



***"What happens behind the
curtains?"***

**An exploration of ICU nurses'
experiences of post mortem care.**

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DSWCAR001

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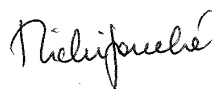
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Definition of Terms

Convenience Sampling

A non-probability sampling procedure that involves the selection of the most readily available people (Brink, van der Walt & van Rensburg, 2012).

Corpse

The body of a dead human (Anderson, Anderson & Glanze, 1994).

Death

Cessation of life (Anderson, Anderson & Glanze, 1994).

End-of-Life Care

Multidimensional and multidisciplinary physical, emotional and spiritual care of the patient with terminal illness, including support of family and caregivers (Anderson, Anderson & Glanze, 1994).

Epistemology

The theory of knowledge concerned with the ways in which human beings know the world (Holloway & Wheeler, 2010)

Generalisability

The extent to which findings of the study can be applied to other events, settings or groups in the population (Holloway & Wheeler, 2010)

Heterogeneity

The degree to which objects are dissimilar on some attribute (Polit & Beck, 2012).

Intensive Care Unit (ICU)

A hospital unit in which patients require close monitoring and specialised nursing. Also known as a Coronary Care Unit (Anderson, Anderson & Glanze, 1994).

Last offices

The laying out and preparation of a dead body for the mortuary or funeral home (Green & Green, 2006). Also known as last rites.

Last rites

A tradition where nurses prepare the dead patient for the undertaker, also known as last offices (Pattison, 2008b).

Methodology

The framework of theories and principles on which methods and procedures are based (Holloway & Wheeler, 2010).

Mortis

The death

Algor – The reduction in body temperature and accompanying loss of skin elasticity that occur after death (Anderson, Anderson & Glanze, 1994:57).

Livor – A purple discoloration of skin in some dependant body areas following death as a result of blood cell destruction (Anderson, Anderson & Glanze, 1994:921).

Rigor – the rigid stiffing of skeletal and cardiac muscle shortly after death (Anderson, Anderson & Glanze, 1994:1376).

Ontology

A branch of philosophy concerning the nature of being. Related to assumptions about the nature of reality (Holloway & Wheeler, 2010).

Phenomenon

The central concept to be researched (Holloway & Wheeler, 2010).

Post mortem care

After death care (Hawker & Waite, 2007).

For this study the researcher has chosen not to use a hyphen in the word post mortem care, as all the literature consulted is consistent with this.

Pseudonym

Fictitious names given to informants to protect their anonymity (Holloway & Wheeler, 2010).

Purposive (or purposeful) sample

Judgemental sample of individuals chosen by certain pre-determined criteria relevant to the research question (Holloway & Wheeler, 2010).

Rigor (Rigour)

Striving for excellence in research through the use of discipline, meticulous adherence to detail and strict accuracy (Grove, Burns & Gray, 2012)

Saturation

A state where no new data of importance to the specific study and developing theory emerge and when the elements of all categories are accounted for (Holloway & Wheeler, 2010).

Semi-structured interviews

An interview in which the researcher has a list of topics to cover rather than a specific series of questions to ask (Polit & Beck, 2012).

Shroud

Cover, cloak, mantle, blanket, layer or veil (Hawker & Waite, 2007).

Thanatology

The study of death and dying (Anderson, Anderson & Glanze, 1994:1543).

Thick description

Dense, detailed and conceptual description which gives a picture of events and actions within the social context (Holloway & Wheeler, 2010).

Triangulation

The use of multiple methods or perspectives to collect and interpret data about a particular phenomenon (Brink, van der Walt & van Rensburg, 2012).

Abstract

"What happens behind the curtains?"

An exploration of ICU nurses' experiences of
post mortem care.

The Aim of the Study

The aim of this study was to explore the experiences of ICU nurses performing post mortem care in an intensive care unit at a private hospital in Cape Town. In addition, the study set out to identify educational needs and to offer recommendations that may address these needs for this sample of ICU nurses.

