findings and, as a result, openly addressed the findings and values with the participants. In addition, the researcher viewed the findings in the light of the researcher's and participants' formed interpretation.

1.9.4 Axiological assumption

“What role do values play in the investigation?” The axiological premise must answer this question. The researcher’s and participants' personal interactions in the context of their different values were unavoidable and necessary in this investigation. Because axiology is the study of "being," it impacts how people perceive themselves concerning others.

According to Polit and Beck (2012), the investigation should focus on the "subjective and non-quantifiable", implying that the context dictates the scope of the study. Individual elements of events are documented in the context of personal experiences, such as nurses’ views on their experiences of allowing patient families to accompany them during emergency procedures. The researcher acknowledges that qualitative research is highly valued and is subject to bias. The context in this study was determined by the values of the various recognised groups, such as the researcher and nurses who had patient relatives present during emergency procedures.

1.9.5 Methodological assumption

The best approaches and means of collecting evidence are referred to as methodology. It is the researcher's responsibility to explain the measures followed to justify the applicability of the information collected from the participants and to clarify the methodological assumptions regarding the accuracy of the data obtained from the participants (Creswell, 2012). The research was conducted using a qualitative, naturalistic methodology in this study. The naturalistic methodological assumption emphasises presenting all of the participants' narrated material and contextualising the entire experience (Polit & Beck, 2012). An inductive technique was used in this study to interpret described information from

nurses who witnessed patients' family members present during an emergency procedure. The findings were reviewed qualitatively, and conclusions were drawn based on the results, which indicated the necessity to develop and implement regulations for patient relatives during an emergency procedure. This study's findings and the strategies implemented could be duplicated in any appropriate setting.

1.9.6 Rhetorical assumption

Rhetorical presupposition in this study is significant since it means that the researcher's reporting was objectively based on what he had witnessed. A rhetorical assumption is unconcerned with truth-seeking but rather reporting through the reality of others. Instead, the research report's argumentative style took a more humanistic approach, attempting to thoroughly explain and communicate the research findings (Firestone, 2013).

1.10 THEORETICAL FRAMEWORK: RELATIONSHIP BASED CARE

The theoretical framework adopted to guide this research study is Relationship Based Care (RBC): A Model for Transforming Practice by Koloroutis et al. (2004). Relationship-Based Care (RBC) was created with the primary goal of transforming nursing practice. The RBC model is based on three fundamentals: nurses' relationships with patients and their families, nurses' relationships with themselves, and nurses' relationships with colleagues (Jennings, 2014).

1.10.1 The nurses’ relationship with patients and family members

The primary goal of the nurse-patient and family member connection is to maintain a continual emphasis on the patient and their family. The nurse recognizes that each patient's

or family's life story will reveal how they handle the patients in the intensive care unit and emergency room. While actively engaging the patient and family in all aspects of treatment, the healthcare provider shows respect and knowledge of what is most important to them. How the nurses view the patient who is being cared for and the role of the family in the patients care. The RBC model was appropriate for this project because it considers the patient and the patient's family's presence during emergency procedures in the intensive care unit. Nurses are now aware that a patient is viewed not as a single entity but as a collection of individuals.

1.10.2 The nurses' relationship with self

The nurse's relationship with oneself is the second critical component—self-awareness and self-care help to establish this bond. Building good connections and honing one's ability to empathise involves self-awareness. How the nurses effectively managed their own stress and express personal values while executing their job. The RBC model application in this study is to explore and describe the views of emergency and intensive care unit nurses regarding family presence during emergency procedures, its impact on values, and the potential for stress. The ability of the healthcare team's employees to work together to offer compassionate care, respect one another, and preserve interpersonal relationships is the third critical relationship. Clinical safety, quality, and family/staff satisfaction can be improved through relationship-based treatment (Jennings, 2014).

1.10.3 The nurses' relationship with colleagues

The third essential relationship examined professionalism and whether the healthcare staff could work together fluidly while family members are present. RBC's primary goal is to

provide consistent, competent care to patients and families while comprehending the nurses' self and interactions with team members. Explore how the nurse's function within the healthcare team while during family presence.

1.11 DEFINITION OF TERMS

The concepts to be defined in this study are obtained from the title of this dissertation: "Views of Emergency and Intensive care unit nurses regarding family presence during emergency procedures at the hospitals in Walvis Bay, Erongo Region, Namibia." The concepts are defined as follows:

1.11.1 View

A view is an angle of considering things, showing us the opinions or feelings of the individuals involved in a situation (Literary Devices, 2021). In this study, the view refers to the way nurses interpret aspects of family presence during emergency procedures in hospitals.

1.11.2 Emergency Unit

A specialised department within a hospital where people with severe injuries or sudden illness are taken for emergency treatment (Omoding, 2011). In this study, the Emergency Unit referred to the unit/ward in a hospital where the study participants are working.

1.11.3 Intensive Care Unit

A specialised department within a hospital that provides life support or organ support systems in critically ill patients (Omoding, 2011). In this study, the Intensive Care Unit referred to the unit or ward in a hospital where the study participants are working.

1.11.4 Nurse

A healthcare practitioner with a qualification in nursing, a certificate in Enrolled Nursing leading to enrolment as an Enrolled Nurse or a Diploma/Degree in nursing leading to registration as a Registered Nurse with the Nursing Council of Namibia (Government of Namibia, 2004). In this study, the participants comprised registered nurses and enrolled nurses.

1.11.5 Family

Family is the primary functional unit in society. Additionally, family has been described as an emotional unit (Sloane et al., 2011). In this study, the family referred to the relatives of patients admitted to the emergency or intensive care units undergoing emergency procedures.

1.11.6 Emergency procedures

An emergency procedure refers to a technique of essential healthcare support with the primary intention of providing immediate care in a reasonable amount of time in order to arrest or prevent worsening of the condition (Omoding, 2011). In this study, emergency procedures related to patients who underwent some emergency procedure where family member/s was present.

1.11.8 Hospital

A hospital is an institution built, staffed, and equipped to diagnose disease for the medical and surgical treatment of the sick and the injured and their housing during this process (Omoding, 2011). This study was conducted at Walvis Bay hospitals, Namibia.

1.12 OUTLINE OF THE STUDY

Chapter 1: This chapter consists of the introduction and background of the study, thereby setting the scene for the research. The motivation for the researcher to conduct the study and the study's objectives are presented in this chapter.

Chapter 2: This chapter describes the literature reviews related to previous research relevant to the current study.

Chapter 3: The research design and methodology used during the study are described, as well as the ethical considerations, data collection methods, and processes followed. This chapter also includes the measures employed to ensure the study's trustworthiness.

Chapter 4: The themes and sub-themes that emerged are outlined in this chapter, together with supporting literature. Direct and verbatim quotes from interviews and field notes are incorporated and discussed.

Chapter 5: This chapter outlines and discusses the study's findings and provides the conclusion. Similar findings obtained by other researchers are referred to in this chapter. In addition, the chapter describes the study's limitations and makes recommendations based on its findings. The conclusion discusses to what extent the study's objectives were achieved.

1.13 SUMMARY

This chapter presents an outline of the whole study, including the introduction of the study, its background and the problem statement. The purpose of the study, its objectives, the

paradigmatic perspective on which it is based, methodology, findings, recommendations and conclusion are also included in this study. The next chapter covers the literature review.

CHAPTER 2

LITERATURE REVIEW

2.1 INTRODUCTION

In this chapter, the researcher explored studies carried out by previous researchers regarding family presence during emergency procedures and resuscitations. Polit and Beck (2012) emphasise that it is critical that the literature on existing studies relevant to the research problem is reviewed and that the current study is placed in the context of the existing knowledge. This literature review was conducted on family presence during emergency procedures using keywords and phrases such as family presence during resuscitation, family presence during Cardiopulmonary Resuscitation (CPR), and nurses' beliefs during resuscitation.

Family presence, also known as Family Witnessed Resuscitation (FWR), has several definitions. According to Jennings (2014), family presence is the practice of family presence while a loved one is being resuscitated. Family presence is the permission for a patient's family to be present at the bedside during resuscitation. It can also be described as family members being present in a patient care area in a location that allows them to see or touch the patient during resuscitation. Feagan and Fisher (2011) highlighted that FWR enabling family presence during resuscitation in the acute care context was a contentious matter.

2.2 FAMILY PRESENCE DURING EMERGENCY PROCEDURES

The nurses frequently urged family members to sit at their loved ones' bedsides and touch them. Although some nurses were stressed during resuscitation, the majority of them agreed

to it. Nurses found that the nurses and family formed an emotional attachment, making it difficult to remain detached during the resuscitation. The patient was considered part of a family unit rather than a solitary human being when family members were present. The workers saw both positive and negative effects because of this (Jabre et al., 2013). Nurses viewed it as reasonable that the patient was treated as part of a family and that the nurse cared for both the resuscitated patient and their loved ones. On the downside, it was difficult for them to remain emotionally detached from that family. Following the resuscitation, the chaplain held debriefings with the affected staff members to allow them to express their emotions. Recognising the emotional toll that stressful situations may have on employees, the concept of forming a critical incident stress squad to help with these situations was suggested. It was further observed that family members rarely interfered with resuscitation and were typically in awe of the activity in the room. Family members felt compelled to be attentive to safeguard their loved ones. Families need reassurance, information, and help to cope with the crisis. Based on the study conducted at Foote Hospital study done in 1982, many families lose autonomy and the ability to give protection and adequately deal with the problem and are left with little choice but to believe the dominating members of the healthcare team (Cavlovich, 2011). The attendance of family members during resuscitation can help families satisfy their emotional requirements.

2.3 ASSOCIATED PROCEDURES RELATING TO FAMILY PRESENCE DURING EMERGENCY PROCEDURES

Family presence during resuscitation and invasive treatments was initially advocated by the Emergency Nurses Association of America (ENA), which was the first significant national group to do so. The ENA acknowledged the practice of encouraging family presence at its

annual conference and issued recommendations based on their conviction that it was in the best interests of the patient and family (Mutair, 2017). According to Yousif and Mohammad (2019), the nurses and medical doctors of the emergency department have an extraordinary mission. They have to manage and stabilise severely ill patients using precise and effective means to enhance their condition. It is imperative to recognise that whilst life-saving procedures are needed in an emergency; efforts should be made to achieve these goals in a timely and safe manner and follow the policies. Emergency procedures are life-saving and are considered adjuncts to resuscitation. Adequate and life-saving resuscitation cannot be completed without these procedures. Effective management of these emergency procedures achieves the highest level of care that directly impacts patients' outcomes. A delay in acquiring appropriate medical assessment and care could make the difference between life and death. It could also bring about a worse outcome for the person, such as paralysis or a life-long disability (OakBend, 2020).

2.4 FAMILY PRESENCE DURING EMERGENCY PROCEDURES IN SOUTHERN AFRICA

In a study conducted by Gordon et al. (2011), most doctors in the Emergency Unit accepted family-witnessed resuscitation. In a study by Ganz and Yoffe (2012), only a few participants expressed that allowing families to be present during resuscitation would eventually bring closure and shorten the grieving process if resuscitation failed. Fifty-three per cent of the Accident and Emergency Unit doctors of both public and private sectors favoured family-witnessed resuscitation). 9 out of 11 participants were concerned that family-witnessed resuscitation may be a traumatic event Sentiments, which were shared by 72% of the Gauteng private and provincial sectors. Gordon et al. (2011) show that the more experienced

the emergency medical doctors are, the greater the chances are of relatives being invited to witness the resuscitation of their loved one, compared to those with less experience not being keen to do so. In the same study, seventy-one per cent of doctors found it difficult to terminate resuscitation when the family members were present, which led to prolonged resuscitation. Sixty-one per cent of doctors believed families would interfere with the team during resuscitation. Fifty-two per cent were afraid of being intimidated by relatives. Davidson et al. (2017) found that family presence was a beneficial experience for participating family members and was viewed as a right, an obligation, and a natural event. Most healthcare providers had positive attitudes toward family presence, and most supported the practice and believed it should continue.

2.6 GUIDELINES ON FAMILY PRESENCE DURING RESUSCITATION

Family presence during resuscitation and invasive treatments was initially advocated by the Emergency Nurses' Association of America (ENA), the first significant national group. The ENA acknowledged the practice of encouraging family presence at its annual conference in 1993 and issued recommendations based on their conviction that it was in the best interests of the patient and family (Mutair, 2017). The ENA developed the first interdisciplinary guidelines and instructional resources in 1995 to help healthcare institutions implement family presence during resuscitation and invasive treatments. The ENA has since released two more editions of the recommendations that highlight the value of family presence, the most recent of which was published in 2007 (ENA). These guidelines have been incorporated into the Emergency Nursing Paediatric Course (ENPC), Trauma Nursing Core Course (TNCC), and Paediatrics Advanced Life Support (PALS) courses offered by the ENA. The American Association of Critical-Care Nurses (AACN), the Society of Critical-

Care Medicine, the Canadian Association of Critical-Care Nurses, the National Association of Social Workers, the Emergency Medical Services for Children, and the National Association of Emergency Medical Technicians have all incorporated family presence into their fields. The American College of Emergency Physicians (ACEP) created family presence standards for safe resuscitation practice and advocated for their implementation in paediatric emergency rooms (Mutair, 2017).

Several professional training curricula have also incorporated family presence. Family presence was incorporated into the American Heart Association's (AHA) Guidelines for CPR and Emergency Cardiovascular Care in 2000, and it is still included in the most recent modifications. According to the AHA's recommendations, healthcare providers should encourage family members' presence during resuscitation. Family presence has become a vital feature of the AHA standards since its debut in 2000. Family presence has become an increasingly recommended approach employed during a crisis in each update in 2005, 2010 and 2015. In the absence of data documenting harm and in light of data suggesting it may be beneficial, offering select family members the opportunity to be present during resuscitation is reasonable and desirable, assuming the patient, if an adult, has not raised a prior objection (American Heart Association, 2015).

2.7 NURSES' PERCEPTION OF FAMILY PRESENCE DURING EMEGENCY PROCEDURES IN-HOSPITAL

Powers and Reeve (2020) investigated the personal, professional, and workplace characteristics linked with nurses' views, self-confidence, and utilisation of FPDR

invitations. In addition, the study aimed to investigate potential barriers to FPDR and nurses' educational preferences to inform the development of interventions that could promote FPDR implementation in this practice context. The nurses in the study did not have an opinion on FPDR. However, 63% had never invited family members to participate in resuscitation. Prior experience with FPDR was the most important predictor of improved perceptions, increased self-confidence, and increased invitation use. To increase FPDR implementation rates in this practise context, it is suggested that nurses be provided with experience, policy, and education.

Similarly, Tudor, Berger, Polivka, Chlebowy, and Thomas (2014) wanted to investigate nurses' experience with resuscitation, perceptions of the benefits and hazards of having a patient's family present, and self-confidence in having a family presence in their workplace. Self-confidence was much higher among nurses who had completed Advanced Cardiac Life Support training, participated in 10 or more resuscitations, was speciality certified, or were members of professional organisations for nurses. Fear of interference by the patient's family, lack of space, support for family members, fear of trauma to family members, and performance anxiety were barriers to family attendance. Al-Mutair, Plummer, and Copnell (2012) emphasized that nurses, as members of the healthcare team and experts in resuscitation, do not want to see their loved ones suffer because of their experiences. Recognizing the scenario, the nurses agreed that family can play a significant role in resuscitation. The majority of the nurses under study were female and young adults. The majority of critical care nurses held a favourable view of family participation during resuscitation, as seen by their possession of the options highlighted in each perspective. On the other hand, respondents prefer a written policy regarding family presence during

resuscitation and gained "some extent" on the option of no written policy and only providing consent to allow families to be present during resuscitation, indicating that the perspective of policy preference gained "low extent."

2.8 EFFECTS OF FAMILY PRESENCE ON FAMILY AND STAFF

Downar and Kritek (2013) cited fears that family presence during resuscitation would impede or modify resuscitation efforts, perhaps increasing the patient's risk of death. It was also concerned that the family would suffer physical or psychological consequences and that the hospital team might face legal consequences. The findings emphasised the psychological distress to the family and questioned if the presence of a resuscitation team member mitigated this impact (family liaison). The study recommended that it would be easier if family members were included in resuscitations regularly. With each experience, providers would feel more at ease, and such procedures would become second nature. Another study by Kosowan and Jensen (2011) in Canadian Cardiac Units in Edmonton were interviewed about their opinions and what they regarded as challenges to family presence. The survey looked at the participants' prior experiences with family presence, the perceived barriers and benefits of family presence, and attitudes toward family presence rules and procedures. The findings revealed that in 44% of respondents, family members should not be present at the bedside. Family members should be permitted to be present during CPR; however, just 40.9 per cent of those polled strongly agreed or agreed. The findings also highlighted that in 43.8 per cent of the participants, family presence during CPR was a patient/family right. In contrast, 45 per cent of respondents said that having family members there would interfere with patient care and 61.5 per cent said it would be unpleasant for team members. Only 15.3

per cent of those polled thought that removing family members would put them in jeopardy of facing legal action.

2.9 PRACTICES AND INTERVENTIONS RELATED TO FAMILY PRESENCE DURING RESUSCITATION

The lack of a standard of practice regarding family presence at the bedside is a problem that must be remedied as our healthcare practice shifts from a patient-centred to a family-centred approach (Omoding, 2011). Based on the study by Ward (2011) on identifying critical care and emergency nurses' policies, preferences, and practices for having patients' families present during resuscitation and invasive procedures. It was discovered that the benefits of family presence at the bedside were that it provided emotional support for patients and patients' families. This related to a positive experience for patients' families, patients, and staff; guided and increased family understanding of the patient's situation. Thus, helped patients' families make decisions about resuscitation, helped patients' families know that everything was done to save their loved one; and facilitated closure and healing. There were also concerns about legal issues, such as lawsuits and family complaints (Ward, 2011).

2.10 SUMMARY

It was concluded that there should be written policies in place in every institution, as more consumers and professional organisations have come to support this effort to have a family presence at the bedside. Formal policies would guide nurses in these situations and help to alleviate some concerns they have voiced. Further research is suggested, comparing

institutions with and without formal written policies to determine differences in provider support, how often patients' families are brought to the bedside, and the desired outcomes of family presence, such as uninterrupted care of patients and meeting the needs of patient's families (Ward, 2011). The next chapter focuses on research methodology.

CHAPTER 3

RESEARCH DESIGN AND METHODOLOGY

3.1 INTRODUCTION

This chapter discusses the design and methodology employed in researching views on family presence during emergency procedures. Thus, it includes the study's research design, population, sample, research instruments and procedures (Sumpi, 2015). Research design is considered a plan of how the researcher may conduct the research (Holloway & Gavin, 2016). Polit and Beck (2012) state that the research design determines how frequently data will be collected and where the study occurs. Research methodologies are the principles and ideas on which researchers base their actions and strategies. The researcher briefly describes the methodology adopted and the reasons and justification (Holloway & Gavin, 2016).

3.2 RESEARCH DESIGN AND METHODOLOGY

A research design refers to a set of procedures that guide the researcher in verifying a particular hypothesis and excluding all other possible hypotheses or explanations (Bless, Higson-Smith, & Sithole, 2013). The design allows the researcher to conclude the relationship between variables. The researcher adopted this approach to better understand the views of emergency and critical care unit nurses regarding family presence during emergency procedures and derive significant themes from the research findings that may be used to support future policy formulation. A qualitative, exploratory, descriptive, and contextual research designs were used to explore and describe the views of emergency and

intensive care unit nurses regarding family presence during emergency procedures at the two hospitals in Walvis Bay, Namibia.