Background to the Study

Post mortem care (care after the death of a human being) is still viewed by contemporary society as a taboo and clandestine aspect of life and is more often avoided both in conversation, writing and thinking.

In many hospitals and other healthcare facilities, post mortem care is performed behind closed doors, in which an aura of mystery is created as to what happens to the dead body in this scenario.

The nurses' experience of post mortem care differs from that of other occupational groups (ambulance officers, medical practitioners and police) as the nurse sees the body before and after death and has an established relationship with the person who has died.

The practical procedure of post mortem care is widely explored by many authors using various procedural guidelines and/or manuals. However, little is known about the nurse's experiences of post mortem care.

Methodology

A qualitative research design using a descriptive method was used to explore the experiences of a purposive heterogeneous sample of six ICU nurses who were working in an ICU of a private hospital in Cape Town.

Data Collection and Analysis

A semi-structured interview which was audio-taped and transcribed verbatim was employed to collect data. Colaizzi's (1978) seven step inductive method was used to formulate naïve themes. Following participant feedback, three main themes emerged: (i) *care of the dead body*; *detachment* and (iii) *thanatophobia*.

Findings

Safeguarding the integrity and physical appearance of the dead body was the major finding and of the utmost priority for the participants in this study. Regardless of how the ICU nurses felt about death, providing professional and quality care to the dead body and the family was seen as significantly important.

The ICU nurses, whilst performing post mortem care, experienced detachment from various relationships. This comprised of the ICU nurse detaching him/herself professionally and emotionally from the dead patient, the family and him/herself from the death experience.

This 'unspoken' experience of thanatophobia became apparent when the ICU nurses were confronted by the reality of their own deaths.

Conclusion and Recommendations

These three themes were discussed in relation to the available literature and recommendations put forward for education and nursing practice and further research.

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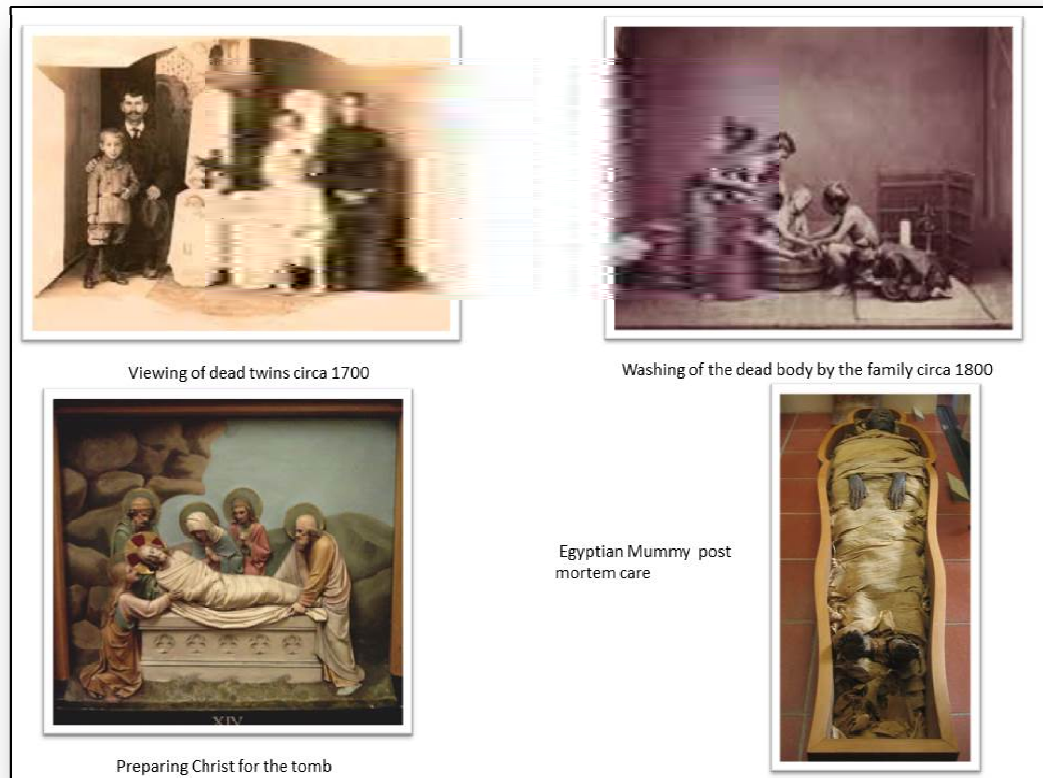
**This dissertation is dedicated to all the ICU nurses at UCT Private
Academic Hospital**