3.3.1 Qualitative Approach

Qualitative research is concerned with the in-depth descriptions of people or events as the researcher attempts to obtain rich, real, deep and valid data (Creswell, 2018). A qualitative approach involves attempting to comprehend people's interpretations and determining what respondents think and feel about a particular issue, in this case, the views of the nurses in the emergency and intensive care units regarding the presence of family members during emergency procedures. The qualitative approach is naturalistic because researchers engage in the subjects' daily lives. Qualitative approach was used as participants were purposefully enrolled based on their familiarity with the topic which encourages the growth of understanding about the topic and provide knowledge about the human experience to the audience. There will be rich description because the participant are knowledgeable on the subject matter.

3.3.2 Explorative design

An exploratory design is conducted to gain insight into an individual, and the need arises when there is a lack of basic information on the new topic of interest (Polit & Beck, 2015). Exploratory research is undertaken to learn more about a specific circumstance, in this case, the views of emergency and intensive care unit nurses regarding family presence during emergency proceudres at the hospitals in Walvis bay, Erongo Region, Namibia. The explorative design was accomplished using in-depth, semi-structured questions, after which

the researcher utilised probing to obtain each study participant's views. This was based on the central question below:

"What are your views on the presence of family members when you are performing emergency procedures?"

Explorative design was used to investigate how the nurses experienced family presence during emergency procedures at their respective units and wards at the two hospitals that were under study, which the researcher sought to learn more about. Explorative research entails a researcher examining ideas and possibilities rather than allowing preconceived notions to guide the investigation.

3.3.3 Descriptive design

According to Polit and Beck (2012), descriptive research is a study with the primary goal of describing an accurate depiction of the features of people or events. The descriptive design allows for observation and description of a situation in the intended research environment. A descriptive design can build various research ideas, identify existing problems with present methods, justify current behaviour in the healthcare context, and make judgments or determine what other healthcare practitioners in similar settings are doing (Burns & Grove, 2017). This study sought to describe the view of emergency and intensive care unit nurses regarding family presence during emergency procedures at the hospitals in Walvis Bay, and to provide recommendations towards developing policies regarding family presence during emergency procedures.

The participants provided information about the phenomenon under research through semi-structured individual interview questions. As a result, the descriptive component of this

study includes a discussion on the views of nurses regarding family presence during an emergency procedure after it has been studied, as indicated (Holloway & Gavin, 2016).

3.3.4 Contextual design

The study's context refers to the environment and the conditions in which the study takes place as well as the participants 'culture and location (Holloway & Gavin, 2016). Contextual research is used when exploring the context of services. It is used when users' tasks include other persons or processes that must be monitored to properly comprehend their wants and objectives. It is used to acquire information on the context of use by asking users about the context in which they work in their respective environments (Duda, Warburton, & Black, 2020). This study was carried out at two hospitals (public and private) in Walvis Bay, Namibia. The researcher knows the FPDR in the Emergency and Intensive Care Units. As a result, a contextual design allows for a better understanding of the factors that influence human meaning.

3.3 RESEARCH SETTING

Research setting refers to the physical location where research takes place such as a unit in a hospital, a clinic or the community (Holloway & Gavin, 2016). This study was conducted in two private and public hospitals in Walvis Bay. The private hospital serves as a specialist-driven hospital that caters to the growing demands of the Erongo community. The Walvis Bay State Hospital serves as a district state hospital catering to the residents of Walvis Bay. The hospitals consist of various departments, including the outpatient department (OPD), the casualty department, the operating theatre, the central sterilisation supply department (CSSD), the neonatal and adult intensive care unit (ICU) except for Walvis Bay State

Hospital, COVID-19 Intensive Care Unit (CICU) and COVID-19 wards, the x-ray department and the various Med-Surg, midwifery and paediatric wards. This study was conducted through semi-structured interviews with nurses in the following departments/wards: The Intensive Care Unit (ICU), Neonatal Intensive Care Unit (NICU), High-Care Unit, Casualty and Out-Patient Department and the COVID-19 Intensive Care Unit. The researcher was based in the city of Walvis Bay and was employed as an ER/NICU/ICU/Covid-19 ICU nurse at the time of conducting the study; he found that there were gaps relating to the topic that was under study and thus undertook to establish new knowledge and offer insight in current practices relating to the topic.

3.4 POPULATION

Population refers to a complete set of persons or objects with shared characteristics that interest the researcher (Brink, Van der Walt, & Van Rensburg, 2013). The population of this study comprised of 35 nurses, of which 18 were from the private hospital and 17 from the state hospital who provide nursing care in emergency rooms and intensive care units, including high-care units at the Walvis Bay State Hospital and Private Hospital specialising in emergency and critical care. The researcher chose this group as the study's population because these nurses are frequently exposed to emergency procedures and active resuscitation, making them perfect candidates for the study.

3.5 SAMPLE AND SAMPLING

A sample is a part or fraction of a whole or a subset of a more extensive set selected by the researcher to participate in a research study (Brink et al., 2013). It thus consists

of a selected group of elements or units of analysis from a defined population. According to Bertram and Christiansen (2014) a sample is a group of people or objects drawn from a broader population to take measurements in a study. Sampling is the process of selecting cases to represent an entire population so that inferences about that population can be made (Polit & Beck, 2012). In this study, a sample size of 31 nurses was reached through data saturation. Data saturation occurs when themes and categories in the data become repetitive and redundant so that no new information can be gleaned by further data collection (Polit & Beck, 2012). Purposive sampling was used in this study as it enabled the researcher to decide which participants to include in the sample (Bertram & Christiansen, 2014). Participants were chosen based on the following inclusion and exclusion criteria.

3.5.1 The inclusion criteria

Inclusion criteria are characteristics the prospective subjects must have to be included in the study (Polit & Beck, 2012). The following inclusion criteria were used:

- Registered and Enrolled nurses who worked in the Casualty/OPD, Adult Intensive Care Unit, or Neonatal Intensive Care Unit for six months or more, who were willing to participate and had consented to participate in the study.

3.5.2 The exclusion criteria:

Exclusion criteria are a set of predefined definitions used to identify subjects who will not be included or specific criteria that a population does not have (Polit & Beck, 2012). The exclusion criteria used in this study were:

- Registered and Enrolled nurses who worked in the Casualty/OPD, Adult Intensive Care Unit, or Neonatal Intensive Care Unit for less than six months.
- Registered and Enrolled nurses who worked in the Casualty/OPD, Adult Intensive Care Unit, or Neonatal Intensive Care Unit for six months or more and who were not willing to participate in the study.

3.6 DATA COLLECTION INSTRUMENT

The data collection instrument is a formal written document used to collect and record information such as questionnaire, test or observation schedule (Polit & Beck, 2012). The following data instruments were used for this study: an interview guide, field notes and a voice recorder.

Interview guide: Used to collect primary data from the participants regarding their views on FPDR at the selected hospitals. Consent forms were signed before the data collection process commenced. An ethical clearance certificate was presented to assure the participants of confidentiality and data utilization. The Ethical clearance number from the University of Namibia Research Ethics Committee was SON/597/2020. An interview guide was employed to direct the conversation, allowing the researcher to maintain consistency with questions throughout the interviews and not overlook any questions that could have ensured the collection of rich data. (Creswell, 2012).

Field notes: Field notes are broad, more analytic and interpretive than simply listing occurrences. It is reflective and descriptive and represents the researchers' efforts to record information and synthesize and understand data (Polit & Beck, 2012). In this study, field

notes were compiled during and subsequent in-depth interviews with participants, while the memories were still fresh for recollection. Shikalepo (2021a) suggest that interviewers should always note down their impressions immediately following an interview. The researcher also studied the verbal and nonverbal cues of the participants, including their facial expressions, eye contact, tone of voice, and body postures. It also allows the researcher to recall and explore the interview procedure (Holloway & Gavin, 2016).

Voice recorder: Ensures that the participants spoken works are recorded verbatim (Polit & Beck, 2012). The recordings allow for much fuller records than notes that are taken during the interview. These recording are used to for subsequent transcriptions (LoBiondo-Wood & Haber, 2014), however, prior consent had been gained from the participants before the recording was done. Creswell and Creswell (2018), pointed out that if the researcher wants to work with complete verbatim data recorded in the interview, each interview should be transcribed into written form. In this study, the voice recorder enabled each interview's recorded data to be transcribed verbatim (Brink et al., 2013).

3.7 PREPARATION OF THE RESEARCH FIELD

Field preparation was conducted according to Creswell and Creswell (2018), in preparation for proper execution of data collection. This informed the researcher on how to approach the participants and deal with situations that might arise during data collection in the field.

The researcher had meetings with the regional health director of the Erongo region three weeks in advance, where the private and public hospital is located. The medical superintendent, nurse manager, and unit managers for the departments where data collection occurred were consulted among the other health professionals. The researcher discussed the

study's aims and the need to provide a suitable room in each unit where the research was done, as per Creswell & Creswell (2018), who emphasised the importance of obtaining consent and consultation from all necessary stakeholders during the study's preparation. As a result, the researcher acquired a room in each department where the study interviews occurred. During the selection of such rooms, factors such as privacy and noise levels were considered. The rooms, one in each hospital were cleaned, and seating arrangements of two chairs facing each other in a non-confrontational way were organised before each interview. The interviews were tape-recorded using a tape recorder. The researcher provided a timetable to all the departmental unit managers well in advance, including the anticipated days and hours for data collection.

3.8 DATA COLLECTION

Data collection refers to selecting participants and gathering data from the participants (Burns & Grove, 2017. The particular stages for gathering the data vary in every study and are determined by the research design and methodologies. The data collection for this study included gathering, analysing, and interpreting information related to emergency and intensive care unit nurses' views on family presence during emergency procedures. Data collection was conducted using in-depth, individual, semi-structured interviews in which 31 participants were interviewed over five months (January 2021-June 2021) until data saturation was reached. The researcher began the data collection by interviewing the private hospital nurses assigned to the various ICUs, OPDs and ERs, and later the Walvis Bay State Hospital nurses working in the Casualty, High Care and OPD. An interview guide was used to assist the researcher with the list of questions during the interview.

During the interview, a tape recorder and field notes were utilised to guarantee that all participants' expressions were recorded and adhered to the guidelines established by Brink et al. (2013), who warn researchers that the correctness of research conclusions can be easily accessed and questioned without high-quality data-gathering methodologies. As a result, the researcher was aware of various data-collection procedures and their benefits and drawbacks to select the most appropriate methodology for the study's aim, setting, and population. Holloway and Gavin (2016) agreed with the abovementioned processes, stating that tape recording is the best technique to capture the precise words spoken during the interview. According to Creswell and Creswell (2018), a pilot study is a procedure for testing and validating an instrument by distributing it to a small group of participants from the intended study population. The researcher conducted a pilot study on the view of four nurses drawn from the target population regarding family presence during emergency procedures in preparation for the main study. The researcher conducted four (4) pilot interviews in this study, two at private and two at public hospitals. There is always the possibility of error, no matter how carefully a data-collection instrument is designed, and the best protection against such error is pre-testing the instrument (Creswell and Creswell (2018). The four (4) nurses who participated in the pilot study were excluded from the research. The pilot study was conducted to test the interview guide and the procedure of collecting data to rectify any problems that could be identified. The pilot study enhanced the trustworthiness of the findings and aided the researcher in using appropriate interview techniques (Creswell and Creswell (2018)

3.8.1 In-depth individual interviews face-to-face interviews

An individual interview is a one-on-one conversation between a participant and a researcher in which the researcher verbally questions the participant (Burns & Grove, 2017; LoBiondo-Wood & Haber, 2014). Interviews produce in-depth data to gain real insight into the participants' experiences. Literature stress that individual interviews can provide insight into other people's experiences, feelings, and sentiments (le May & Holmes, 2012). In this study, the researcher, who was interested in acquiring rich data by obtaining nurses' views on the presence of family members during emergency procedures, found interviews to be the most acceptable strategy for obtaining rich information on those experiences. Leary (2012) stress that the researcher should establish the interview setting to maximise respondents' comfort, develop rapport with the interviewee and gain cooperation by making them feel at ease and competent. In this study, a quiet and well-arranged room free from distractions was located to promote the comfort of both researcher and participant during the interview. The researcher welcomed the participants in the interview room, offering a chair and assuring them of confidentiality regarding the information to be shared.

Prior to the interviews, the researcher obtained the written consent from the participants after explaining the objectives of the study. The consent to use the tape recorder during the interviews was also obtained from the participants. The researcher urged participants to answer questions as honestly as possible and informed them to seek clarification if a question was unclear. All participants were informed of their right to withdraw from the study if they so desired without any penalty. The interviews started with the central question namely: "*What are your views regarding the presence of family members during emergency procedures at Walvis Bay hospital?*". Verbal and nonverbal communication techniques were

used to encourage participants to verbalise their thoughts, feelings, views, and experiences. A total number of thirty-five (35) participants were interviewed until data saturation. This is in line with Burns and Grove (2017), who states the number of participants in a qualitative study is optimal when information saturation and verification are attained in the study area. Verbatim transcription of each interview was done after the interviews in order to ensure the study's credibility. The data collection of this study was done as from January 2021 to May 2021. Interview guide, tape recorder and field notes enabled the data collection. The tape recordings and field notes guaranteed the data's authenticity (Holloway & Gavin, 2016).

3.8.2 Interview guide

The researcher employed an interview guide as a data-collecting tool to ensure that the interview questions were consistent and that no questions that could have contributed to collecting rich data were overlooked, the goal of the interview guide is to assist the interviewer in remembering the topics to discuss, mainly when asking probing questions (Creswell, 2012).

3.8.3 Field notes

According to Holloway and Gavin (2016), field notes are a field observation record that precisely captures the participants' remarks. Thus, the researchers' field notes are a written description of what they hear, observe, feel, experience, and think about during the interview (Sumpi, 2015). In this study, field notes aid the researcher in remembering and exploring the interview process, ensuring that valuable information is not lost. The researcher recorded observations in written form while participants were observed or shortly afterwards. The researcher collected direct quotes illustrating the participants' opinions and the phenomena

under study when composing field notes. After the interview, this was done as soon as possible while the memory was still fresh, and the specifics were not forgotten. Capturing the participants' behaviour and words allowed the researcher to reflect on and engage with the data (Holloway & Gavin, 2016).

It is recommended that researchers take notes during recorded interviews in case recording equipment malfunctions (Creswell, 2012). According to Babbie (2012), quality assurance in qualitative research requires the researcher to maintain track of their fieldwork as a type of quality control. By so doing, the researcher creates a historical record of the entire process that they can refer to later if necessary. The researcher took field notes during and immediately after the semi-structured in-depth interviews with the participants in this study.

3.8.4 Voice recorder

The authenticity of the data collected was ensured by the voice recordings and the keeping of field notes (Holloway & Gavin, 2016). After permission was obtained from participants, the researcher used the voice recorder to capture the interview proceedings. Tape recordings enable accurate and factual data to be gathered from participants (Creswell, 2012). Soon after each interview was over, the researcher listened to the tape-recorded interview to check the audibility and completeness (Burns et al., 2017). The recorded 31 interactions were used for verbatim, word-for-word transcriptions, which promoted the credibility of the study (Creswell, 2012).

3.8.5 Communication techniques used during data collection

According to Creswell and Creswell (2018), the researcher’s interviewing skills largely determine the quantity and quality of information exchanged during interviews. Poor

interviewing skills, question phrasing, or a lack of understanding of the participants' culture or frame may result in a data collection that yields few valuable results. During the contact with participants, the researcher was not only limited to asking questions and documenting replies but also used the following essential communication tactics to gain a comprehensive knowledge of the participants' experiences:

Bracketing is the process of suspending or putting aside what is known about the event being investigated so that the researcher does not misinterpret the occurrence as experienced by the participant (Burns & Grove, 2017). In bracketing, the researcher identifies and sets aside their views and prejudices about the phenomenon to properly comprehend the participants' experiences. It entails excluding the researcher's past preconceptions based on prior experience to perceive and hear the topic under discussion with an open mind (Holloway & Gavin, 2016). In this study, bracketing began throughout the data-gathering process and continued throughout the data processing.

Active listening: Holloway and Gavin (2016) emphasised the interviewers' need for excellent listening skills. Because active listening allows the interviewer to grasp and clarify what is being said and provide relevant feedback, it is essential for a productive and effective relationship. Throughout the interviews, the researcher listened attentively to verbal and non-verbal information. At the same time, participants made contributions through eye contact, nodding their heads at times, and maintaining an open demeanour. Participants' non-verbal messages, which included deep breathing, yawning, adjusting themselves into chairs, nodding in agreement with a point, and shaking their heads in disagreement, were recorded in the field notes.

Probing: Probing is used to deepen a participant's response to a question, increase the richness of the collected data, and provide indications to the participants about the intended level of response (Holloway & Gavin, 2016). It is a technique for persuading the participants to provide more information about the topic. The researcher used the approaches listed below to encourage the participants to elaborate on their answers during the interviews.

Clarifying: Asking participants to clarify what they said is known as clarifying responses (Holloway & Gavin, 2016). In this study, the researcher asked the participants to clarify ambiguous or vague answers by stating things like, "Could you tell me more about....." and "You seem to be saying...” Clarification allowed the researcher to determine whether or not what he had heard was accurate.

Encouraging: To inspire a participant to pursue a line of thinking encourages them to participate freely in the study (Holloway & Gavin, 2016). During the interviews, the researcher encouraged the participants to share their experiences and provide valuable data by stating things like, "I find that fascinating." “Tell me more...”

Patience/Allowing time for elaboration: Interviewers must convey to participants that their opinions are heard and respected (Holloway & Gavin, 2016). Before moving on to the next question, the researcher gave the participants enough time to consider what they wanted to say. During the interview, no one was rushed.

Acknowledging: is the act of repeating a participant's response to demonstrate that the researcher is paying attention (Holloway & Gavin, 2016). The researcher acknowledged the participants' responses, for example, by stating, "Did you say.....?"

Procuring details: If participants' replies lacked specificity, the researcher asked follow-up questions to elicit more information (Holloway & Gavin, 2016).

Paraphrasing: A verbal answer in which the interviewer restates what the subject has stated, using new terms without compromising what was said, is known as paraphrasing (Holloway & Gavin, 2016). When paraphrasing was necessary during the interviews, the researcher restated what the participants had stated without adding new thoughts. This gave the researcher a better grasp and greater clarity via paraphrasing.

Minimal verbal response: The term minimal verbal response refers to a spoken response accompanied by nodding. Therefore, during the interview, the researcher allows the participant to perform 90% of the talking because an interview is not a discussion but a story-telling opportunity (Holloway & Gavin, 2016).

Focusing: If the participant deviates from unrelated topics, the researcher should pull them back as soon as possible (Holloway & Gavin, 2016). During the data-gathering process, the researcher focused primarily on questions about the problem statement.

Observational skills: Observational skills were used to observe the expressions of participants.

Summarising: The researcher summarised the discussions by focusing only on the most significant concepts or arguments and omitting the less important ones. The participants could verify that the researcher had accurately grasped the information supplied during the interviews when the interviewer summarised it.

3.9 DATA ANALYSIS

Data analysis in qualitative research starts within the data collection process, with the results of early data analysis guiding later data gathering and thus playing a significant part in data selection, exclusion, and reduction. It also allows for the rapid theorisation of the findings (Ervin et al., 2019).