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Chapter One Introduction



1.1. Background to the Study

Contemporary society views most aspects of death to be clandestine and regard talking about death as taboo or forbidden (Lawler, 1991). In many hospitals and other healthcare facilities, post mortem care is performed behind closed doors, in which an aura of mystery is created as to what happens to the dead body in the presence of others.

The frequent occurrence and the emotional impact of patient death in the Intensive Care Unit (ICU) sparked my interest into the experiences of ICU nurses performing post mortem care.

Having explored the literature on this topic, an unanswered question arose: ***"Are ICU nurses prepared to perform post mortem care of patients who have died from various causes?"***

1.1.1. Death and the Meaning of Death

Castles and Murray (1979:22) perceive as 'the end of life, or the beginning of eternal life, furthermore, final separation from loved ones' or a lasting reunion; the attainment by man of ultimate harmony with nature or the defeat of man by nature.' The ICU nurse is faced daily with these conflicting views as they care for patients. The ICU nurse remains aware of death as the 'last developmental stage, a goal, a fulfilment' but in conflict with the goal of keeping the patient alive (Castles & Murray. 1979:23).

Castles and Murray (1979) acknowledge and describe that the felt impact of death by nurses may occur 'more than once, in more than one role and with different intensities.' Castles and Murray (1979:23) emphasise the importance individuals working in healthcare institutions, processing the meaning of death 'both as individuals who will die and as members of the health-care discipline with the responsibility of caring for the sick until they die.' The mere thought of death proves to be challenging for the ICU nurse.

1.1.2. Historical Overview of Post Mortem Care

Wolf examined historical nursing literature to determine the patterns of nursing care administered to dying and dead patients from the year 1890 to 1906. Wolf (1991:86) noted the nurse's close contact and familiarity with death. The literature highlighted 'the nurse is the first person generally to know that the patient is really dead' (Wolf, 1991:86). Wolf (1991:87) noted that nurses 'saw death frequently.' One of the nurse's in Wolf's study commented; 'Death, too, comes as a daily guest, unwelcomed and dreaded by most until he stands at the very door, when in my experience, he is not feared at all' (Wolf, 1991:86).

The nurse was the first to know that the patient has demised, as the signs of death were common knowledge to nurses. In early literature it is evident that the nurse was often responsible to notify the medical practitioner of the patient's death and preparing the patient's body for burial by performing post mortem care. The cleansing of the body by

nurses was accepted practice, even during natural disasters when 'strangers, professional nurses, and others bathed dead bodies before burial' (Wolf, 1991:87). In traditional practice ministers, priests and nuns also prepared bodies for burial.

The nurse who initiated post mortem care in 1890 was cautioned to 'avoid delays,' as the work was 'far easier if done at once' (Wolf, 1991:88). Wolf (1991:88) provided evidence from the literature that it may have been usual for nurses to be called from their 'usual routine of the ward work' to lay out a woman for the undertakers' in the patient's home. Historically, cleanliness of the dead body was expected by the undertaker and the nurse was the person to 'guarantee' this (Wolf, 1991:88).

Wolf also describes nurses' attitudes towards death. Evidence was given that preparing the patient's body after death was experienced as 'difficult' for nurses (Wolf, 1991:91).