This study used qualitative approaches such as reading, coding, presenting, reducing, and interpreting to analyse words rather than numbers (Giesen & Roeser, 2020). In addition, the researcher used Tesch's Steps of qualitative data analysis and content analysis (Burns & Grove, 2017).

3.9.1 Content Analysis

The researcher also adopted qualitative techniques which were used to analyse words, rather than numbers as recommended by Creswell (2018) namely, finding, reading, coding, displaying, reducing and interpreting and are discussed as follows:

Reading: The researcher read and re-read the material and made notes in the margins of the field notes throughout this step. The researcher was able to come up with the study's themes and sub-themes in this way.

Coding: While reading the responses from the participants, the researcher began assigning codes to pieces of text.

Coding is the process of grouping data by bracketing chunks (text or image segments) and writing a word in the margins representing a category. It entails segmenting phrases, paragraphs or images into categories and then labelling those categories with a term (Creswell & Creswell, 2018).

The researcher read the transcribed data and field notes before assigning preliminary codes to the intriguing data during the coding procedure. This is in line with the recommendations of Creswell (2012) for qualitative researchers to use the coding process to organise data into a small number of themes, at least five to seven, because text and picture data are so dense and complex that not all information can be used in a study. As a result, under this sub-objective, the researcher attempted to "winnow" the data by focusing on relevant and helpful information while ignoring the rest.

The researcher used coding to attach preliminary codes to similar data or adjust codes to subsume related data. The data were given final codes; patterns and relationships were discovered, and themes and sub-themes were generated (Salomo, 2016). A theme is a reoccurring pattern that emerges from a thorough examination of qualitative data (Polit & Beck, 2012). According to LoBiondo-Wood and Haber (2014), themes concisely describe enormous amounts of data. As seen in Chapter 4, Table 4.1, four themes with nine sub-themes resulted from the data analysis. Various quotes from participants in support of themes are featured in Chapter 4 of this study. When the researcher and the study supervisor (independent coder), an experienced coder with a PhD in Nursing, met to assess the data and reach a consensus, the coding's credibility was confirmed.

Displaying: After the coding was completed, the researcher began studying the themes and sub-themes displayed.

Reducing: The data was reduced to crucial points after thoroughly examining the themes and sub-themes.

Interpretation: This entails making meaning of the information. The researcher reached a general and final interpretation of the study's findings at this point.

3.9.2 Tesch's Eight (8) Steps of Qualitative Data Analysis

Tesch's eight (8) steps entail breaking down, examining, comparing and categorising raw data. The researcher adopted this process due to its systematic approach and clear descriptions (Creswell & Creswell, 2018). The steps are described under Table 3.1.

Table 3.1 Tesch's steps of data analysis and its application to the study

Tesch's Steps of Data Analysis	Application to the study
1. Make sense of the overall.	• The researcher read the entire transcript several times and engaged himself in the minutiae to understand the complete interview by breaking it down into components. The researcher ignored the present answers and listened to what the participants had to say by reviewing the interview transcript field notes.
2. Choose one of the shortest and most intriguing interviews, read it, and figure out what it means.	• The researcher's principal task was to look for relevant data elements and analyse them by comparing them to other data and categorizing them.
3. Sort the topics into columns based on their importance, uniqueness, and leftovers.	• To examine the database, the researcher took notes in the margins of the transcripts. Similar topics were clustered together in a column as themes and sub-themes, and the work was performed with several participants.
4. To check whether new categories and codes arise, assign each topic a code and write the codes next to the appropriate portion of the text.	• The researcher returned to the data in this study after organising the themes into columns by abbreviating the topics as codes and writing codes next to the appropriate text segments. The emphasis in the coding was on trustworthiness and believability. The same code was assigned to similar objects.
5. Organise your ideas into categories using the most unambiguous language possible. Look for ways to condense your entire number of categories by grouping related topics.	• To develop descriptions, the researcher employed the coding procedure. The coherence of all themes that were grouped was evaluated. As a result of the coding, several themes emerged as the main results of this study, which were used as headings in the findings section.
6. Decide on a final acronym for each category and alphabetise the codes. The researcher must review the materials several times before arriving at the final categories and codes.	• A final column was developed containing themes and sub-themes.
7. Gather all the data from each category in one place and do a preliminary analysis. Data reduction is a type of analysis that sharpens, sorts, concentrates, discards, and organises data to draw and verify conclusions.	• Assigning the same codes to the descriptions was essentially a data reduction technique.
8. If required, recode your data.	• After initial coding, the data were recorded.

(Creswell & Creswell, 2018; le May & Holmes, 2012)

3.10 ETHICAL CONSIDERATIONS

Research ethics are central to all research involving human participants (le May & Holmes, 2012). Ethical considerations ensure that a researcher continue with a research process that is ethically cleared whereby the safety and wellbeing of the participants are guaranteed (Shikalepo, 2021a). Leary (2012) outlined six aspects dominating the discussion of ethics in research that involves human participants: lack of adequate human consent, invasion of privacy; coercion to participate; potential physical or mental harm; deception and violation of confidentiality.

Polit and Beck (2012) described ethics in the context of academic research as a system of ethical values that relates to the degree to which research processes comply with professional, legal, and social obligations to protect the rights of the research participants. The approval to conduct the study was obtained from the University of Namibia's School of Nursing and Public Health, School of Postgraduate Studies, the Ministry of Health and Social Services (MoHSS) with ethical clearance certificate SON/597/2020. The following three (3) fundamental ethical principles were applied during the study:

3.10.1 Principle of Respect for person

The principle respect for persons implies that, people should be recognised as autonomous agents with the right to self-determination and the freedom to participate or not participate in research (LoBiondo-Wood & Haber, 2014). On the other hand, the right to self-determination is based on the ethical principle of respect for persons and implies that humans are capable of determining their fate. In this study, informed verbal and written consent was obtained from nurses to participate in the study. All participants voluntarily participated in the study after a thorough explanation of the importance of the research study. Participants

could decide to discontinue being part of the study without being judged. All sources used were acknowledged. Falsification of information was avoided as well as manipulation of design and methods. The researcher obtained informed consent from participants willing to participate in the study and be recorded. The rights of the participants were explained to participants by the researcher before they started with the discussion, as explained in the ethical consideration.

The participants were given detailed information regarding the study via a participant information sheet. To get verbal, informed consent, the researcher allotted enough time to explain to each participant what the study was about and what was expected of them in terms of participation. The researcher obtained the subjects' permission to be recorded before using the tape recorder to collect data. The researcher stated that the tape recordings would be held in a lockable cabinet for five years after the study's completion

According to Burns and Grove (2017), confidentiality refers to managing private data in research so that the participants' identities are not linked to their responses. Furthermore, anonymity means that even the researcher cannot link a participant's identity to their unique response. The participants in this study were guaranteed anonymity in their presentations, reports, and publications. According to le May and Holmes (2012), anonymity is kept in qualitative research by coding the data so that participants cannot be recognised in any presentation of the findings. The researcher was accountable for guaranteeing that data collected during the study were kept confidential in a closed cupboard and that no one except the supervisors had access to it. Numbers were used instead of names during data collection to maintain anonymity.

3.10.2 Principle of Beneficence

According to the principle of beneficence, people must be active in promoting good and preventing harm. The researcher in this study ensured that the advantages of the study outweighed the risks at all times, protecting the participants from discomfort and harm (Akaranga & Makau, 2016). Debriefing sessions explained the consent form and interview procedure before commencing the data collection to avoid harm. No physical investigation was conducted during the study that may harm participants.

3.10.3 Principle Justice

The principle of justice, which includes being fair and unbiased, is the foundational ethical basis for fair treatment. In this study all participants were chosen for reasons directly linked to the research but not because they were readily available (Salomo, 2016). Nurses who were emotionally distressed were referred to a psychologist to ensure they received the necessary help. In this study, written informed consent forms were given to participants to sign if they agreed to participate. Given that the researcher encountered no linguistic barriers, no translator was used in this study. The researcher was guided in the study by three essential ethical principles, which are explained in the table 3.2.

Table 3.2: Application of four fundamental ethical principles

Ethical Principles	Application to the study
Principle of respect for persons	
The participants in this study had complete freedom to choose whether or not to engage in the study, with no external controls, while maintaining their right to privacy and freedom of choice (LoBiondo-Wood & Haber, 2014). As a result, the researcher avoided using coercion, personal data collecting, or fraud in any way (Burns & Grove, 2017). As a result, voluntary participation was secured. Anonymity and confidentiality: When private information is disclosed without a person's knowledge or against their choice, it is considered an invasion of privacy (Burns & Grove, 2017).	• Participants' names were kept anonymous • Participants were informed that they had the right to withdraw at any stage of the interview without penalty. • Each participant was treated with respect • Researcher assigned a participant number to each of recordings • No names of the participants were mentioned in the findings • A private room was used during the interview process • Only the researcher and participant were present for the interview process during the data collection period
Principle of Beneficence	
As a result, the researcher did not conduct any medical or other physical studies on participants in this study (Brink et al., 2013; LoBiondo-Wood & Haber, 2014)	• The research had the contact information of a psychologist that was made readily available for participants who experienced emotional distress during the interview as patient death and emergency procedures were a sensitive topic for some of the participants. • The benefits of researching the topic were made clear to the participants and how it could be used to build on the body of knowledge of the profession. • Potential discomfort around being interview or discussing sensitive issues were avoided or minimised by using a private room for conducting the interviews
Principle of Justice	
Interviews were conducted with all participants who met the eligibility requirements.	• Participants were all treated fairly, equally and equitably • Participants were carefully selected using the inclusion criteria • Ethical principles of respect of persons, beneficence and justice were adhered to.

3.11 MEASURES FOR ENSURING TRUSTWORTHINESS OF THE DATA

The research's validity and reliability will be evaluated based on its trustworthiness. In qualitative research, reliability refers to the soundness and suitability of the methodology used (Salomo, 2016). According to Holloway and Gavin (2016), qualitative research should be evaluated using criteria designed expressly for it. The goals are centred on qualitative research, and trustworthiness was measured using the following criteria: credibility, transferability, dependability, and conformability.

3.11.1. Credibility

Throughout the research, the study's credibility was maintained. The term "credibility" relates to one's belief in the facts of veracity and interpretations. It also refers to processes used in qualitative research to verify that data is accurate, valid, and sound (LoBiondo-Wood & Haber, 2014). More extended participation and observation, peer review or debriefing, member checking, and external audits are all standard validation procedures employed by qualitative researchers (Salomo, 2016). On the other hand, le May and Holmes (2012) introduced several different approaches for improving the credibility of qualitative research through saturation, member checks, audit trail, and peer debriefing.

Building trust with participants, knowing the culture, and checking for disinformation resulting from distortions supplied by the researcher or informants are all part of long-term involvement and observations in the field (Creswell, 2012). When a researcher spends significant time with individuals to better understand them and acquire insight into their lives, their credibility is boosted (Du Plooy-Cilliers, Davis, & Bezuidenhout, 2014). According to Morgan (2014), the capacity to form relationships with people who will reply to the researcher's research questions is a common benefit of exploratory qualitative work.

This allows the researcher to gain a better understanding of the research participants and allows him/her to get to know the research participants.

Peer review, often known as debriefing, is an external review of the research process. The peer reviewer's job is to keep the researcher honest by asking probing questions regarding techniques, interpretations and meanings. The member check is the most critical strategy for establishing credibility (Creswell, 2012). It entails polling study participants to see if they agree with the researcher's interpretations of the findings (le May & Holmes, 2012).

This study's report includes information about the researcher, such as his credentials, to retain the study's credibility (Polit & Beck, 2012). The researcher has worked as an Intensive Care Unit Experienced Registered Nurse for three years at a private hospital and has five years of experience as an Emergency Care Practitioner. He has been working as a health professional for the past nine years, so he is thoroughly familiar with the research field and its attendant issues.

3.11.2 Transferability

As a facet of a study's trustworthiness, transferability refers to the extent to which qualitative findings may be applied to other settings (Du Plooy-Cilliers et al., 2014; Polit & Beck, 2012). The amount of information qualitative researchers disclose about study environments is one way of enhancing transferability (Salomo, 2016).

Moreover, it is often impossible to work with a large and representative sample in qualitative research, focusing on the quality of information obtained from participants rather than the sample size. Inductive generalisations from the sample to the target population are possible

due to the depth and richness of the information presented. As a result, "transferability" refers to the data's generalisation ability (Jooste, 2013). Due to shared traits, the researcher's extensive description allows readers to transfer knowledge to various situations and decide whether the findings can be transmitted.

It is critical for the researcher to ensure transferability by including enough (thick) descriptive data in the research report for readers to assess the data's application to different situations. When explaining a case or writing on a theme, a detailed description indicates that the researcher has gone into great depth (Salomo, 2016). As a result, a detailed explanation is required to enable someone considering a transfer to determine whether such a transfer is feasible (Polit & Beck, 2012).

3.11.3 Confirmability

Confirmability refers to objectivity, or the likelihood of two or more independent people agreeing on the data's veracity, relevance, or meaning (Polit & Beck, 2012). It ensures that the data support the results, conclusions, and recommendations and that the investigator's interpretation and the evidence agree internally (Brink et al., 2013). Other people who examine the data must come to the same conclusion as the researcher (Salomo, 2016). Findings must be recorded verbatim without the researcher's biases, motivations, or opinions to meet the requirement of confirmability (Polit & Beck, 2012). Thus, in this study, confirmability was applied by ensuring that the data collected supported the research objectives, and the researcher successfully interpreted it to assess the investigator’s agreement with actual evidence when the data was analysed and interpreted.

3.11.4 Dependability

Dependability is the term used to describe data stability (reliability) through time and under various conditions (Salomo, 2016). To ensure dependability, the study supervisors double-checked the research technique employed in this study and the questions in the interview guide for relevance before beginning data collection. An audit of the research process establishes both dependability and confirmability (Creswell, 2012). According to Brink et al. (2013), dependability necessitates an audit in which the inquiry auditor follows the researcher's process and techniques in the study and evaluates whether they are appropriate.

3.11.5 Authenticity

Authenticity refers to how accurately and faithfully the researcher depicts diverse realities (Salomo, 2016). The study is said to be authentic if the work takes readers into a virtual experience of the lives represented and allows them to develop a heightened awareness of the situations depicted. When a narrative achieves authenticity, readers can better comprehend the lives depicted, having a sense of the mood, feeling, experience, language, and context (Polit & Beck, 2012). In this study, interviews were all recorded in order to capture participants' views regarding family presence during emergency procedures. Similarly, the report of the study contains the direct quotes from the participants depicting their views regarding family presence during emergency procedures.

Table 3.3 Application of the Criteria of credibility, transferability, conformability, dependability and authenticity

Criteria of credibility	Method of application
Prolonged engagement	• The researcher spent six months (January 2021 to June 2021) conducting interviews with individuals. The data was collected until saturated. • The researcher is a Registered Nurse who has worked with nurses in the ER, ICU, and NICU of the Walvis Bay private hospital and regularly interacted with nurses from the Walvis Bay State Hospital, where the interviews were conducted. This allowed him to create rapport with the participants and gain their trust. Having a close relationship with participants allowed for access to more detailed information.
Member checking	• Replaying the recording, the researcher requested the participants' views regarding the integrity of the findings and interpretations.
External audits	• An external auditor in South Africa audited the research findings in this study to see whether the data supported the findings, interpretations, and conclusions.
Peer review or debriefing	• The credibility of this study was ensured through peer review by colleagues and supervisors who went through the data collected.
Criteria of transferability	**Method of application**
Dense description	• The researcher ensured the data's transferability by including sufficient descriptive information in the research study for users to evaluate the data's applicability to other situations.
Purposive sampling	• A method of purposive sampling was used to select participants who would be able to provide detailed information about their views regarding family presence during emergency procedures.
Criteria of confirmability	**Method of application**
Confirmability audit	• The researcher attended the thesis workshop at the University of Namibia at the beginning of the course, which equipped him with the necessary knowledge to pursue a study. • A literature review was conducted during the study.
Criteria of dependability	**Method of application**
Dependability audit	• Before actual data collection, the interview guide's study methods and questions were reviewed for relevance by the study's researcher's supervisors. • The study supervisors guided the researcher to ensure adherence to the institution's protocols. • The study's methodology was described in detail. • A literature review was conducted during the study.
Triangulation	• Individual interviews, field notes and a voice recorder were used as data collection methods. The researcher compared the notes with the recordings. • A qualitative approach with explorative, descriptive and contextual designs was used.
Peer examination	• Research experts were involved in giving opinions on the study.
Criteria of authenticity	**Method of application**
	• Interviews were tape-recorded in order to capture participants' views regarding family presence during emergency procedures. Field notes used were verified with transcripts. • All transcripts were reviewed to ensure that they did not include any evident transcription errors (Creswell, 2014). • The report of the study contains the direct quotes from the participants depicting the views of nurses regarding family presence during emergency procedures as described by participants in Chapter 4.

3.12 SUMMARY

The qualitative, explorative, descriptive and contextual research designs were described in this chapter. It specified the research population, the sampling method, the research instrument, and the data collection protocol, including ethical considerations. Data analysis steps were discussed, and procedures to assure reliability and applicability to the study. The researcher will discuss the identified themes and sub-themes discovered during data analysis with applied literature control in the following chapter.

CHAPTER 4

FINDINGS AND DISCUSSION OF FINDINGS

4.1 INTRODUCTION

The previous chapter discussed research design, data collection, analysis method and ethical considerations. This chapter analysed the data and discussed the results of the data analysis. The segments that contained similar central meanings for each participant were grouped during data analysis as supported by LoBiondo-Wood and Haber (2014), and literature control was incorporated. This study's objective was to explore and describe the views of emergency and intensive care unit nurses regarding family presence during emergency procedures at the hospitals in Walvis Bay, Erongo Region, Namibia. Thirty-one (35) participants were selected utilising purposive sampling and non-probability sampling techniques based on inclusion criteria that were predetermined. Data were compared, and commonalities were identified under the pre-determined themes. Purposive sampling was maintained, and participants were selected until data saturation was reached at 31 participants.

In this study, the researcher used content analysis and the data analysis was recorded manually. The data were transcribed into themes and sub-themes using the thematic analysis approach established after data analysis (Burns & Grove, 2017). During the data analysis process, four key themes emerged. The researcher adopted the emic perspective, which holds that "there is no single valid opinion." This method allowed for some interpretation of the information a wide range of participants provided.

According to LoBiondo-Wood and Haber (2014), a theme is a label that explains facts in a condensed fashion to help the reader grasp the material from an emic standpoint. The findings are examined and supported by existing literature to determine if they align with the conclusions of previous research and fill the gaps in previous studies findings. Furthermore, the literature control shows if the themes one has noticed have been reported before. Moreover, a literature control improves the dependability and credibility of the data. The researcher describes the field activities and the participants in the next section.

A theme can also be defined as values that pervade literary work to make a point or draw attention to a common problem (Rodriguez, 2014). Themes are derived from codes related to the data from individuals in this study. The researcher illustrated the data's depth by explaining the relationship between the extracted themes and the quotes, reflecting the phenomenon as it occurred, which is necessary to ensure the study's credibility (Polit & Beck, 2012).

A sub-theme is similar to any other theme except that it inherits the parent theme's resources (Govida, 2014). As a result, a sub-theme can be a product of another theme, and the researcher can branch and organise it as they see proper. Four (4) themes emerged from this research and are shown in Table 4.1 (below). Each theme was covered, with actual quotes from the interviewees if needed and relevant and appropriate material to back it up.

Table 4.1 Study's themes and sub-themes

Themes	Sub-themes
4.3.1 Theme 1: Participants expressed different views concerning benefits of FPDR for family members	4.3.1.1 Comfort by being present at the end of the patient's life 4.3.1.2 Understanding of the activities of the resuscitation team and the serious nature of a patient's condition during emergency procedures
4.3.2 Theme 2: Participants expressed different experiences concerning risk for family members	4.3.2.1 Experience of emotional trauma by witnessing emergency procedures 4.3.2.2 Interference with emergency procedures by family members
4.3.3 Theme 3: Participants expressed different views with regards to benefits for nurses	4.3.3.1 Potential to build an interpersonal relationship with family members 4.3.3.2 Presence of family members may lead to quality and safe patient care
4.3.4 Theme 4: Participants expressed different views with regards to risks for nurses	4.3.4.1 Discomfort due to family presence 4.3.4.2 Concerns about the possibility of litigation 4.3.4.3 Lack of policy regarding family presence during emergency procedures

4.2 DESCRIPTION OF PARTICIPANTS

The sample of participants consisted of 31 respondents comprising 23 registered and 8 enrolled nurses assigned to the various acute wards of the private and state hospitals of Walvis Bay in Namibia. The demographic profile of the nurses is shown in Table 4.1. It includes gender, age, gender, ethnicity, religion (If Christian, denomination specified), nursing education, nursing specialisation, nurse designation, current unit/ward worked in and years of experience. Data were collected from all 31 participants, and none opted to withdraw from the interview.

The participants' ages ranged between 25 and 60 years. The average age of the participants was 35 years old, with the youngest being 25 and the most senior 60 years, respectively. The majority of the participants were female, totalling 25, while 6 participants were male. The participants were all nurses, 23 were registered nurses with either a degree or diploma in nursing and eight were enrolled nurses with certificates in nursing. Some registered nurses held various specialisations; six were in ICU, one in NICU, one in Nursing Management, one in Stoma Therapy, Occupational Health and Safety, one in Pharmacotherapy, one in Community Nursing and one in Nursing Management. The participants were all Christians. The 31 participants were affiliated with different denominations, such as the Evangelical Lutheran Church in Namibia, Anglican Church, Roman Catholic Church, Universal Church of the Kingdom of God, etc. The reason for asking them about their affiliation and church attendance was to determine how the norms and beliefs in the church could influence their views regarding family presence during emergency procedures. The nurse with the least experience had nursed for one year, while the most experienced had been in the profession for 41 years.

Table 4.2: Demographic summary

Characteristics of participants	Frequency	Percentage
Age:		
20 – 25	2	6.45%
26 – 30	8	25.81%
31 – 35	5	16.13%
36 – 40	7	22.58%
41 – 45	2	6.45%
46 – 50	3	9.68%
51 – 55	3	9.68%
56 – 60	1	3.23%
Gender		
Male:	6	19.35%
Female:	25	80.65%
Race:		
Black	26	83.87%
Coloured	4	12.90%
White	1	3.23%
Religious Denomination:		
Anglican Church	1	3.23%
Evangelical Lutheran Church in Namibia (ELCIN)	13	41.93%
Roman Catholic Church	6	19.35%
Universal Church of the Kingdom of God	1	3.23%
Jehovah's Witnesses	1	3.23%
Pentecostal Churches	6	19.35%
Rhenish Mission	1	3.23%
Seventh-Day Adventists	1	3.23%
African Methodist Episcopal	1	3.23%
Non-Denominational Christian	1	3.23%

Nursing Education:		
Certificate	8	25.81%
Diploma	15	48.39%
Degree	8	25.81%
Characteristics of participants	Frequency	Percentage
Specialisation:		
Critical and Coronary Care	9	29.03%
Emergency Care	1	3.23%
Neonatal Critical Care	1	3.23%
Nursing Management	1	3.23%
Stoma Therapy	1	3.23%
Occupational Health	1	3.23%
Pharmacotherapy	1	3.23%
Community Nursing	1	3.23%
Nursing Education	1	3.23%
Non-Specialised	14	45.16%
Nurse Designation:		
Enrolled Nurse	8	25.80%
Registered Nurse	23	74.20%
Current Unit/Ward:		
Neonatal Intensive Care	4	12.90%
Emergency Centre	15	48.39%
Adult Intensive Care	12	38.71%
Years of Experience:		
0-5	12	38.71%
6-10	4	12.90%
11-15	7	22.58%
16-20	3	9.68%
21-25	1	3.23%
26-30	1	3.23%
31-35	2	6.45%
36-40	0	0%
41-45	1	3.23%
Private Hospital Nurses	18	58.06%
State Hospital Nurses	13	41.93%

4.3 DESCRIPTION OF RESEARCH FINDINGS

The results described in this chapter are based on transcriptions of the individual interviews (Burns & Grove, 2017), giving the researcher bona fide information about the participant's views. Qualitative data analysis searches for themes that are the prominent aspects or qualities of a phenomenon under research (Tashakkori & Teddlie, 2020). Following data analysis, one of the researcher's most important jobs was identifying the study's themes. The researcher collected enormous amounts of data simplified using themes (LoBiondo-Wood & Haber, 2014).

4.4 DISCUSSION OF THEMES

This section discussed the themes and sub-themes in detail about the views of Emergency and Intensive Care Unit nurses regarding family presence during emergency procedures at the hospitals in Walvis Bay, Erongo Region, Namibia.

4.4.1 Theme 1: Participants expressed different views concerning benefits of FPDR for family members

This theme describes how nurses perceived the benefits of having family members present during emergency procedures. Benefits refer to a valued or desired outcome and describe how the study's participants viewed their relationship with the family members present during emergency procedures (Cambridge Dictionary, 2022a).

The importance of family members being present was identified in Mutair (2017), a study examining whether the family should be allowed during resuscitation and suggested that the benefits of family members being present include obtaining the patient's history quickly,

which helps nurses provide more holistic care; encouraging more professional behaviour among staff during resuscitation; strengthening the links between nurses and the families and therefore alleviating many of their doubts. He further suggests that it enables family members to recognise that everything is being done to save the patient. It also allows the family to say goodbye to their loved ones if death occurs. Nurses need to have positive attitudes towards patients and patient care if good quality care is provided, even with family's presence during emergency procedures (Omoding, 2011). De Stefano et al. (2016) goes on to state that having family present gave the relatives a send of acceptance of the loss, thus shortening the grieving process and denial of the death of their loved one. In this study, it was found that many nurses shared the same perceptions about the benefits of family presence. Thus the following sub-themes were identified, which support this theme about nurses' views and experiences regarding family presence during emergency procedures.

4.4.1.1 Sub-theme 1: Comfort by being present at the end of the patient's life

Comfort is defined as a state that involves a sense of subjective well-being in reaction to an environment or situation (Ahmed-Kristensen & Stavrakos, 2012). Family members want to be present during the last moments of a loved one's life. Therefore, family presence provides an opportunity to give final goodbyes and therefore provide some comfort to the relatives. Accordingly, the 2020 Joint Commission recommendations encourage families to participate in end-of-life activities. Family advocacy before and during resuscitation can be pivotal in providing comfort for relatives in the patient's last moments (Tennyson, 2019). Some of the participants indicated that having the presence of families at the patient's bedside helped families better understand the gravity of the situation and, thus the outcome of the emergency

procedures, especially when resuscitation was negative. Concerning comfort, this is what one of the nurse participants had to say:

> *"As if she had seen it before, she went to the corner standing there, and then when we asked her to go out. She was never in our way, although she saw what we were doing for a few minutes. It wasn't long, but for a few minutes, she saw what we were doing. So she moved to the back. I think she was comforted just by being there at the last moments of her dad."* [P5]

Another participant mentioned that:

> "*And then afterwards, after we finish everything, that's when we tried to explain to her, but she accepted it because she knew that the baby was too big for her. And she never went for ANC classes. So it was not detected earlier''*. [P7]

A different participant went on to say:

> "*I mean, we, as people, we also have our relatives that have gone through, you know, lost their lives, and there's a point, you feel like I wish I were there. So you give that person an opportunity to be there in this last moments if that person cannot be saved"*. [P12]

Another participant offered a similar response:

> *"And I think with them being present, they get closure much easier because they can see what you are doing and how hard you are really struggling to save that life".* [P17]

Patients' relative's wishes should be respected when they wish to provide supportive care

and their desire to be with their loved ones during end-of life-events, such as emergency procedures and resuscitation (Omoding, 2011). As evident in the interviews with the nurses it can be said that comfort can come from the family member just touching the patients' hand, seeing attempts to revive the patient, being present to say a final prayer, or to be in close proximity of the patient during resuscitation which gives the relative the sense that they were there during the difficult moment. Joyner (2018) argues that family presence affords families a sense of closure and comfort by easing their anxieties, assuring them that everything was done for their loved ones, and improving health professionals' behaviour by humanising the patient. Not allowing patient family members to be present during the patients last moments of life can be viewed as a violation of patient and family autonomy as well as the Patient Charter of Namibia (Ministry of Health and Social Services, 2016), which states that the patient and patient relatives have the right to make voluntary decisions with understanding without undue influences.

4.4.1.2 Sub-theme 2: Understanding of the activities of the resuscitation team and the serious nature of a patient's condition during emergency procedures

Understanding is the power of comprehension and making experience intelligible by applying concepts (The Merriam-Webster.com Dictionary, n.d.-c). According to the nurse participants, common advantages of having relatives present included that it would help families to grasp the serious nature of the patients' condition, which would, in turn, allow them to understand the heart of the interventions performed as well as know that all possible medical interventions were performed (Omoding, 2011).

One participant reinforced this view:

"But it's good for them to be there. So that they accept and see what's really happening if somebody's explaining what's happening, they even agree to the whole procedure". [P11]

Another participant further stated:

"It also helps to calm and reassure the person we are attending to at times they might be nervous failing to communicate to them properly, but a family member knows how to talk to them. It allows relatives to see the serious nature of the patient, so depending with the seriousness of the emergency, yeah, I don't see any problem they can be allowed". [P6]

Witnessing the emergency procedure and resuscitations and seeing everything possible being done may help the patient's relatives bear the sorrow of the patient's death. This assures that when the procedure is successful, everything that could help the patient was done and thus the emotional distress in the coming days is reduced. This is what one of the participants had to say relating to family members understanding the activities of the resuscitation proceedings:

"they can be present and witness what is happening during the resuscitation so that they can inform others what was happening, and they can satisfy themselves, that enough was done to revive their relatives, should that be a negative outcome" [P18]

The participants' assertions agree with Tennyson's position (2019), which states that family presence during an unsuccessful emergency procedure enhances communication, humanises

the patient, provides dignity and supports the grieving process. Family presence can help to maintain connectedness and bonding in the patient-family relationship, provide an opportunity to educate the patient's family about the patient's condition, allow them to express their care for the patient, to support the patient and the staff, and reduce their fear and anxiety. The family can also grasp the urgency of the situation, the efforts put in by the health care workers during the care of the patient and removes the misconception that procedures and being a patient is a monotonous activity. This is supported by Jabre et al. (2013) who states that family members rarely interfered with procedures and were in awe of the activities in the room and at the attempts of the healthcare workers to save their loved one at all means possible. It helped the family cope with the situation and the aftermath of the outcomes because they were there to see.

4.4.2 Theme 2: Participants expressed different experiences concerning risk for family members

In this study, risk means someone or something that creates or suggests a hazard (The Merriam-Webster.com Dictionary, n.d.-a). Generally, nurses provide curative, preventative, supportive and rehabilitative care to patients to help them meet their holistic needs. However, some nurses believed that it would not be beneficial for patient relatives to be present as they would likely develop psychological issues related to seeing such traumatic events. This is reflected in the following sub-themes.

4.4.2.1 Sub-theme 1: Experience of emotional trauma by witnessing emergency procedures

Many of the participants believed that emergency procedures, especially resuscitation, are a very traumatic event and, as such, would cause emotional trauma to the family members

which could be worsened by watching these procedures performed on their loved ones; therefore, some nurses would use this argument to deny the relatives the choice to be present (Tennyson, 2019).

The following quotations are clear indications of what participants have experienced as far as nursing care for physical need is concerned:

> *"You know, and at the end of the day, I feel that it is very traumatic for her to see that seeing her father dying. And with the nurses, they're trying to do what they can to at the end of the day, she will sit there with guilt, sometimes we feel guilty and say that, oh, if the nurses only could have done this for you, maybe if I could have brought my father earlier on this wouldn't have happened."* [P1]

One participant expressed strong views on this issue:

> *"What I really think is, it is emotional traumatic. The incident was an emergency intubation, and also the child was having seizures. And the father was present I think he just stood there. And actually, his, his actions were as if we were hurting the child. And sometimes in an emergency, you have to use either force or you have to, to be very pertinent in what you're doing. So that it was not, it was not easy, it was night and the child was in respiratory difficulty. And so the doctor had to take a decision to put CVC, to give emergency medication. So he had to really just put a needle in his jugular vein to help the child. So even the doctor's reaction, and as well as the father's reaction, they looked at each other as if they want to take each other on. It can be traumatic for them, they will see that picture in, in their minds. Day in day out".* [P10]

De Stefano et al. (2016) goes on to state that the relatives would witness that everything possible had been done to save their relative. The experience would be less traumatic for the relative than imagining what happened at a later stage. Furthermore, evidence showed that relatives who were present do not experience more prolonged distress or an increased sense of anxiety than those in the control groups (Al daken et al., 2017). Nurses worried about relatives interfering due to emotional distress they may be experiencing during the emergency procedure. Oczkowski, Mazzetti, Cupido, and Fox-Robichaud (2015) go on to state that relatives may be out of control, unable to manage their emotions, and thus obstruct the process, while other nurses believed that the presence of family members depended on the circumstances surrounding the need for resuscitation and anticipating how the procedure would affect the family.

4.4.2.2 Sub-theme 2: Interference with emergency procedures by family member.

Many of the nurse participants believed that patient relatives would become unsettled by the traumatic nature of the emergency procedure and be tempted to interfere with the procedure. Some of these nurses had the experience of having patient relatives interfere with emergency procedures either by getting in the way of the health workers, being verbally abusive, or dictating what the health care workers should do. The nurses frequently verbalised that emergency procedures would produce so much stress in relatives that they would interfere with the treatment; even having the relatives present would be a form of interference (Al-Mutair et al., 2012). The following quote from one of the study participants illustrates this:

> *"They want to stand and watch. Most of the time stand and watch. They also interfere, like they come, like can't you see this person is bleeding, please. They panic*

most of the time in panic mode and some get to that extent that they are aggressive. I think the image they have of these state hospitals are not helping people well, state hospital people are dying. I think now it's more of a perception for someone to just come just the moment they enter they start insulting already." [P25]

Another participant commented:

"Because sometimes they can interfere with your way of doing things they can sometimes be demanding, and they can sometimes tell you what to do. They can sometimes try to dictate the situation as well. And out of emotions because it's an emergency case some they won't understand the way we understand and they won't handle it the way that we were trained to handle the emotions. We can be empathetic, but not sympathetic. But they will be sympathetic and act according to the emotion so them being there can sometimes not be a good idea". [P5]

The above sentiments from the participants support the findings of a study conducted by Wirthwein (2011) where professionals included the fear that family members might interfere with emergency and resuscitative efforts, be critical of staff efforts, observe behaviours that could be interpreted as uncaring or inappropriate, cause staff to lose concentration, and distract team from the patient. However, in a study by Omoding (2011), nurses felt that a chaplain or nurse counsellor present to explain what was happening during the emergency procedure would prevent interference and provide emotional support. These are mainly related to the fears of the nurses and being confronted by relatives related to the care they rendered, however, when a nurse is confident in the care he/she renders and this care is of the standard expected from a registered professional then the nurse usually performs well

regardless of the family's behaviour. The researcher having worked in both ER and ICU in both the state and private hospital was able to observe that the nurses provide adequate care especially on the level required during an emergency procedure. These fears relate to psychological reason and the self-consciousness the nurses may have which seems more prominent during the newer qualified nurse. This is supported by Gordon et al. (2011) which states that the more experienced the health professionals are, the greater the chances are of relatives being invited to witness resuscitation of their loved one, compared to those with less experience not being keen to do so.

4.4.3 Theme 3: Participants expressed different views with regard to benefits for nurses

Family presence during an emergency procedure is considered a form of health promotion, as it is meant to improve the health status of individuals, families, communities, states and the nation. It enhances the quality of life for all people (Mutabazi-Mwesigire, 2014). Every nurse's responsibility includes engaging in the practice of promoting health. However, overall health promotion occurs infrequently and only when nurses have time left over after completing their tasks (Kemppainen, Tossavainen, & Turunen, 2012). Education, organisational, and management concerns have all been cited as significant roadblocks to health-promoting nursing practice. Nurses must be taught how to spot health-promoting possibilities in the acute setting and plan for and implement health promotion so that it becomes second nature to their work (Kemppainen et al., 2012).

Family presence can help maintain connectedness and bonding in interpersonal relationships, provide an opportunity to keep the family informed about the patient's condition, facilitate expressions of family caring toward patients, allow the patient's family

to support the patient and the staff, and reduce fear and anxiety among the patient's family members. Nurses are seen as compassionate individuals who work within a culture or organisation. As a result, nurses prioritise the nurse-patient connection and respect the patient's freedom to make independent decisions (Ward, 2011).

The nurses were asked to reflect on what they viewed as benefits for nurses of having family present during the emergency procedure and experiences that they may have had in this regard. Nurses were generally open to relatives being present if they followed the rules set by the nurses, and the nurses' discretion played a significant role in their views, as supported by the following sub-themes.