1.1.3. The Term Post Mortem Care

Wolf, (1991) explains that post mortem care was historically conducted in private houses. Post mortem care was the common phrase used for autopsy. The nurse's role was to prepare the dead patient for autopsy and also care for the dead patient after the autopsy. This involved dressing the incisions made by the medical practitioner during the autopsy. The word post mortem care evolved from this practice where nurses cared for the dead body on completion of autopsy.

Currently post mortem care refers to 'after-death services' or 'laying out the dead', that nurses perform for their dead patients (Wolf, 1991:90).

Wolf (1991) acknowledges that nurses continue to have intimate contact with their dead patients. They are witnesses and participants with patients and their families at 'the most private events of human experiences' (Wolf, 1991:92). Wolf (1991) concludes by commenting that nurses accept this trust and responsibility when performing post mortem care.

1.2. Research Problem

The nurses' experience of post mortem care differs from that of other occupational groups (ambulance officers, medical practitioners and police) as 'the nurse sees the body before and after death and in many cases has an established relationship with the person who has died' (Lawler, 1991:188). The transition from living to death is an event that happens at the bedside with the nurse in attendance (Quested & Rudge, 2002). The practical procedure of post mortem care is widely explored by many authors using various procedural guidelines and/or manuals. However, little is known about the nurse's experiences of post mortem care.

For the researcher, the ICU nurse is ideally placed to provide a better understanding of their experiences encountered whilst performing post mortem care. These experiences offer opportunities to address challenges that they may encounter whilst performing post mortem care in the ICU.

Month 2014	Total number of deaths UCTPAH	Total number of ICU deaths	Overall % of death occurrence in ICU
January	8	5	62
February	4	2	50
March	2	2	100
April	4	2	50
May	4	2	50
June	6	4	66
July	10	7	70
August	4	3	75
September	3	3	100
October	7	5	71
November	2	1	50
December	6	5	83
Total	60	41	69%

Table 1: ICU Death Statistics: January 2014 – December 2014, UCT Private Academic Hospital (UCTPAH)

1.3. Research Question

“Are ICU nurses prepared to perform post mortem care of patients who have died from various causes?”

The types of patient deaths may vary from being traumatic, disfiguring, unforeseen or even peaceful in both adults and children. In light of the ICU nurses’ experiences of such patient deaths, this may offer opportunities to attend to the educational and emotional needs that nurses’ face whilst performing post mortem care.

1.4. Purpose and Objectives of the Study

The aim of this study is to describe the experiences of ICU nurses performing post mortem care in an intensive care unit at a private hospital in Cape Town.

To achieve this aim the study intends to:

- Identify and describe nurses’ experiences of post mortem care.
- Explore the educational and emotional needs of the ICU nurses related to post mortem care.

The following chapter presents the literature that was reviewed in an attempt to answer the research question.

Chapter Two Literature Review

2. Introduction

The literature search was conducted in a systematic manner using the electronic database EBSCO consulting: CINAL, PsychINFO, Academic Search Premier, Scopus and MEDLINE. Specific inclusion and exclusion criteria were used to conduct the literature search focussed on intensive or critical care nursing. Only relevant English language text was consulted that is peer reviewed. The literature consulted was dated from November 1986 to 14 April 2012.

The literature review about the topic of post mortem care is exceedingly limited. Having reviewed the literature using the keywords: '*care of the dead, post mortem care, last offices, care of the deceased, last rites, last respects,*' only ten studies were identified. These will be discussed in chronological order.

2.1. Post Mortem Care

The original work of Wolf describes the performance of post mortem care as 'carrying out' specific procedures for example washing of the patient and covering the body after death (Wolf, 1986:33). Wolf also reminds nurses of the moral and ethical dimensions of their work and emphasises 'the value of death with dignity' as a central value to health care services and providers (Wolf, 1986:34).