4.4.3.1 Sub-theme 1: Potential to build some interpersonal relationships with family members.

An interpersonal relationship is described as a connection between two or more people that might be temporary or long-term. Interpersonal relationships are a dynamic, ever-changing system, and rapport, empathy, trust, respect, mental expectations, flexibility, uniqueness, irreplaceability, interdependence, self-disclosure, honesty, and accountability are all common traits of good interpersonal interaction (Caughlin, Koerner, Schrodt, & Fitzpatrick, 2011). These characteristics are what nurses rely on to build good relationships with patients and patients' relatives, which in turn leads to a good relationship with the community (Atchison, 2012). Nurses who had a favourable view of family presence were often more self-confident and perceived fewer risks. Nurses also believed that nurses would need to be more open to family presence to build relationships of trust with the community. This is demonstrated in what the participants stated during the interviews:

"Yeah, with families, it is also good. Let me say if I can put it in the sense that it could be my relative. I will be willing to see that person; my relatives are not dying. Or the doctor's helping well. But as long as they're not a lot at the same time. Especially I want to say if it's the daughter, yeah, I can let the daughter stay there alone. But if they're not, the more they, it's going to do something else". [P20]

Another participant went on to say:

"I experienced a case whereby a man was brought into casualty by the wife. So the whole time the wife wanted to be there, to see what is happening to the husband. So because it was the wife, we allowed her to be there. And then everything that we did to the patient, resuscitation everything the wife was present. She was just looking at what was happening. She wasn't saying that much and just wanted to be close to her husband. He passed away. She was calm about it and understood. She understood everything at the end of the day, she was saying thank you, you've tried your best" [P27]

The process of caring is central to the nursing profession. The nurse's relationship with patients' family members is an essential and practical prerequisite for promoting patient and family-centred care. It promotes a therapeutic relationship and can help nurses establish positive outcomes in interpersonal relationships. Another participant responded:

"They appreciate, and sometimes we even end up having close relations, not really a close readership, a relationship, where they can come and say sister that I need this help and this assistance. And some, at some level, they also try to give us gifts" [P31]

Another participant further stated:

> *"But afterwards, she accepted it. And she asked for counselling. And she brought presents, for all of us for the doctors and nurses working on her mother and said 'no, you really tried, my mother was really sick'. And I really appreciate your efforts as the health workers."* [P31]

Communication is an integral part of interpersonal relationships. Communication with families establishes a foundation of trust in the nurse-patient interaction. If nurses take the time to chat to relatives and provide comfort, the family will feel more at ease, trust the medical team's abilities, and accept the outcome. The nurse-family interaction could be viewed as crucial to high-quality nursing and emotional support and a solid, positive interpersonal relationship, as the patient gains from teamwork and cooperation between nurses and the patient family. Nurses' contacts with patient families, on the other hand, have a high risk of being unpleasant, especially when relatives disagree with the treatment plan, which can escalate to confrontation. As a result, nurses may use their discretion in inappropriate ways, creating substantial barriers in the nurse-patient relationship (Loghmani, Borhani, & Abbaszadeh, 2014). It can be confirmed that nurse who were able to communicate with the patients relative in their spoken language were able to build better rapport as they could express concepts in terms that the relatives could understand and relate and thus build a good interpersonal relationship. Many of the Doctors at the hospitals were also from foreign countries and therefore could only communicate in English, giving the nurse the opportunity to translate what the doctor may want to relay more effectively and thus get to know the family better and stimulate a trust relationship. Fischhoff (2012) stated that communication facilitates good decision making by the family and provides a positive

experience for the family. Hence, the researcher is in support of the findings that emerged from the study and the literature as it was experienced and observed while working at the Walvis Bay Hospital ICU and ER.

4.4.3.2 Sub-theme 2: Presence of family members may lead to quality and safe patient care

Quality patient care is a broad concept that covers a wide range of topics. It is the healthcare system's safe, effective, patient-centred, timely, efficient, and equitable treatment of patients (Mutabazi-Mwesigire, 2014). It refers to the extent to which individual and community health services boost the likelihood of desired health outcomes while remaining consistent with current professional knowledge. Nursing care can promote quality patient outcomes such as appropriate self-care, demonstration of health-promoting behaviours, health-related quality of life and a sense of being well-cared for (Zhu, Zheng, Liu, & You, 2019). The majority of participants were highly motivated and enthusiastic about providing high-quality nursing care that included patient autonomy, demonstrating a desire to make a positive difference in the lives of patients and the healthcare system.

This was evident in what was stated by a participant:

> *"It's really difficult to deny a patient certain thing and I would not be able to tell my patient No, just for no reason. Unless there's an actual good reason. And I can totally explain it to my patient, but my patient really requested, we are all human, and we all have families; I would imagine my child going through a crisis and my child wanting mom to be there. So I would not just deny it. But depending on who else works, and I also report to superiors who have to be informed, and we will decide on it. We need to consider the safety of the patient, relatives and nurses. We need to*

be sensitive to all parties involved in order to provide quality care as family are an extension of the patient and play an important role". [P2]

Another participant expressed the following views:

"It depends with how you are initiating your nursing practice. So if you're cutting corners, I should say it's not formal if you're not doing the proper thing then they may observe and they might take a video of what is going on, if problems arise, yeah, they will see you as 123 [sic] or these people did not do 123 [sic]. So yeah, but a bunch of people are professional. If you are doing your things correctly. I don't see yourself getting into any problem. And also after you have to explain to the relatives what you're doing if time allows. As nurses we need to provide quality nursing care, because we are whom the patients see most of the time. We are also the bridge between the patient and the relatives. Therefore, it's important to involve the relatives so that when they go back into the community, they can share their positive experience". [P6]

The participants were aware of the importance of establishing trust with patients and families and involving them in the healthcare process, as this promoted overall satisfaction and high-quality care. Nurses are vital to patients' health, contentment with healthcare services, and the overall quality of care they receive. They are uniquely positioned to form relationships with patients and advocate for them because of their direct interaction. Nurses passionate about their profession are driven, have excellent communication skills, have the bravery to advocate for their patients, speak out when anything goes wrong, and devote time and energy to their patients. Nurses who are not enthusiastic about their work will be unable to provide high-quality nursing care to patients (Shikalepo, 2021b). The findings revealed that nurses

in the private hospital than those in state hospital had greater work satisfaction due to higher remuneration, better patient to nurse ratios, better resources and health outcomes which goes hand in hand with providing quality care. This is reinforced by (Hamid, Malik, Kamran, & Ramzan, 2014), who reported that private-sector nurses were generally content, but public-sector nurses were generally discontent. Public-sector nurses were most dissatisfied with their compensation, workload, and available resources. They were solely happy with the work's social background. Therefore, a poor nurse-patient and nurse-patient-relative relationship decreases the quality of care and causes unnecessary friction that may have lasting implications (Molina-Mula & Gallo-Estrada, 2020).

4.4.4 Theme 4: Participants expressed different views with regard to risks for nurses

Assessing and managing risk is considered a core concept of nursing. Risks are inherent in every action or omission in patient care. All of the decisions that nurses must make have ethical foundations for determining what constitutes a danger. The participants make choices and take actions that protect patients and the general public. Nurses should strive to protect and support the patient's health while also providing safe and competent care. When nurses work beyond their scope of practice, the risks increase, and the burden becomes unmanageable. As a result, identifying and managing appropriate risks may necessitate the nurse having to consider the rights and responsibilities of all persons concerned (Forrest, 2012). The participant’s shared robust disagreement with the view that patient relatives should not be allowed at the bedside during emergency procures. This relates to their right to work in a safe environment for themselves and their patients (American Nurses Association, 2020). The participants believed that the relatives posed a danger of physical or verbal violence to the healthcare team that they would interfere in the activities of the

healthcare team. Thus, this would cause psychological trauma if relatives were to witness the events of the emergency procedure. Additionally, it would increase the risk of litigation for the healthcare team, as the patient relatives would not understand the activities of the emergency procedure and misinterpret them. The following sub-themes emanate from the experiences of physical discomfort and psychological changes in the body.

4.4.4.1 Sub-theme 1: Discomfort due to the presence of family member.

Discomfort can be defined as being uncomfortable physically or mentally or something that causes this (Cambridge Dictionary, 2022b). Nurses must make decisions all the time, and situations arise that might make them feel uneasy, particularly when the decision is thought unethical for the nurse (Healthy Nurse Health Nation, 2017). The researcher believes that if a nurse feels that family presence makes them uncomfortable, it would most likely decrease the likelihood of them being supportive of having patient relatives at the bedside during emergency procedures. Nurses who felt most uncomfortable with family presences tended to experience being watched and evaluated by family members while performing the emergency procedures. This may be attributed to the family's misinterpretation of the procedures, which would give rise to complaints, interruption of proceedings, and issues with limited physical space and risk of litigation (Omoding, 2011, p. 39). This is evident in what was stated by the following participants:

> *"I am not that fond of having them there. I am not saying it is wrong or right. But I am not that comfortable with having them there. And I'm not saying I don't feel competent in what I will be doing. But having to work on someone's relative, their loved one, their child, them watching it just put some other kind of pressure on you*

also. They are often not calm enough and you need the best time, the best way for you to work effectively is when you are not also becoming anxious or getting distracted and being able to focus and often with them present, you're not going to be as effective. Maybe you will, there are ways for you to actually get distracted or feel pressured or that kind of thing". [P2]

Another participant went on to say:

"I don't know. I think it also puts a lot of pressure on you, if the family members expect you to do everything, maybe perfect the first time around, which doesn't always happen sometimes in emergency situations, you're, you know, if you can't get the cap of the pink needle off, for example, you know, you've been under such pressure it just, you know, so then there is extra pressure on you to perform to the best of your ability so that I think that extra pressure might also hamper the whole situation". [P9]

Finally, one participant stated that:

"I will mostly. I will feel uncomfortable when the relatives are not behaving. If they are not behaving, yes, and they are not acting as humans, like our community, people, they are very rude. They are very rude, so to say. So I will be, I won't be comfortable dealing with a patient and their relatives, they are here yelling and making a scene. Sister why are you doing what and them they brought the patient to you but then they it's like they want to take over for a patient. They are there talking to the patient, they are there trying to do what to a patient and whatnot. They give me the patient; they give me the card. If and when they go sit there. If there is anything on to ask. I can

ask them. If there is nothing I carry on with my patient and later on I explained the whole procedure". [P23]

The researcher through his own experiencing as a nurse who worked in NICU related to the various nurses who felt more comfortable with family presence when a minor is involved. Nurses believed that a familiar face would help keep the minor calm during traumatic procedures as minors fear the hospital setting and healthcare staff, equating them to painful experiences. This is supported in findings by McLean, Gill, and Shields (2016), that patient treatment was uninterrupted in 100 percent of FPDEP cases. Parents viewed FPDEP favourably, believed it benefited their child, and indicated that it reduced their anxiety. The majority of parents felt they had a right to be present at the event, which was described by all parents as requiring their participation. After three months, no parents reported distressing recollections. Providers were also favourable about FPDEP and noted that parental attendance had no negative impact on care. In addition, the nurse believed that family attendance during an emergency procedure was a legal obligation and would therefore be more receptive to having a parent or caretaker present in the absence of parents. According to Ferreira, Balbino, Balieiro, and Mandetta (2014), it was found that professionals with longer careers and experience in the management of emergency procedures in children felt more comfortable with the presence of family.

This is evident in what the participants stated:

"It depends now, to what type of emergency was there, they are different. Maybe if it's someone like maybe a child now, who fell and fractured there, I can say the family can stay. Since it's a child and we are strangers to them, then at least the child can

feel more comfortable once the parents are there. It depends now to your situation. [P8]

Another participant felt that:

> *"Emergency situation in a minor, I would love the parents to be there, I would want the parents to be there, just to give that child that emotional support. It's very important, because let's say, for instance, you're having a child with a respiratory distress, not the mother is not there, and this child is just seeing these new faces that you don't know. And then there's getting more anxious and then the asthma gets worse, whatever the condition the child has. So it's always better for the parents to be there just to hold on to the child and to give that affirmation that no it will be okay the Sisters will take care of you. You know, whenever the parent are there children are more at ease. And they cooperate even much better".* [P1]

Birmingham Children's Hospital's written policies allows parents to be present in the resuscitation room if they choose after receiving a detailed explanation and prior notification from the resuscitation team leader. There is an increasing trend of more parental involvement in the care of minors, which many staff consider to be a parental right. Children are regarded as very susceptible groups during invasive treatments and resuscitation because their vulnerability and inability to care for themselves is heightened (Omoding, 2011). According to studies, parents and caregivers believed that their children wanted them around and gave them strength, causing the children to be less afraid. It also gave parents the impression that all possibilities had been exhausted in the event of a resuscitation (Ward, 2011). For this reason, nurses are open and encourage a parent to be present during an emergency procedure, as observed during the study.

4.4.4.2 Sub-theme 2: Concerns with the possibility of litigation

Litigation is defined as the process of fighting or defending a case in a court of law (Collins Dictionary, n.d.). Liability is the state of being legally responsible for one's commissions and omissions (The Merriam-Webster, n.d.-b). A patient or relatives may pursue claims against healthcare providers when suspecting the healthcare provider to have caused injury or death to the patient through a negligent act or omission (Morton, 2021). When a member of the public is dissatisfied with the services rendered by a nurse, they may approach the Nursing Council of Namibia to lodge a complaint for assessment by the Council officials. Different repercussions range from fines, suspension from the roll or register, termination of registration and imprisonment (HPCNA, n.d.). Nurses verbalised that they had concerns regarding liability and litigation due to misinterpretations of the emergency procedures and mistaking interventions as acts of harming or injuring the patients, such as the aggressive nature of chest compressions during CPR. This could also lead patient families to interfere with the healthcare team due to misunderstanding the events. The participants believed that a chaplain or additional nurse would help inform the relatives about the processes occurring during the procedure and thus enlighten and inform the family of the attempts to save their relative.

This is demonstrated by what the participants:

> *"I think it increases it. Because family members can come up with lies.*
>
> *You know that they can make up anything, I haven't come across it but the way, they will just lie when they go tell the story, Yeah, she didn't even give oxygen she didn't do this and that, they will come up with lies. Will they never say we tried our best I don't think so".* [P1]

Another participant further stated it:

> *"I think in instances where we know we've done our maximum for a patient, family members might want you to go beyond that, even though we know that the outcome might not be any different or it's now time to stop. So I think in that sense, the litigation might be a bit worse because they now say, but you didn't do everything. There was still time there was still a heartbeat, or there was still, you know, anything that could indicate that there was the life you know, and then we just stood around and wait for the numbers to decrease. I think it would ease them into the situation better if a type of nurse counsellor is present, because then it wouldn't be such a traumatic experience. For example, my family members dying, these people are just standing around and watching. But if there would be a counsellor, like you listen, yeah, this is happening. And this means that the heartbeat that you see is not actually, you know, a physical heartbeat. It's just an impulse, for example, you know, so all those kinds of things, if all those aspects were taken into consideration, then maybe it could work".* [p9]

Additionally, another participant stated:

> *"If anything bad happens maybe the patient dies, so, they will create stories.*
>
> *In my own opinion, they just should not to be present, to see or to look at what you are doing. Even if even you are doing the right thing, they will just not be happy because they don't know, they just say no the nurses and the doctors they did not act, or they were supposed to do this and this, why did they not do this".* [P21]

The presence of patient relatives during emergency procedures can be considered to be in an ethical dilemma because typically, the patient's permission is required before medical information may be disclosed to the relatives. Allowing these relatives into the emergency resuscitation or procedure room could perhaps be seen as flouting the patient's right to confidentiality, and a breach in patient confidentiality could be subject to action or possible litigation. This breach can occur when the relative is informed that a family member has been admitted to hospital and are critically ill. However, when patients are in a critical condition and unconscious, then the patients' relatives may be valuable in providing necessary and vital medical information (Omoding, 2011).

Some relatives may misunderstand or misconstrue observed remarks or actions as offensive leading to complaints and litigation. Errors may occur during resuscitation, and the relatives being present may increase self-awareness of the nurses or a sense of being watched and thus cause them to function more generic due to the "eyes" watching them, which may have the potential for litigation (Omoding, 2011). Often the emergency process relies on deciding what might work on the next try; many relatives do not understand how much guessing and trying something goes into the process. There are also some nurses who find comfort in dark humour to cope with the activities of emergency proceedings. Family members being present might misconstrue this as being insensitive and find offence in the practice of not knowing or understanding the actual reason for this. Strengthening the above explanation, a participant mentioned:

> *"If a relative is present and something goes wrong with a procedure, then they will have to testify, you know, or they will have to tell what happened in everything. And*

since they maybe do not understand what should be done in this procedure, they might not see it as something that was meant to help the patient. They would be like, Oh, they did this, and they did that. And that harmed my child, or that harmed my husband or whatever, it caused more harm. But then if you are also not present, then you do not know what happened". [P3]

One of the participants concurred:

"Especially now with the perception that is in the community, the risk is very high. They will expose unnecessary things or turn around the story into the story they want to fit in. Even if I have done right things they're always trying to find that small something to turn it into something big. Some of the things might be true, but it's only that now you don't know the truth, they're not there but the perception is unnecessarily negative". [p25]

There were nurses of the view that if you carry out your duties to the best of your abilities, there would not be a risk of litigation as the family would appreciate the efforts to attend to the patient. Studies by Oczkowski et al. (2015), the legal risks to health care providers of FPDEP, although a regular source of worry, are small, and should lessen as FPDEP becomes routine practice. Similarly, some nurses were undecided as to whether family presence causes risk for litigation or not. These nurses felt that it would probably be based on the situation and factors that would lead to litigation. Reinforcing the above, one participant said:

"I can say it depends from person to person. There can be that say for instance, you are resuscitating and you are trying your best and she is there to see, really they try their best. There are some who will say, you are the cause of it for the person to die but there are those ones who will say, No, thank you. We really appreciate it because you try your best it's actually 50/50". [P7]

One participant said:

> *"That, you know, it can be, this is a 50/50, you can get a family member that is present during the resus. And you do everything right and this person is there and, you know, usually or there's no cameras at the patient bed. So there's no recording, or evidence this person can go out there and perhaps the patient does not make it, patient dies, this person can go out and say but they did not give oxygen, they did not do what and then it's the your word against his, then on the other hand, you can get a relative that is there and actually testifies to the fact that you did what you did, and then you did it the right way. And, that's good, because sometimes you can be alone in your Casualty. Obviously, we have a bell and our responders come... But there will be at least 30 seconds to a minute that you will be alone. They testify to the fact that you actually did what you had to do. So it also helps you but a lot of times they will go and tell lies or make up things like you didn't do that or you did this wrong. And so that's where it can be a problem when they are present".* [P16]

The researcher notes that many of the nurses were concerned about losing their license to practice as nurses due to misunderstanding by the patients relative could lead to a case with the professional board responsible for regulating nursing. The nurses believed that once they lose their license they would have no other means of making a living or practicing within different context with the absence of registration with the professional board. Several studies (De Stefano et al., 2016; Porter et al., 2014; Tudor et al., 2014; Twibell, Siela, Riwitis, Neal, & Waters, 2018) have indicated that nurses' fear the risks of having patient family present during emergency procedures are primarily unwarranted, including the possibility of litigation and thus losing their ability to practice as health professionals. It also reveals that

attempts to orient and educate personnel about the process have resulted in a greater acceptance of relatives' presence (Wirthwein, 2011).

4.4.4.3 Sub-theme 3: Lack of policy regarding family presence during emergency procedures.

Policy is defined as a set of ideas, or a plan of what to do in particular situations agreed to officially by the organisation (Cambridge Dictionary, 2022c). A hundred per cent of nurse participants in this study stated that there was no FPDEP policy and that they would either rely on the doctors' directions, consult with a superior or use their discretion when deciding FPDEP. This is one primary reason nurses did not allow patient relatives during emergency procedures (Motsepe, 2016). The following statement by one participant confirmed this:

> *"Currently, we don't have policies. We don't have a policy regarding that is only us who felt that, okay. We let's omit or let them sit there but we don't have a policy in place at the hospital". [P1]*

Another participant stated:

> *"No. There was only a verbal policy that family members are not allowed to be present. Only by nurses' discretion". [P7]*

One of the participants confirmed the above by stating:

> *"To be honest, we don't have a directive, directly telling me what to do. It's something that we've been asking over and over and over again. So basically, I don't have a directive telling me what to do. I just follow my own discussion". [P13]*

Supporting the above, one of the participants stated:

"I think only in private hospitals; however, in public hospitals, they don't even allow it. People now know their rights that is why they are more relaxed now, so people are allowed to come in and see what is happening and so it depends on those who know their rights. So they can tell you, no, I want to be there and you can't stop them, it's their right". [P15]

Nurses expressed concerns about expectations that "relatives being there" means unrestricted, unaccompanied access to the procedure room, exacerbating an already complex and emotionally charged scenario. This, however, was contrary to the intent and purpose of a well-drafted policy, which was intended to recognise and respect the patient's and relatives' rights as stated in the patient charter, as well as the patient-nurse, family-nurse, and family-patient relationships, all while maintaining a system that protects the patient's and environment's integrity (Feagan & Fisher, 2011). The researcher can agree that the lack of FDEP policies can be a cause of frustration not only for patients and relatives, but can be a concern for nurses as there isn't clear directive to which the nurse can refer to in the case of an emergency procedure. The lack of directive would thus put the health team in an odd predicament if patient relatives demand to be present, or when there are relatives that are unruly. A clear FDEP with various criteria would help the health team lead in making decision about family presence during resuscitation. An FPDEP policy would be advantageous if it detailed the responsibilities of nurses during family presence which could promote holistic family-centred care in the various hospitals (Omoding, 2011). If a policy is not formulated, then family presence is left to the nurses' discretion, resulting in inconsistent and unfair treatment of patient relatives.