Later in 1991, Wolf conducted a study in Philadelphia, using a descriptive phenomenological approach to explore nurses' experiences of performing post mortem care to patients who had donated organs (Wolf, 1991:73). This study consisted of nurses from the operating room, organ procurement agency and intensive care, who were interviewed using a semi-structured guide. Wolf highlights that the nurse views post mortem care as an opportunity to achieve 'closure' with the patient and to share

with the family and others the 'common need to respect the mortal remains of a human being' (Wolf, 1991:74).

Wolf states further and describes the nurses' perception of post mortem care as providing comfort 'even after death' (Wolf, 1991:73). Post mortem care is also viewed as part of the 'hidden work' that nurses perform (Wolf, 1991:74). Wolf concludes that nurses view post mortem care as a ritual to 'improve the condition of the patient' by 'washing away traces of suffering' (Wolf, 1991:75).

In Lawler's 1991 study in England, looking at the social methods which nurses use to manage the dead, she stated that the management of the deceased is seen as a rich resource of information on how the nurse may deal with death (Lawler, 1991). Lawler highlights that the nurses' experience is unique from that of other health-care professionals in that the nurse views 'the body' before and after death and has an established relationship with the deceased (Lawler, 1991:188). Lawler also acknowledges that the 'privatisation' of death by human society results in the patient's death being largely unappealing as a topic for research (Lawler, 1991:188).

Lawler explains that for some nurses handling the deceased is no different from handling a 'living body' (Lawler, 1991:189). The nurses 'handle' the dead in the same way as when the patient was alive by carefully 'handling' the dead body and talking to the deceased as if he/she was still alive (Lawler, 1991:189).

For some nurses, Lawler clarifies that death may present emotional difficulty and a sense of disturbance (Lawler, 1991). Several nurses treat the dead as 'a thing' often seen as an object that no longer has the status of a person but still 'the body' is treated with respect (Lawler, 1991:189). Some nurses described that their first experience as student nurses', were feelings of disorganisation due to a lack of skill in dealing with the dead patient. This resulted in the nurse feeling completely unprepared and inadequate (Lawler, 1991). Lawler also comments that due to this sense

of inadequacy, nurses use 'speed' as a method to manage difficult and potentially embarrassing situations.

Lawler poses that when the nurses' touch the dead body they are affected by 'a deep sense of uncertainty, bordering on superstition' (Lawler, 1991:190). The author also describes that the spiritual aspect of death is important to some nurses and may be related to the uncertain feeling of life after death (Lawler, 1991).

In the English study, Lawler emphasised that the nurse is aware of the expectations required of them to perform post mortem care. Respect of the dead body is imperative but at times the nurses' self-control 'deserts' them (Lawler, 1991:190). Most of the nurses in this study had 'dead body stories' to tell. Often the 'dead stories' caused the nurses to 'giggle' and the performing of post mortem care ended in a 'farce' (Lawler, 1991:190). Lawler explains that uncontrollable laughter is a common occurrence in situations of uncertainty and fear. This type of laughter releases tension and helps the nurse manage his/her discomfort (Lawler, 199:190).

For Lawler the conclusion of this study is that death and the dead body is a problem for nurses as this may symbolise the nurse's own mortality (Lawler, 1991).

Quested and Rudge analysed a procedure manual: '**Last Office**' to explore and analyse nursing care practices of patient death. Quested and Rudge explain that nurses are responsible for presenting the deceased to the patients' relatives by preparing 'the body' for burial (Quested & Rudge, 2002:558). Nurses, through their actions of post mortem care, socially construct the deceased to a 'cultural ideal' for viewing by the relatives (Quested & Rudge, 2002:559). After viewing of the body by the relatives, the deceased is 'created as a corpse' by the nurse with the addition of shrouds and labels (Quested & Rudge, 2002:558).

In performing post mortem care, the nurse mediates the move of the deceased from 'embodied person-hood' to 'becoming dead' (Quested &

Rudge, 2002:559). Quested and Rudge also commented that the management of the deceased may be a rich source of information on how nurses deal with death (Quested & Rudge, 2002). This is in keeping with Lawler's English study (1991) which was previously discussed.

Green and Green described post mortem care as the 'laying out of a body' which may be interpreted as an example of nurses' respect for the deceased (Green & Green, 2006:182). The authors describe this care as 'cleaning and tidying' of the deceased, 'straightening' and protecting 'the body' and finally the deceased is 'made safe' for others to handle and 'pleasant' to view (Green & Green, 2006:182).

It was also emphasised by Green and Green (2006) that nurses regard post mortem care as the last act of service to the deceased. They argue that post mortem care may not have the same meaning in current nursing practice due to the high usage of temporary agency personnel, shorter hospital stay by the patient thus a lesser degree of continuity of care (Green & Green, 2006).

Blum, in a historical perspective (1850-2004) of the nurses' role in the care of the dead, the expected behaviour from nurses performing post mortem care was described (Blum, 2006). The nurse is advised to exhibit a degree of control of his/her emotions whilst doing post mortem care (Blum, 2006). In order for the nurse to cope with high levels of anxiety, the nurse may exhibit laughing, joking or having casual conversations with other staff members in order to 'depersonalise' the body (Blum, 2006:59). At times, the nurses refer to the body as 'it' and often wear unnecessary gowns and gloves in order to protect themselves from the conscious reality of death (Blum, 2006:59).

Blum states that the nurse interprets the act of post mortem care as one of a 'special service' to the patient and this can be perceived as a 'farewell to a caring relationship' (Blum, 2006:58). Privacy, respect and dignity remains central to the care of the deceased irrespective of death (Blum, 2006).

Preventing injury to the body by ensuring cleanliness and proper patient identification is of the utmost importance to the nurse (Blum, 2006). The nurse treats the body tenderly and can be seen as 'the last tender office' that can be offered (Blum, 2006:59). The other major role of the nurse in performing post mortem care is ensuring that all legal requirements are performed such as patient identification, protecting the body tissues and discharging the body to an appropriate area for collection by the funeral home (Blum, 2006).

Blum insists that the student nurse cannot be left alone when doing post mortem care as the actual contact with death is depressing for 'the young and inexperienced mind' (Blum, 2006:59).

In a study by Hadders in Norway, the experiences of 27 nurses' working in the ICU on interventions and dealings with the deceased were explored. Using the methodology of ethnography, the study revealed that the basis for nurses' post mortem care is to safeguard the integrity of the human body at all times (Hadders, 2007). Hadders suggests that the personal integrity that is safeguarded during post mortem care is closely linked with, and tied to the integrity of the deceased and the nurses themselves (Hadders, 2007).

Hadders explains that the social identity of the deceased is maintained by the nurse treating the deceased as alive or capable of perception and feeling. This behaviour may be interpreted as the nurses' avoidance of the 'deadliness' of his/her work (Hadders, 2007:219).

The washing, caring and preparing of the deceased for viewing by relatives may be seen as a way of maintaining the personhood of the deceased (Hadders, 2007). The invitation to the relatives to participate in post mortem care and to 'take leave of the deceased' through viewing, may contribute to the personalised care and the maintenance of the social identity of the deceased during post mortem care (Hadders, 2007:219).

Nurses safeguarded their own integrity by acting respectfully towards the deceased as disrespectful behaviour was disturbing to them (Hadders,

2007). The nurses in this study reported their dislike towards rough handling of the dead to the extent that some procedure manuals prescribe that post mortem care be performed by two nurses (Hadders, 2007). Another comment made by the nurses in this study was the dislike towards nurses that talk about 'irrelevant and banal issues' while carrying out post mortem care and a 'hush voice' is preferred during the procedure (Hadders, 2007:214).

Hadders describes that whilst the nurse performs post mortem care, the nurse sways between poles of nearness and distance to the deceased in order to manage their exposure to death (Hadders, 2007:207). These experiences may alternate between interpreting the deceased as a 'sentient person' (person capable of perception and feeling) or an 'inanimate body' (spiritless, decaying body) (Hadders, 2007:219).