4.5 Summary

This chapter outlined and discussed the themes and sub-themes obtained from a data analysis of the interviews conducted with nurses regarding family presence during emergency procedures in two hospitals in Walvis Bay, Erongo Region, Namibia. Four main themes and several sub-themes were formulated after the data analysis. It was evident from participants' verbatim quotes that nurses considered issues of FPDEP concerning both risks and benefits of family presence during emergency procedures for patient relatives and nurses. Relevant literature was incorporated into the discussion. The next chapter discusses the study's conclusions, guidelines, limitations and recommendations.

CHAPTER 5

SUMMARY, CONCLUSIONS, LIMITATIONS AND RECOMMENDATIONS

5.1 INTRODUCTION

The previous chapter dealt with data analysis and interpretation, discussions of findings and literature control. Content analysis was used, which entailed manual data analysis. Four themes were identified from the views of the nurses regarding family presence during emergency procedures and were discussed accordingly. This chapter will focus on conclusions, limitations and recommendations based on the study's findings. Conclusions were drawn from the findings related to the research question: "What are the nurses' in the state and private hospital's views regarding family presence during emergency procedures?" The conclusions were aligned with the objectives of the study.

5.2 SUMMARY OF THE STUDY

The results were discussed in relation to previous literature to show similarities and differences with other studies in different contexts. The study aimed to explore and describe Emergency and Intensive Care Unit nurses' views regarding family presence during emergency procedures at Walvis Bay, Namibia hospitals.

5.2.1 Methodology of the research study

Qualitative, exploratory, descriptive, and contextual research designs were used in this research study. The research population of 35 participants was selected using non-probability and purposive sampling based on the inclusion and exclusion criteria. To achieve the study's objectives, face-to-face, semi-structured interviews were conducted as the

primary data collection method. A set of questions were posed to each participant as per the qualitative data collection process, such as the sampling method, the research tool, and the data collection protocols. Data were collected until data saturation was reached at 31 participants. The data analysis steps and procedures were discussed to ensure the reliability and applicability of the study. Tesch's descriptive method of data analysis was used to guide the process of data analysis. Before attempting the stages of data analysis, all tape recordings were transcribed. The following data analysis steps were used: a) recording, b) transcribing c) developing the themes and sub-themes, as illustrated in Table 4.1 (Salomo, 2016, p. 35). Data were collected over five months (January 2021- May 2021), allowing the researcher to engage and understand the phenomenon under study (Holloway & Gavin, 2016). During the interviews, the researcher introduced the topic of the research study, followed by the open-ended questions where probing was utilised in order to fully understand the participant's views and to generate rich data. During the interviews, essential communication techniques included active listening, summarising, reflecting, and clarifying (Holloway & Gavin, 2016). The first two interviews were pilot interviews which produced significant and valuable data, which enhanced the trustworthiness of the findings and aided the researcher in using appropriate interview techniques. The data gathered were measured using the criteria of trustworthiness, such as credibility, transferability, dependability and conformability (Holloway & Gavin, 2016). The study was also conducted within the ethical framework and consent granted by the University of Namibia's School of Nursing, School of Postgraduate Studies, the Ministry of Health and Social Services (MoHSS), and the nurse managers of Walvis Bay hospitals. Ethical considerations for the study were based on respect for persons, beneficence, anonymity and confidentiality and fair treatment and justice (Burns & Grove,

2017). The researcher ensured that no harm befell the participants during the study. Codes were used in the interview tools. The research data and the master list of the participants were kept in the researcher's office, locked away in a safe that only the researcher and supervisors had access to. The participants' interests were protected and prioritised by the researcher throughout the study (Sibinga, 2018).

5.2.2 Objectives of the study

The research study had two objectives: Objective 1 and Objective 2. They were to explore and describe the Emergency and Intensive Care Unit nurses' views regarding family presence during emergency procedures. These are discussed below.

5.2.2.1 Objective 1: To explore the Emergency and Intensive Care Unit nurses' views regarding family presence during emergency procedures at two hospitals in Walvis Bay, Namibia.

Participants were asked to share their views regarding family presence during emergency procedures at two hospitals in Walvis Bay. Their views and experiences were obtained through face-to-face, semi-structured interviews. The interviews were recorded and transcribed verbatim (Creswell, 2012). A total of 30 interviews were conducted before data saturation was reached. Field notes were also taken. Rich, detailed data was obtained and is described under Objective 2.

5.2.2.2 Objective 2: To describe the Emergency and Intensive Care Unit nurses' views regarding family presence during emergency procedures at two hospitals in Walvis Bay, Namibia.

A description of views was done by analysing data according to Tesch's eight steps. Thereafter, data was coded and categorised into themes and sub-themes. The study then revealed clear sentiments, views and experiences from participants, including a mix of opinions regarding the benefits of family presence, the risk of litigation and a sense of fear regarding being watched. Several nurses did not support the idea of having family members present during emergency procedures in the ICUs and ERs of the hospitals such as Walvis Bay State Hospital. While the inclusion of family members during resuscitation attempts to promote transparency, emotional support, and patient-centred care, it can also introduce various unwanted effects such as discomfort, liability, lack of policy, traumatic experience and interference by family members are identified as significant risks for nurses to support this practice. In such instances some nurses were concerned that family members would become overwhelmed or interfere with medical procedures. For example emergency procedures require undivided attention, and the presence of family members may cause distractions or impede the ability of the healthcare team to provide timely and effective care. Witnessing a loved one in distress or undergoing invasive procedures can be traumatic for family members, according to some nurses interviewed. When contemplating the potential long-term effects of such experiences, nurses who are apprehensive of family presence may prioritize the emotional well-being of the family and decide to not permit family members. One of the primary concerns identified for the nurses was the fear of increased liability. When family members are present during resuscitation, they are more likely to observe

unfavourable outcomes or medical errors. In such situations, patients may query the quality of care or hold healthcare professionals accountable, which may result in litigation. In general nurses adhered to established protocols and provided appropriate care, nurses fret that they may be the subject of legal action. In addition, the presence of family members during resuscitation can complicate decision-making and present difficulties for medical personnel. In situations of extreme stress, family members may exert pressure on the healthcare team, demand specific interventions, or disagree with the recommended course of action. This can create ethical dilemmas for nurses, who must weigh the wishes of the patient's family against what they believe is in the patient's best interest (Mohammed et al., 2019).

On the contrary, there are those nurses who were comfortable with the presence of family members who believed that it would be beneficial and have positive outcomes for patient care. Several nurses agreed that having family members present during emergency procedures could provide emotional support to both the patient and their loved ones. During critical moments, the presence of familiar faces can reduce anxiety and provide a sense of reassurance. In particular racial differences were noted amongst nurses, with the coloured and baster nurses being more open to family presence whilst the black nurses felt it would be too traumatic for the patient’s family members. This may be associated with beliefs and superstitions around illness, and the concept of death, (Ekore & Lanre-Abass, 2016) pointed out the fear of death and grief among the African community. Experience with FPDEP was the most important predictor of improved views, increased self-confidence, and increased invitation by nurses for family members to be present during emergency procedures. Nurses acknowledge that family members frequently have an in-depth understanding of a patient's

medical history and can provide essential information to the healthcare team. When family members are present, healthcare professionals and the patient's relatives can communicate and collaborate more effectively. Ethically, nurses may perceive family presence as a means of upholding patient rights and maintaining care transparency. It is consistent with patient-centered care, informed consent, and shared decision-making principles (Vincent & Lederman, 2017).

Significant associations existed between nurses' self-image and their views of the advantages of family presence during emergency procedures. Self-confidence was much higher among nurses who had completed post graduate qualifications training ICU nursing or ER nursing and who had participated in a number of emergency procedures especially resuscitations. Fear of interruptions by the patient's family, lack of space in the room, lack of support for family members by a counsellor or chaplain, fear of emotional and psychological trauma to family members, and performance anxiety were barriers to family presence during emergency procedures. Changing the practices of family presence during emergency procedures will entail developing new policies, assigning a team member to attend to the patient's family during resuscitation such a 'nurse counsellor', and mandating that nurses complete training on the research that supports family presence and changes in clinical approach to family centered care and family presence in the care of the patient when it comes to emergency procedures. It is crucial to study the view of patients as to whether they want family members present and to determine whether the family members want to be present during resuscitation for both adult and paediatric emergencies. The researcher noted that the few white nurses who were all from the private hospital in the sample group were more inclined to have a parent present during the emergency procedure of neonates or

paediatric patients. This is consistent with Brooten et al. (2016), who indicated that while caring for parents who have lost an infant or kid, it is vital to consider their specific requirements and cultural conventions, as these can vary from person to person and from generation to generation within the same community. Adopting and implementing family presence policies and guidelines may be tremendously helpful for nurses if they are presented with evidence-based data and ethical reasoning that address common concerns they raise. The objective of structured FPDEP guidelines is to recognise the rights of patients and families and respect the nurse-patient, nurse-family members and patient-family relationships while maintaining a system that protects the integrity of the patient care environment. Family presence practices were more common among female nurses, nurses with degrees and among registered nurses.

However, there was an association between the nurses' characteristics and knowledge of family presence practices. Registered Nurses were more inclined to allow family presence rather than enrolled nurses. Family presence practices were significantly associated with nurses who worked in private as they had a more significant independent function and were able to fulfil more of their scope of practice, including patient advocacy. This correlated to a study by Urasa and Darj (2011). It was noted that there were differences in the nurses' views; many expressed the need for written policies, procedures and guidelines for written policies regarding FPDEP and suggested assigning a 'nurse counsellor' to evaluate the readiness of family members to be present and explain to them the proceedings while they were attending the emergency event.

5.3 CONCLUSION

This study's objective was to explore and describe the views of Emergency and Intensive Care Unit nurses regarding presence of family members during emergency procedures and determine whether family presence would be a viable, beneficial option in health services. A set of questions were posed to each participant, the first being: "Have you ever experienced family members being present during the emergency procedure?" The interviews proved to be a source of rich data on the participants' views regarding this issue. Both Emergency and Intensive Care Unit nurses had mixed views and opinions regarding the presence of family members, with ICU nurses being more receptive to the practice. Emergency unit nurses were more receptive to family presence during an emergency procedure when it involved minors as they felt that it would reassure and calm the minor. Though there were no other religions to contrast with, it was found that there was no correlation between the denomination of the church and the likelihood of permitting or denying family presence. Most nurses had some experience with family presence during emergency procedures. Among the nurses, religion, specialisation, and years of experience played a role in nurses' views, eliciting a positive perception of family presence during emergency procedures. There were no policies, procedures or guidelines regarding family presence during emergency procedures, and a majority felt that a formal policy would encourage best practices. There was also a prevailing view that if family presence during the emergency procedure were to be implemented, it would be beneficial for family members to be accompanied and supported by a nurse or counsellor during and after the process. The issue of family presence during emergency procedures is decades old, and it is time that Namibia implemented evidence-based practices on the matter.

5.4 LIMITATIONS

5.4.1 Methodological limitations

Purposive sampling, therefore, findings are contextual. The sample was not randomised and could thus contain systemic bias. Experiences of other members of multidisciplinary team not captured. Limited literature

5.4.2 Geographical limitations

The study was conducted in hospitals in Walvis Bay. The findings cannot be generalised outside of Walvis Bay, Namibia, due to the geographical, economic, and cultural orientation. The findings were not representative of nurses in other hospitals across the country.

5.5 RECOMMENDATIONS

The following recommendations are based on the conclusions drawn from Objectives 1 and 2. Recommendations were made based on managerial, educational and research-related aspects.

5.5.1 Management

- A policy developed by the MOHSS in state health facilities and by hospital managers in private health facilities.
- Unit managers should establish and implement individualised policies in all units that serve as ‘think and decide on how to deal with a request from family members to be present.
- To protect health professionals from litigation, hospital managers in private and health superintendents in public health services should establish and implement

policies to set up rules and regulations regarding managing family presence during emergency procedures.

- Trials may be warranted to identify and adopt evidence-based practice.

5.5.2 Education

- Training of ‘nurse counsellors’ by a tertiary institution in conjunction with health services that are empowered to facilitate the activities of family member presence during emergency procedure.
- The creation of an online learning module would allow nurses or any other healthcare professional to enrol online and learn about FPDEP, which would be educative and assist with the roll-out of FPDEP policies.
- Nurses should receive annual in-service training by social workers and psychologists organised by hospital managers and nursing services managers regarding the intricacies of family presence during emergency procedures, detailing the dos and don’ts. This is because nurses spend the most time with patient relatives of critically ill patients and are, therefore, the foundation of the healthcare system as well as agents of change.
- Nurse training institutions should consider formulating and implementing FPDEP policies and guidelines as part of the curriculum in basic nursing sciences.

5.5.3 Future research

Research regarding family presence during emergency procedures, inclusive of resuscitation, has been well-established internationally. However, none is related to the

Namibian context, and this study will serve as the first of its kind. The following are recommendations by the researcher for possible future research.

- Larger sample size should be targeted as the researcher could not generalise the findings of the study outside Walvis Bay
- A quantitative or mixed-method study should be undertaken to assess the knowledge, attitude and practices of nurses in the Emergency and Intensive Care Units regarding family presence in Namibia.
- A study should be carried out on the views of family members and patients regarding family presence during emergency procedures.
- An analysis of the environment should be undertaken to determine whether a conducive environment exists for family presence during emergency procedures in Namibian hospitals.
- A model should be developed by healthcare leaders and/or tertiary institutions that can be adopted by healthcare facilities to facilitate family presence policies during emergency procedures using a holistic approach which would consider patients, relatives, nurses, the healthcare team, and healthcare systems.

5.5.4 Contribution to the body of knowledge

This study contributes to the body of knowledge, particularly to the qualified nurse in practice and society in general. This information will enrich the quality and experiences of nurses regarding the management and care of patients and the requests of family members to be present during emergency procedures. It also contributes to knowledge concerning the roles that nurse counsellors may play in supporting family presence during emergency procedures. Ultimately, the outcome of this study will result in better care and improved

quality of life for patients, families and the healthcare team. The results may be used to create training programmes to increase existing knowledge, improve practices, and change nurses' views and perceptions. In addition, it adds to the available literature on nursing science to enhance future research.

5.6 SUMMARY

The final chapter presented a summary of the study, including its conclusion, limitations, and recommendations. The views of Emergency and Intensive Care Unit nurses regarding family presence were discussed. At present, no policies regarding Family Presence during Emergency Procedures exist, and many of the nurses felt that a policy would guide them on how to deal with the situation. Hospitals that wish to employ a family-centred approach would benefit from such a practice as it would be inclusive in allowing family members to be present during their relative's crises. If nursing follows an evidence-based approach, then Family Presence during Emergency Procedures would be a natural path to take, as research has shown that there are many benefits and advantages to having such a policy, in line with global standards.

REFERENCES

Ahmed-Kristensen, S., & Stavrakos, S. (2012). *Definition of comfort in design and key aspects- A literature review*. In Proceedings of NordDesign Conference 2012 (p. 77). Aalborg University, Center for Industrial Production

Akaranga, S.I., & Makau, B.K. (2016). Ethical considerations and their applications to research: a case of the University of Nairobi. *Journal of Educational Policy and Entrepreneurial Research*, 3(12), 1-9

Al daken, L., Ahmad, R., Abu-snieneh, H., Ghadeer, Al-D., Maysoun, A.,...& Abu-Moghli, F. (2017). Policy Development: Family Presence during Resuscitation (FPDR) Procedure. *International Journal of Nursing and Health Science*, 4(2): 22-30

Al-Mutair, A. S., Plummer, V., & Copnell, B. (2012). Family presence during resuscitation: a descriptive study of nurses' attitudes from two Saudi hospitals. *Nursing in Critical Care*, *17*(2), 90–98. https://doi.org/10.1111/j.1478-5153.2011.00479.x

American Heart Association. (2015). *American Heart Association Guidelines for Cardiopulmonary Resuscitation and Emergency Cardiovascular Care*. http://dx.doi.org/10.1016/j.resuscitation.2016.04.026

American Nurses Association. (2020). *Healthy Work Environment*. ANA Enterprise. https://www.nursingworld.org/ErrorHandling/ErrorFallback.html?aspxerrorpath=/practice-policy/work-environment/

Anjum, S. (2018). *Systematic Approach to Acute Cardiovascular Emergencies.* https://www.intechopen.com/books/essentials-of-accident-and-emergency-medicine/systematic-approach-to-acute-cardiovascular-emergencies

Atchison, C. M. (2012). *The effect of an educational intervention on nurses' opinions regarding family presence during resuscitation*, p 6. Indiana

Babbie, E. R. (2012). *The Practice of Social Research*, 13th Edition (13th ed.). Wadsworth Publishing.

Bashayreh, I, Saifan, A, Batiha A & Abu Ruz, M. (2015). "Family Presence during CPR in Adult Critical Care Settings: Hearing the Voice of Jordanian Health Professionals". *Life Science Journal*; 10(4) (PDF) Policy Development: Family Presence during Resuscitation (FPDR) Procedure. Available from: https://www.researchgate.net/publication/317618021_Policy_Development_Family_Presence_during_Resuscitation_FPDR_Procedure

Bertram, C., & Christiansen, I. (2014). *Understanding research: An introduction to reading research*. Van Schaik.

Bless, C., Higson-Smith, C., & Sithole, S. L. (2013). *Fundamentals of Social Research Methods*.

Brink, H., Van der Walt, C., & Van Rensburg, G. (2013). *Fundamentals of research methodology for healthcare professionals* (3rd ed.). Formset Print.

Brooten, D., Youngblut, J. M., Charles, D., Roche, R., Hidalgo, I., & Malkawi, F. (2016). Death Rituals Reported by White, Black, and Hispanic Parents Following the ICU

Death of an Infant or Child. *Journal of Pediatric Nursing*, 31(2), 132–140. https://doi.org/10.1016/j.pedn.2015.10.017

Brophy, J. M., Keith, M. M., & Hurley, M. C. (2018). Assaulted and Unheard: Violence Against Healthcare Staff. *New Solutions: A Journal of Environmental and Occupational Health Policy*, *27*(4), 581–606. https://doi.org/10.1177/1048291117732301

Burns, N., & Grove, S. K. (2017). *The practice of nursing research: Appraisal, synthesis, and generation of evidence* (6th ed.). Saunders Elsevier.