In 2008(a), Pattison, a critical care nurse, designed a continuing professional development practice guideline, '**Last Office**', which delineates the practical processes of care for patients who have died (Pattison, 2008a). The 2008(a) guidelines highlights that performing post mortem care is a 'highly intimate' practice that ideally should reflect the social, cultural and religious beliefs of both the deceased and the family (Pattison, 2008a:42). Pattison admits that post mortem care is complex as it may differ within cultural and religious practices. Pattison argues that post mortem care can be 'upsetting' to the nurse, but it can also be a form of 'closure' (Pattison, 2008a:48).

Shortly after the publication of the '**Last Office**', Pattison continued by further developing these guidelines on post mortem care. In Pattison's newer practice guideline, she outlines the steps that are involved in the preparation of the patient following death and also discusses some of the practical considerations and reactions to death that the nurse may encounter (Pattison, 2008b).

Pattison adds that the 'laying out' process may involve washing and dressing the deceased in a particular way in preparation for the

undertaker. Consequently, this process can be inextricably associated with personal rituals (Pattison, 2008b:49). These are 'washing the patient in a certain way according to religious preferences', dressing the dead in a particular manner and religious behaviours seen at death - for example saying of prayers. Pattison acknowledges that the nursing act of post mortem care (an act of care with compassion), enables the family to see that their loved one was respected and cared for even after death (Pattison, 2008b).

Pattison recommends that it is important to perform all procedures at the end of the patient's life with the utmost sensitivity. These procedures are viewed as the last caring act for the patient and may be remembered by the families in future years (Pattison, 2008a). Pattison also recognises that nurses have the opportunity to develop their skills and awareness when performing post mortem care by reflecting on issues of grief and informing families about procedures after death (Pattison, 2008b).

Çelik, Uğraş, Durdu et al., (2008) conducted a study of nurses working in a medical and surgical intensive care unit to identify the critical care nurses' knowledge about the care of deceased adult patients. The participants consisted of 61 nurses who were working in the adult neurosurgery, coronary, cardiovascular, surgical, post-anaesthesia and emergency ICUs of a university hospital in Istanbul, Turkey.

Çelik and colleagues identified that nearly (58/61) 95% of the ICU nurses were caring and respectful of the privacy of the deceased. After placing the deceased in an appropriate position, the nurses proceeded to clean the body. Only a small percentage of nurses (6/61: 9.8%) stated that they closed the eyes of the deceased, placed a pillow under the deceased's head, dressed the deceased in a clean gown, combed the deceased's hair and replaced dentures (Çelik et al., 2008:57).

Nursing Interventions	n	%
Separate deceased person from other patients with curtain or screen	58	95.0
Wipes away blood and drainage on the body and covers with a dressing	51	83.6
Puts a folded towel under the deceased patient's chin and ties it	41	67.2
Holds the eyelids closed for several minutes to assure closure	40	65.5
Covers deceased patient with a clear sheet up to the shoulders and calls the family into the unit to spend time with their relative	37	60.6
Put a towel or small pillow under the deceased patient's head	10	16.3
Close the eyelids with cotton thread	6	9.8
Puts a clean gown on the deceased patient and combs hair	5	8.1
Ensure dentures in place before family spend time with deceased patient and removes them afterwards	4	6.5

Table 2: Nursing actions prior to the family spending time with their deceased relative (Çelik et al., 2008:57)

It was also reported that only (15/61) 24% of the nurses were able to support or show interest towards the family of the deceased. Those who did show emotional support to the family stated that they created a private environment for family members to 'say goodbye' and tried to leave the family alone (Çelik et al., 2008:57).

Çelik et al. highlight that the only activity undertaken by the nurse after family viewing was the handing over of the deceased belongings to the family. It was also shown that some of the nurses may have forgotten the information that they had been given in their student nurse training about post mortem care. For these nurses, post mortem care was learnt from their nursing co-workers in the ICU (Çelik et al., 2008).