Cambridge Dictionary. (2022a). Policy. In *Cambridge Dictionary*. Retrieved February 21, 2022, from https://dictionary.cambridge.org/dictionary/english/policy

Cambridge Dictionary. (2022b). Discomfort. In *Cambridge Dictionary*. Retrieved February 21, 2022, from https://dictionary.cambridge.org/dictionary/english/discomfort

Cambridge Dictionary. (2022c). Benefit. In *Cambridge Dictionary*. Retrieved February 21, 2022, from https://dictionary.cambridge.org/dictionary/english/benefit

Cascio, M. A., Lee, E., Vaudrin, N., & Freedman, D. A. (2019). A Team-based Approach to Open Coding: Considerations for Creating Intercoder Consensus. *Field Methods*, *31*(2), 116–130. https://doi.org/10.1177/1525822x19838237

Caughlin, J. P., Koerner, A. F., Schrodt, P., & Fitzpatrick, M. A. (2011). Interpersonal communication in family relationships. In M. L. Knapp & J. A. Daly (Eds.), The

Sage Handbook of Interpersonal Communication (pp. 679-714). New York, NY: Sage Publications.

Cavlovich, D. (2011). Family presence at the bedside during resuscitation. *Nursing Made Incredibly Easy*, *9*(2), 56. https://doi.org/10.1097/01.NME.0000394040.73335.02

Coady, N. (2016). *Theoretical Perspectives for Direct Social Work Practice, Third Edition: A Generalist-Eclectic Approach* (3rd ed.). Springer Publishing Company.

Collins Dictionary. (n.d.). *Litigation definition and meaning | Collins English Dictionary*. Www.collinsdictionary.com. Retrieved July 5, 2021, from https://www.collinsdictionary.com/dictionary/english/litigation

Creswell, J. W. (2012). *Qualitative inquiries and research designs: Choosing among five approaches* (3rd ed.). Sage Publications: California.

Creswell, J. W. (2014). *Research design: Qualitative, quantitative, and mixed methods approaches* (4th ed.). Sage Publications.

Creswell, J. W., & Clark, V. L. P. (2017). *Designing and Conducting Mixed Methods Research*. SAGE Publications.

Creswell, J. W., & Creswell, D. J. (2018). Research Design: Qualitative, Quantitative, and Mixed Methods Approaches (5th ed.). SAGE Publications, Inc.

Davidson, J. E., Aslakson, R. A., Long, A. C., Puntillo, K. A., Kross, E. K., Hart, J.,... Curtis, J. R. (2017). Guidelines for Family-Centered Care in the Neonatal, Pediatric, and

Adult ICU. *Critical Care Medicine*, 45(1), 103–128. https://doi.org/10.1097/ccm.0000000000002169

De Stefano, C., Normand, D., Jabre, P., Azoulay, E., Kentish-Barnes, N., Lapostolle, F.,…Adnet, F. (2016). Family Presence during Resuscitation: A Qualitative Analysis from a National Multicenter Randomized Clinical Trial. *PloS one*, 11(6), e0156100. https://doi.org/10.1371/journal.pone.0156100

Downar, J., & Kritek, P. A. (2013). Family presence during cardiac resuscitation. *The New England Journal of Medicine, 368*, 1060–1062. https://doi.org/10.1056/NEJMclde1301020 PMID:23484836

Du Plooy-Cilliers, F., Davis, C., & Bezuidenhout, R. (2014). Research matters. Paarl Media: Paarl.

Duda, S., Warburton, C., & Black, N. (2020). Contextual Research. Human-Computer Interaction. Design and User Experience, 33–49. https://doi.org/10.1007/978-3-030-49059-1_3

Edmonds, W. A., & Kennedy, T. D. (2013). *An Applied Reference Guide to Research Designs: Quantitative, Qualitative and Mixed Methods*. Sage Publications: California.

Ekore, R., & Lanre-Abass, B. (2016). African cultural concept of death and the idea of advance care directives. *Indian Journal of Palliative Care*, 22(4), 369. https://doi.org/10.4103/0973-1075.191741

Ervin, J. N., Kahn, J. M., Cohen, T. R., & Weingart, L. R. (2019). *Teamwork in the intensive care unit.* https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6662208/

Feagan, L. M., & Fisher, N. J. (2011). The Impact of Education on Provider Attitudes Toward Family-Witnessed Resuscitation. *Journal of Emergency Nursing*, *37*(3), 231–239. https://doi.org/10.1016/j.jen.2010.02.023

Ferreira, C. A. G., Balbino, F. S., Balieiro, M. M., & Mandetta, M. A. (2014). Family presence during cardiopulmonary resuscitation and invasive procedures in children. *Revista Paulista de Pediatria : Orgao Oficial da Sociedade de Pediatria de Sao Paulo*, *32*(1), 107–113. https://doi.org/10.1590/S0103-05822014000100017 PMID:24676198

Firestone, W. A. (2013). Meaning in method: The rhetoric of qualitative and quantitative research. *American Educational Research Association Journal*, 16(7), 16–21.Retrieved from: http://edr./sagepub.com/content/16/7/16.short

Fischhoff, B. (2012). Good Decision Making Requires Good Communication. *Drug Safety*, *35*(11), 983–993. https://doi.org/10.1007/bf03261986

Forrest, C. (2012). *Assessing and managing risk*. Www.independentnurse.co.uk; Independent Nurse. https://www.independentnurse.co.uk/professional-article/assessing-and-managing-risk/64199

Ganz, F. D., & Yoffe, F. (2012). Intensive Care Nurses' Perspectives of Family-Centered Care and Their Attitudes Toward Family Presence During Resuscitation. *The Journal of Cardiovascular Nursing*, *27*(3), 220–227. https://doi.org/10.1097/jcn.0b013e31821888b4

Giesen, L., & Roeser, A. (2020). Structuring a Team-Based Approach to Coding Qualitative Data. *International Journal of Qualitative Methods*, *19*, 160940692096870. https://doi.org/10.1177/1609406920968700

Giles, T. (2015). *Family Presence during Resuscitation: A constructivist grounded theory. Research Gate*. Retrieved August 1, 2022, from https://www.researchgate.net/publication/293817609_Family_presence_during_resuscitation_a_constructivist_grounded_theory

Gishu, T., Weldetsadik, A. Y., & Tekleab, A. M. (2019). Patients' perception of quality of nursing care; a tertiary center experience from Ethiopia. *BMC Nursing*, *18*(1). https://doi.org/10.1186/s12912-019-0361-z

Gordon, E., Kramer, E., Couper, I., & Brysiewicz, P. (2011). Family-witnessed resuscitation in emergency departments*: Doctors' attitudes and practices*. http://www.samj.org.za/index.php/samj/article/view/5002/3587

Government of Namibia. (2004). Nursing Act 8 of 2004. In Legal Assistance Centre (No. 2040). Namibia Government Gazette. https://www.lac.org.na/laws/2014/5591.pdf

Govida, O. (2014). *Creating a sub-theme*. Retrieved May 16, 2014 from https://drupal.org/node/225125

Halm, M. A. (2017). Aggression Management Education for Acute Care Nurses: What's the Evidence? *American Journal of Critical Care*, *26*(6), 504–508. https://doi.org/10.4037/ajcc2017984

Hamid, S., Malik, A. U., Kamran, I., & Ramzan, M. (2014). Job satisfaction among nurses working in the private and public sectors: a qualitative study in tertiary care hospitals in Pakistan. *Journal of Multidisciplinary Healthcare*, 25. https://doi.org/10.2147/jmdh.s55077

Hammarberg, K., Kirkman, M., & De Lacey, S. (2016). *Qualitative research methods: When to use them and how to judge them*. https://academic.oup.com/humrep/article/31/3/498/2384737

Healthy Nurse Health Nation. (2017). *Moral Distress: What It Is And What To Do About It Blog. Healthy Nurse, Healthy Nation TM*. https://engage.healthynursehealthynation.org/blogs/8/531

Holloway, I., & Gavin, K. (2016). *Qualitative research in nursing and healthcare 4th edition).* Wiley Blackwell.

HPCNA. (n.d.). *Health professions councils of Namibia*. Health Professions Councils of Namibia. http://hpcna.com/

Jabre, P., Belpomme, V., Azoulay, E., Jacob, L., Bertrand, L., Lapostolle, F.,... Adnet, F. (2013). Family Presence during Cardiopulmonary Resuscitation. *New England Journal of Medicine*, 368(11), 1008–1018. https://doi.org/10.1056/nejmoa1203366 jabre

Jennings, J. L. (2014). *Nurses Perceptions of Family Presence during Resuscitation in the Emergency Department*. Digital Commons @ RIC. Retrieved July 17, 2022, from https://digitalcommons.ric.edu/etd/239/

Jooste, K. (2013). *The principles and practice of nursing and health care: Ethos and professional practice, management, staff development, and research.* South Africa: Van Schaik.

Joyner, B. (2018). Does Family Presence in the Trauma Bay Help or Hinder Care? *AMA Journal of Ethics*, *20*(5), 507–512. https://doi.org/10.1001/journalofethics.2018.20.5.sect1-1805

Kemppainen, V., Tossavainen, K., & Turunen, H. (2012). Nurses' roles in health promotion practice: an integrative review. *Health Promotion International*, *28*(4), 490–501. https://doi.org/10.1093/heapro/das034

Kisting, D. (2011). Families plan to sue hospital. *The Namibian Newspaper*.

Koloroutis, M. (2004). *Relationship-Based Care: A Model for Transforming Practice*. Creative Health Care Management.

Kosowan, S., & Jensen, L. (2011). Family presence during cardiopulmonary resuscitation: cardiac health care professionals' perspectives. *Canadian journal of cardiovascular nursing = Journal canadien en soins infirmiers cardio-vasculaires*, *21*(3), 23–29

le May, A., & Holmes, S. (2012). *Introduction To Nursing Research*. Routledge. https://doi.org/10.1201/b13215

Leary, M. R. (2012). *Introduction to behavioural research methods*. Pearson.

Literary Devices. (2021). Point of view - examples and definition of point of view. *Literary Devices*. https://literarydevices.net/point-of-view/

LoBiondo-Wood, G., & Haber, J. (2014). *Nursing research: Methods and critical appraisal for evidence-based practice* (8th ed.). Elsevier

Loghmani, L., Borhani, F., & Abbaszadeh, A. (2014). Factors affecting the nurse-patients' family communication in intensive care unit of kerman: a qualitative study. *Journal of Caring Sciences*, *3*(1), 67–82. https://doi.org/10.5681/jcs.2014.008

Lor, P. J. (2019). Preparing for research: metatheoretical considerations. In *International and Comparative Librarianship* (pp. 163-229).

Margavi, M. K., Bagheri-Nesami, M., Mousavinasab, N., & Lolaty, H. A. (2020). Frequency of violence against nurses and its related factors during cardiopulmonary resuscitation in emergency wards. *Journal of Nursing and Midwifery Sciences*, *7*(4), 262. https://doi.org/10.4103/jnms.jnms_59_19

McLean, J., Gill, F. J., & Shields, L. (2016). Family presence during resuscitation in a paediatric hospital: health professionals' confidence and perceptions. *Journal of Clinical Nursing*, *25*(7–8), 1045–1052. https://doi.org/10.1111/jocn.13176

Ministry of Health and Social Services (MOHSS). (2016). *Patient Charter of Namibia*: http://www.mhss.gov.na/documents/119527/120639/PatientCharter.pdf/e4a6d336-de3d-40ce-b886-c23d5abc8e2c

Mohammed, A. A., M, R. J. A., & Saad, A. R. (2019). Critical Care Nurses' Perspectives towards Family Presence during Resuscitation. *Journal of Medicine and Healthcare*, 1–29. https://doi.org/10.47363/jmhc/2019(1)101

Molina-Mula, J., & Gallo-Estrada, J. (2020). Impact of Nurse-Patient Relationship on Quality of Care and Patient Autonomy in Decision-Making. *International Journal of Environmental Research and Public Health, 17*(3), E835. Advance online publication. https://doi.org/10.3390/ijerph17030835 PMID:32013108

Morgan, D. L. (2014). *Integrating qualitative and quantitative methods: A pragmatic approach.* Sage Publications: California.

Morton, H. (2021). *Medical Liability/Malpractice ADR and Screening Panels Statutes*. Www.ncsl.org. https://www.ncsl.org/research/financial-services-and-commerce/medical-liability-malpractice-adr-and-screening-panels-statutes.aspx

Motsepe, T. L. (2016*). Nurses' Experience and Attitudes towards family witnessed resuscitation in accident and emergency units in two South African Hospitals.* http://wiredspace.wits.ac.za/handle/10539/19490

Mutabazi-Mwesigire, D. (2014, April 10). *Perceptions of quality of life among Ugandan patients living with HIV: a qualitative study - BMC Public Health*. BioMed Central. https://bmcpublichealth.biomedcentral.com/articles/10.1186/1471-2458-14-343

Mutair, A. A. (2017). Should Family be Allowed during Resuscitation. *Resuscitation Aspects*. https://doi.org/10.5772/intechopen.70189

MVA Fund Road Crash & Claims Report. (2020). The Motor Vehicle Accident Fund. http://www.mvafund.com.na/

OakBend. (2020). *Types of emergencies*. OakBend Medical Center. https://www.oakbendmedcenter.org/types-of-emergencies/.

Oczkowski, S. J., Mazzetti, I., Cupido, C., & Fox-Robichaud, A. E. (2015). Family Presence during Resuscitation: A Canadian Critical Care Society Position Paper. *Canadian Respiratory Journal*, *22*(4), 201–205. https://doi.org/10.1155/2015/532721

Omoding, T. (2011). *Perceptions of nurses and family relatives towards family witnessed resuscitation in critical care units of Kenyatta National Hospital and Aga Khan University Hospital*. Retrieved May 30, 2020, from http://erepository.uonbi.ac.ke/bitstream/handle/11295/3780/Omonding_perception%20of%20nurses.pdf;sequence=1

Polit, D. F., & Beck, C. T. (2012). *Nursing research: generating and assessing evidence for nursing practice* (9th ed.). Lippincott, Williams & Wilkins.

Polit, D. F., & Beck, C. T. (2015). *Nursing Research: Generating and Assessing Evidence for Nursing Practice*. LWW.

Porter, J. E., Cooper, S. J., & Sellick, K. (2014). Family presence during resuscitation (FPDR): Perceived benefits, barriers and enablers to implementation and practice. *International emergency nursing*, 22(2), 69-74.

Powers, K., & Reeve, C. L. (2020). Original Research: Family Presence During Resuscitation: Medical–Surgical Nurses' Perceptions, Self-Confidence, and Use of

Invitations. AJN, *American Journal of Nursing*, 120(11), 28–38. https://doi.org/10.1097/01.naj.0000721244.16344.ee

Repko, A. F. (2012). *Interdisciplinary Research: Process and Theory* (Second), 23. Sage Publications: California.

Resuscitation Council UK (2016). Advanced Life Support, 7th edn. London: RCUK

Rodriguez, A. (2014). *What is the theme of a research paper?* Retrieved May 16, 2014 from: http://www.ehow.com/facts_7612831_theme-research-paper.html

Salomo, S. (2016). *Experiences of men diagnosed with prostate cancer in the four northern regions*. University of Namibia Repository. https://repository.unam.edu.na/handle/11070/1958.

Shikalepo, E. E. (2021a). *Research Proposal: Planning and Design*. Windhoek: Sta Creations

Shikalepo, N. F. (2021b). *Knowledge, attitude and practices of nurses regarding early detection, caring and support of men with prostate cancer at health facilities in Windhoek.* University of Namibia.

Sibinga, S. C. T. (2018). *Ensuring Research Integrity and Ethical Management of Data.* IGI Publishers.

Sloane, P. D., Slatt, L. M., Ebell, M. H., MD, Smith, M. A., MD, & Power, D., V. (2011). *Essentials of Family Medicine.* (6th ed.). Lippincott Williams & Wilkins.

Sumpi, N. (2015). *A psychosocial educational programme to facilitate the reintegration of incarcerated women who had dumped babies and / or committed infanticide in Namibia.* http://hdl.handle.net/11070/1702

Tashakkori, A., & Teddlie, C. (2020). *Foundations of mixed methods research: Integrating quantitative and qualitative approaches in the social and behavioural sciences*. Sage Publications: California.

Tennyson, C. (2019). Abstract 385: Family Presence During Resuscitation: A Needs Assessment. *Circulation*, *140*(Suppl_2). https://doi.org/10.1161/circ.140.suppl_2.385

The Merriam-Webster. (n.d.-b). Liability. *Merriam-Webster*. Retrieved September 25, 2021, from https://www.merriam-webster.com/dictionary/liability

The Merriam-Webster.com Dictionary. (n.d.-a). Risk. In *The Merriam-Webster.com Dictionary*. Retrieved October 24, 2022, from https://www.merriam-webster.com/dictionary/risk

The Merriam-Webster.com Dictionary. (n.d.-c). *Understanding*. Retrieved October 24, 2022, from https://www.merriam-webster.com/dictionary/understanding

Tudor, K., Berger, J., Polivka, B. J., Chlebowy, R., & Thomas, B. (2014). Nurses' perceptions of family presence during resuscitation. *American Journal of Critical Care*, 23(6), e88-e96.

Twibell, R., Siela, D., Riwitis, C., Neal, A., & Waters, N. (2018). A qualitative study of factors in nurses' and physicians' decision-making related to family presence during resuscitation. *Journal of clinical nursing*, 27(1-2), e320-e334.

Urasa M & Darj E. (2011). Knowledge of cervical cancer and screening practices of nurses at a regional hospital. *Tanzania African health sciences*; 11(1): 48-57. Tanzania

Vincent, C., & Lederman, Z. (2017). Family presence during resuscitation: extending ethical norms from paediatrics to adults. *Journal of Medical Ethics, 43*(10), 676–678. https://doi.org/10.1136/medethics-2016-103881

Waldemar, A., & Thylen, I. (2018). *Attitudes and experiences of Family Presence During Resuscitation (FPDR) among Swedish nurses and physicians in cardiac care units. Resuscitation*, 130, e63. https://doi.org/10.1016/j.resuscitation.2018.07.122

Ward, A. (2011). *Nurses' views of family presence at the bedside during resuscitation* https://pdfs.semanticscholar.org/1d4b/0e0a0a802d2373b7ad4c8520fc5c7237ddf4.pdf

Wirthwein, L. (2011). *Nurses' perceptions of family presence during resuscitation a research paper submitted to the graduate school* - https://careersdocbox.com/75400640-Nursing/Nurses-perceptions-of-family-presence-during-resuscitation-a-research-paper-submitted-to-the-graduate-school.html

Yousif, A., & Mohammad, A. (2019). Resuscitation procedures in emergency setting. *Essentials of Accident and Emergency Medicine.* https://doi.org/10.5772/intechopen.76165

Zhu, X., Zheng, J., Liu, K., & You, L. (2019). Rationing of Nursing Care and Its Relationship with Nurse Staffing and Patient Outcomes: The Mediation Effect Tested by Structural Equation Modeling. *International Journal of Environmental Research and Public Health*, *16*(10), 1672. https://doi.org/10.3390/ijerph16101672

ANNEXURES

ANNEXURE A: ETHICAL CLEARANCE CERTIFICATE FROM UNAM

UNAM
UNIVERSITY OF NAMIBIA

ETHICAL CLEARANCE CERTIFICATE

Ethical Clearance Reference Number: SON /597/2020 **Date: 16 December, 2020**

This Ethical Clearance Certificate is issued by the University of Namibia Research Ethics Committee (UREC) in accordance with the University of Namibia's Research Ethics Policy and Guidelines. Ethical approval is given in respect of undertakings contained in the Research Project outlined below. This Certificate is issued on the recommendations of the ethical evaluation done by the Faculty/Centre/Campus Research & Publications Committee sitting with the Postgraduate Studies Committee.

Title of Project: Views Of Nurses Working In The Emergency And Intensive Care Units Regarding Family Presence During Emergency Procedures At The State And Private Hospitals In Walvis Bay, Erongo Region, Namibia

Researcher: BENJAMIN SEBULON KLAAS MANETTI

Student Number: (200953729)

Supervisor: *Dr. H. J. Amukugo*

Campus: School of Nursing

Take note of the following:

(a) Any significant changes in the conditions or undertakings outlined in the approved Proposal must be communicated to the HREC. An application to make amendments may be necessary.
(b) Any breaches of ethical undertakings or practices that have an impact on ethical conduct of the research must be reported to the HREC.
(c) The Principal Researcher must report issues of ethical compliance to the UREC (through the Chairperson of the Faculty/Centre/Campus Research & Publications Committee) at the end of the Project or as may be requested by HREC.
(d) The HREC retains the right to:

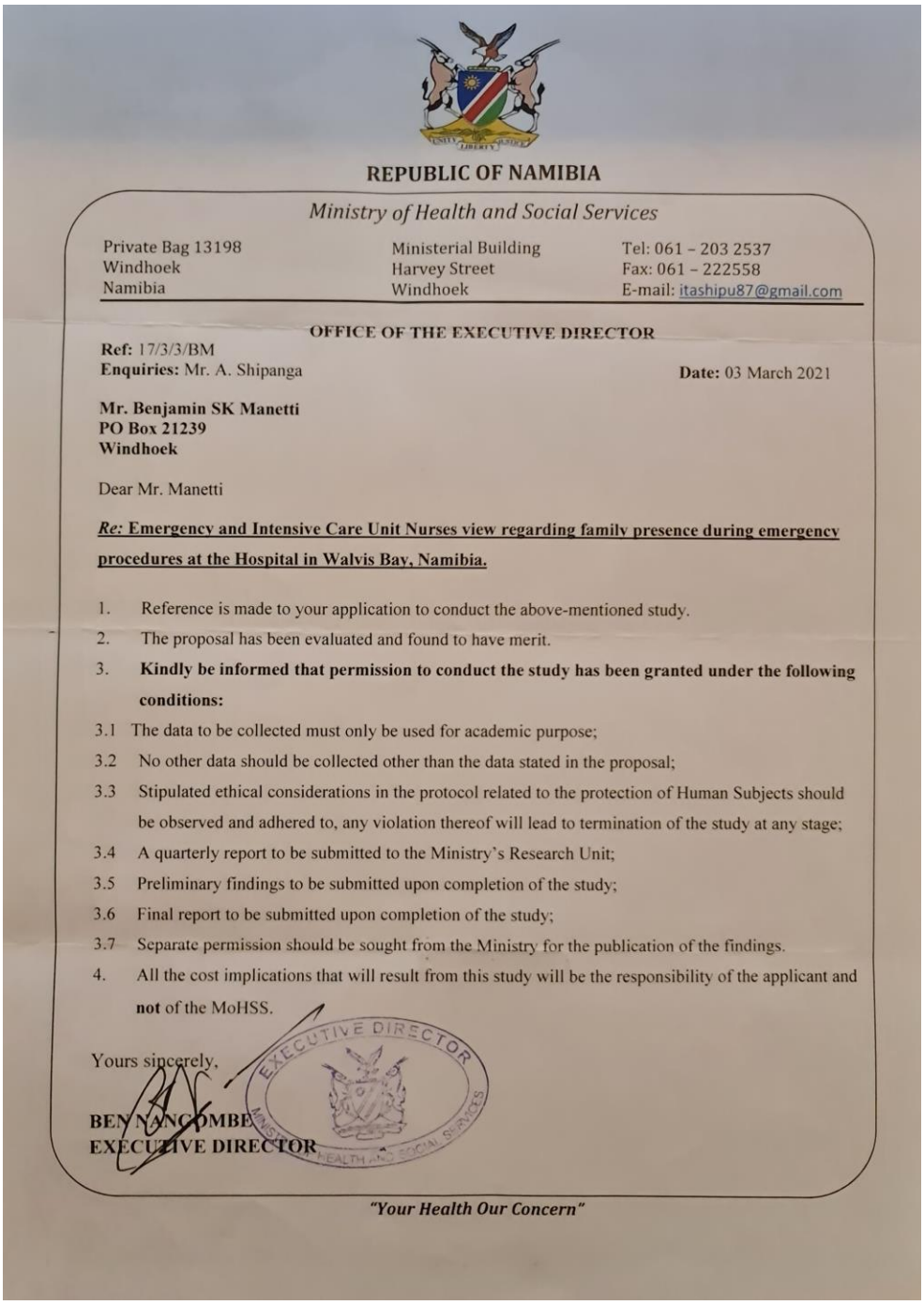
(i) Withdraw or amend this Ethical Clearance if any unethical practices (as outlined in the Research Ethics Policy) have been detected or suspected,
(ii) Request for an ethical compliance report at any point during the course of the research;
(iii) Cognizance and the observation of Namibia's Research Science and Technology Act, 2004 which makes it compulsory for Non-Namibian based researchers to obtain the compulsory Research Permit from the National Commission on Research Science and Technology (NCRST), FIRST, BEFORE the research can commence.

HREC wishes you the best in your research.

Dr. J.E. de Villiers HREC Chairperson

Ms. P. Claassen: HREC Secretary

ANNEXURE B: PERMISSION LETTER TO CONDUCT A STUDY FROM MoHSS



REPUBLIC OF NAMIBIA

Ministry of Health and Social Services

Private Bag 13198
Windhoek
Namibia

Ministerial Building
Harvey Street
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Tel: 061 – 203 2537
Fax: 061 – 222558
E-mail: itashipu87@gmail.com

OFFICE OF THE EXECUTIVE DIRECTOR

Ref: 17/3/3/BM
Enquiries: Mr. A. Shipanga

Date: 03 March 2021

Mr. Benjamin SK Manetti
PO Box 21239
Windhoek

Dear Mr. Manetti

***Re:* Emergency and Intensive Care Unit Nurses view regarding family presence during emergency procedures at the Hospital in Walvis Bay, Namibia.**

1. Reference is made to your application to conduct the above-mentioned study.
2. The proposal has been evaluated and found to have merit.
3. **Kindly be informed that permission to conduct the study has been granted under the following conditions:**

3.1 The data to be collected must only be used for academic purpose;
3.2 No other data should be collected other than the data stated in the proposal;
3.3 Stipulated ethical considerations in the protocol related to the protection of Human Subjects should be observed and adhered to, any violation thereof will lead to termination of the study at any stage;
3.4 A quarterly report to be submitted to the Ministry's Research Unit;
3.5 Preliminary findings to be submitted upon completion of the study;
3.6 Final report to be submitted upon completion of the study;
3.7 Separate permission should be sought from the Ministry for the publication of the findings.

4. All the cost implications that will result from this study will be the responsibility of the applicant and **not** of the MoHSS.

Yours sincerely,

BEN NANGOMBE
EXECUTIVE DIRECTOR

EXECUTIVE DIRECTOR
MINISTRY OF HEALTH AND SOCIAL SERVICES

"Your Health Our Concern"

ANNEXURE C: INFORMED CONSENT FORM FOR PARTICIPANTS

INFORMED CONSENT TO PARTICIPANT

VIEWS OF EMERGENCY AND INTENSIVE CARE UNIT NURSES REGARDING FAMILY PRESENCE DURING EMERGENCY PROCEDURES AT THE HOSPITALS IN WALVIS BAY, ERONGO REGION, NAMIBIA

Researcher: Benjamin Sebulon Klaas Manetti

Dear participant

I am Benjamin Sebulon Klaas Manetti, registered with the University of Namibia, doing the degree Masters in Nursing Science. I wish to conduct a research project with the title above. The study will be conducted under the supervision and guidance of Dr H. Amukugo in the School of Nursing and Health Sciences University of Namibia. This study aims to explore and describe the views of Emergency and Intensive care unit nurses regarding family presence during emergency procedures at the hospitals in Walvis Bay, Namibia.

Your participation will provide information that may drive policy change and increase knowledge in this regard. Participation in this study will take approximately 1-2 hours. The procedure is as follows. You will be a participant in a face to face semi-structured interview with the researcher. You will be responding to question that I will pose to you. You are also welcome to ask for clarifications or pose questions during the interview if the question is not clear. Your participation in this study is entirely voluntary and you have the right to withdraw at any time should you feel so.

The study data will be coded; no names will be used during this study. Your identity will remain anonymous during the study or when published with permission from the Ministry of Health Social Services to improve the quality of care. The researcher and the supervisor are the only people who will have access to the data collected. You are among the study population selected for this study. Should you agree to participate, please sign your consent with full knowledge of the nature and purpose of the study.

If you have any concerns or questions regarding the research, please feel free to contact Benjamin Sebulon Klaas Manetti at 0812599917 or email at bskmanetti@gmail.com. The main supervisor Dr Amukugo at 061-2064617 or email hamukugo@unam.na

You may withdraw your consent at any time and discontinue participation without any penalty. You are not waiving any legal claims or rights because of your participation in this study. Thank you for your participation.

I……
……

Agree to participate in this research project on my own will

Signed at…….

…… ……..

Participant signature Date

ANNEXURE D: AN INTERVIEW GUIDE

SEMI STRUCTURED INTERVIEW GUIDE FOR NURSES

VIEWS OF EMERGENCY AND INTENSIVE CARE UNIT NURSES REGARDING FAMILY PRESENCE DURING EMERGENCY PROCEDURES AT THE HOSPITALS IN WALVIS BAY, ERONGO REGION, NAMIBIA

Date:

Time:

Interview number:

Researcher: Benjamin S.K. Manetti

Institution: University of Namibia

The following are questions that will be used in the semi structured face to face interview for nurses, this form will also include field notes that will be written by the researcher. The interview with the participants will be recorded using an electronic tape recorder after the introduction of the researcher and gaining consent for conducting the interview. The interview forms part of the study: Emergency and Intensive care unit nurses' views regarding family presence during emergency procedures at the hospitals in Walvis Bay, Namibia.

SECTION A: DEMOGRAPHIC DATA

1. Socio-Demographic data

1.1 Age

1.2 Gender

1.3 Ethnicity

1.4 Religion: If Christian, specify which denomination

1.5 Nursing education, i.e. certificate, diploma or degree

1.6 Any specializations

1.6 Your nurse designation

1.7 Current unit or ward worked

1.8 Years of experience

SECTION B: SEMI-STRUCTURED INTERVIEW GUIDE

- Have you ever worked in a situation where a family member was present during an emergency procedure?
- What were your experiences regarding family members being present during emergency procedures?
- What are your views on the presence of family members when you are performing emergency procedures?
- How has your performance been affected by family members being present during emergency procedure?
- How comfortable or uncomfortable would you feel with family presence during an emergency procedures?
- `What policy, procedure or guideline have you come across in the workplace regarding family presence during emergency procedure?
- If you are aware of guidelines that are documented regarding family presence what training have you received towards implementing the guidelines?
- How do patient's relatives during emergency procedures expose caregivers to greater or lesser risk to litigation?
- How have you managed the request of a family member that would like to be present during an emergency procedure?

Thank you for your participation!

ANNEXURE E: TRANSCRIPTION OF AN INTERVIEW

INTERVIEW NO 1

Place: Private Hospital in Walvis Bay

Date: 04/06/2021

Time: 12H00 – 12H18 Duration: 18:01 Minutes

SECTION A: DEMOGRAPHIC DATA

1.1 Age: 52

1.2 Gender: Female

1.3 Ethnicity Oshiwambo (Black)

1.4. Religion: Roman Catholic (Christian)

1.5 Nursing Education: Diploma in Comprehensive Nursing Science

1.6 Any specialisations: Stoma Therapist

1.7. Registered Nurse (ER)

1.8. Outpatient Department and Emergency Centre

1.9. Years of Experience: 30 Years

SPEAKERS

Nurse Participant, Researcher

Researcher: Good morning Sister. My name is Benjamin Manetti, a student from the University of Namibia. I am doing a research study on the views of emergency and intensive care unit nurses regarding family presence during emergency procedures at hospitals in Walvis Bay, Namibia. Your participation will allow me to conduct the study and will enable me to collect and analyse necessary data that will enable me to make recommendations that may help in the development of family presence during emergency procedures that could benefit the health fraternity and the community. I would therefore like you to grant me the permission to interview you for the study. Rest assured that your identity will be confidential and anonymous during the presentation of the findings of this study. Do you consent to the interview?

Nurse Participant: Yes

Researcher: Have you agreed to the interview?

Nurse Participant: Yes

Researcher: Okay, I'm going to start with the first question. Have you ever worked in a situation where a family member was present during an emergency procedure?

Nurse Participant: Yes

Nurse Participant: We had a case where the father had a myocardial infarction at the time. So his daughter brought him in, she came in with an entourage. The Ambulance drivers and

everything. So as we were resuscitating she was like, on us, she's feels that we are not doing enough. Sister, why can't you do this, why don't to move him like this, why don't you turn him like this, she was interfering in the whole process while we were busy. So at the end of the day, we have to move her out so that we can do our work.

Researcher: What were your experiences regarding family member being present during emergency?

Nurse Participant: Yeah, her reaction was like, why do you want to push me away? I want to say goodbye to my father, you know, all those type of things. You know, and at the end of the day, I feel that is very traumatic for her to see that her father dying. And with the nurses, they're trying to do what they can, she will sit there with guilt, sometimes we feel guilty and say that, oh, if the nurses only could have done this for you, maybe if I could have brought my father earlier on this wouldn't have happened .No, they didn't do enough. If they only maybe could have given oxygen or they could have turned him the way that I wanted him to turn so he could have lived. So all those things. So that's why I personally feel that family members should not be present. And at the end of the day, they will feel that okay with their layman's knowledge that they have, they will think that no, maybe they could have done this, whatever they wanted us to do. It was not done. And then they will end up injuring the people doing CPR, No, you didn't do enough or try to fight you know, all those funny things happen always.

Researcher: What are your views on presence of family members when you are performing emergency procedures?

Nurse Participant: Let's start with the like husband and wife. Okay, maybe the husband is the one sick. And now it's not really that is, is a is an emergency. But when the husband is in the cubicle, you start with the history taking, instead of the husband giving his view of how he feels and everything. The wife is the one who's giving the history. And it's really disturbing because I want to hear from the horse's mouth. How do you feel? But then we end up with the wife answering. It's very disturbing. You don't get the history that you want. You get the history of what the wife wants you to hear. So, and in cases where there is maybe like a psychiatric patient or a child under the age of 18, I won't really meant to have a care giver to be there to give me the history. And in the case of sometimes, the working mothers, I would rather have the caregiver to be present to give me the history, because she's the one staying with the child for many hours, eight hours while the mother's at work, She's the one knowing the whole history of the child, most of the time that the parents don't know, what is going on with their kids.

Researcher: And in the case of you said, in the case of children under 18, what if there is an emergency situation. Emergency situations such as respiratory distress, dehydration, severe diarrhoea?

Nurse Participant:

Emergency situation in a minor, I would love the parents to be there, I would want the parents to be there, just to give that child that emotional support. It's very important, because let's say, for instance, you're having a child with a respiratory distress, not the mother is not there, and this child is just seeing these new faces that you don't know. And then there's getting more anxious and then the asthma gets worse, whatever the condition the child has. So it's

always better for the parents to be there just to hold on to the child and to give that affirmation that no it will be okay the Sisters will take care of you. You know, whenever the parent are there children are more at ease. And they cooperate even much better.

Researcher: So what you are saying is that in the case of family members during emergency procedures, you prefer relatives to be present with minors than with adults?

Nurse Participant: Yes,

Nurse Participant: We'll talk about the elderly. Above 70 or 80. Yeah. Those ones also you will need the caregiver to be there. An adult critical patient, I would rather not have family members even if it is a small child, I won't not have family members there. But if it is for cases, like putting up a drip, giving inhalations, the family members can be a mother or a father can be one parent can be there. Yeah.

Researcher: Okay. In the case of asthmatic patient in respiratory distress, or babies with a fracture, those types of emergencies, and they request for family members, how do you handle things? If they ask for relatives to the present?

Nurse Participant: I think if I did not really think it is necessary for the family member to be there, because they are just a distraction. If the patient asks then you tell them No. Because it's hospital policy. I don't know. Apart from them being a distraction, they will say you are doing things the wrong way. The emergency room is also small. There is not enough space for all of us with their family members. They want to see the faults that you're committing or something that they don't know what's going on.

Researcher: So you've mentioned the policy, what policies, procedures or guidelines have you come across in the workplace regarding family presence during emergency procedures,

Nurse Participant: Currently we don't have policies. We don't have a policy in place at the hospital.

Researcher: So who is who is made that decision?

Nurse Participant: It is the nurse's discretion.

Researcher: How is your performance been affected by family members being present during emergency procedures?

Nurse Participant: My performance? It has not done anything. Really. It's just that they are distracting. But it doesn't really influence my performance, I perform the way I should.

Researcher: So the distraction doesn't affect your performance.

Nurse Participant: Not really, it does not distract my performance. It irritates me. The fact that I'm irritated, it doesn't influence my performance, I will perform the way I have to.

Researcher: Okay. And how comfortable or uncomfortable would you feel with family presence during an emergency procedure?

Nurse Participant: Clearly feel very uncomfortable.

Researcher: Could you tell me more?

Nurse Participant: Distraction, them talking in between and then feeling that you are not doing enough? And then, you know, and then trying to tell you what to do. When the doctors come the first things that the doctors do, they will ask family members to leave,

Researcher: If you are aware of guidelines that are documented regarding family presence, what training have you received towards implementing these guidelines, I understand you earlier mentioned that there are no policies or procedures or guidelines.

Nurse Participant: There was no training.

Researcher: Okay, how does patients relatives during emergency procedures expose caregivers wants to greater or lesser risk of litigation?

Nurse Participant: I think it increases it. Because family members can come up with lies.

Researcher: Could you tell me more?

Nurse Participant: I'm just saying I haven't come across it. But you know the way they come up with and makeup things. You know that they can make up anything, I haven't come across but the way, they will just like when they go tell the story, Yeah, she didn't even give oxygen she didn't do this and that, they will come up with lies.

Researcher: So you don't think that will increase the risk of litigation?

Nurse Participant: Will they never say we tried our best I don't think so.

Researcher: How have you managed the request of a family member that would like to be present during a procedure?

Nurse Participant: I haven't come across one yet. But if a family member requested, I don't think that I will turn it down. I will explain to the family member that this is what's going to happen. This, you know, this is now a critical situation it's life and death. So he might survive or he might not. But if the family member requests I will maybe ask the doctor present and the other nurses, and the hospital authority whether we came to allow because it can be very, very traumatic for this relative. They can have post-traumatic stress or whatever. So and then after proper consultation with a family member, we can allow the family member to be present.

Researcher: so you are open to the possibility of it?

Nurse Participant: Yes.

Researcher: If there was an option such a policy?

Nurse Participant: I am Yes, But I must first explain what's going to happen, telling the truth, you relative might not make it and this thing can be you know, when we do compressions, it can be traumatic, all those things were said so, the family member present should know what to expect, It’s not what you see, in the movies. This can be hard, this is a real-life situation. Yeah. And maybe we have to end up putting up the trachy.

Researcher: Thank you very much. We'll come to the end of the interview.

ANNEXURE F: EDITOR'S CERTIFICATE

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CERTIFICATE

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This is to certify that I have edited this document for English style, language usage, logic and consistency; it is the responsibility of the author to manually accept or reject the suggested changes and interact with the comments in order to finalise the text. The references are to be finalised by the client

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