Haug, Chang, Sun and Ma (2009) embarked on a study exploring nursing students' experiences of their first encounter with death during the clinical practice in Taiwan. Using purposive sampling, 12 first year nursing students were selected from an acute haematological ward in a major teaching hospital in Central Taiwan.

Data was collected by one-on-one, in-depth semi-structured interviews. A qualitative descriptive method was implemented and Colaizzi's seven-step method of induction was used to analyse the data. After data saturation, three themes and eight sub-themes emerged (Haug et al., 2009).

Themes	Sub-themes
Providing care during the dying period	<i>Feelings of dread and terror</i>
	<i>Hardship of experiencing patient's life fading away</i>
	<i>Devotion to patient care</i>
	<i>Self-affirmation</i>
Facing the moment of patient death	<i>State of being scared or trapped</i>
	<i>Emotional breakdown</i>
Adjustment after patient death	<i>Acceptance or avoidance</i>
	<i>Growth or escape</i>

Table 3: Nursing students' experiences of their first encounter with death during clinical practice (Haug et al., 2009:2284)

During the interviews, the student nurses avoided topics about death in their local culture.

The findings from this study demonstrated the importance of understanding the student nurse's first experiences of patient death. These results proved to be beneficial for the clinical instructors and nursing personnel in understanding the students' pressure and difficulties experienced before, during and after the patients' death (Haung et al., 2009:2280).

The authors concluded that several recommendations be implemented from the study. These included emotional support for the student nurses, teaching of patient deaths and post mortality (Haung et al., 2009).

More recently, Kent, Anderson and Owens (2012), explored nurses' early experiences of patient's death using a sequential quantitative-qualitative mixed method. A convenience sample of 500 practising registered nurses who were enrolled in postgraduate nursing programmes were recruited by electronic mail (email) invitations. Of the 500 emails sent, only (174) 35% responded and completed an online questionnaire. The questionnaire included topics on clinical circumstances, preparedness, support mechanisms and memorable patient death.

The result of this study revealed that the registered nurses (107) 61%, experienced their earliest memory of patient death during their undergraduate training and, (41) 23% in their first year of qualification. From these experiences, (140) 80% took place in acute settings such as ICUs and in the paediatric wards. Whilst some of the nurses reported that the practical death experience, including post mortem care was a 'rewarding' learning experience, others reported 'acute helplessness, guilt or marked on-going distress' (Kent, Anderson & Owens, 2012: 1259).

From this study, the authors acknowledged that little can be done to control the clinical circumstances of nurses' early experiences of patient death. However, it may be possible to minimise the negative factors by understanding more about the nurse's reactions to death. Other negative factors include feelings of inadequacy, exclusion and role conflicts. Of particular importance is that nurses' early experiences of patient death

appear to have a lasting impact on their professional and personal lives (Kent, Anderson & Owens, 2012).

2.2. Summary

The registered nurse interprets post mortem care as an act of closure of a relationship of caring for the deceased patient. Nurses find post mortem care difficult and may experience it as a physical, emotional and spiritual encounter. The nurse experiences present different ways of handling the dead, death and the situation around the demise of a patient. Ultimately, the act of post mortem care portrays the respect and dignity upheld by the nurse for the human body. Subsequently the nature of her actions reflects the integrity of the nurse and her practice.

The following chapter describes the methodology and method that will be used to answer the research question.

I will be utilising a qualitative research design using a descriptive method to analyse and present the findings.

Chapter Three Methodology

3. Introduction

The concept of methodology may be explained as the principles and ideas on which researchers base their procedures and strategies (Holloway & Wheeler, 2010:21). For the purpose of this study, a qualitative research design was selected utilising a descriptive method. The aim of a qualitative research design is to understand the phenomenon in its entirety. This approach is seen as complex and broad (Brink, van der Walt & van Rensburg, 2012:11). Chapter three describes the research methodology and research method.

3.1. Aim

The nature of the research question determines the research design, data collection method and the process of data analysis which will be used (Brink, van der Walt & van Rensburg, 2012:54). This study was embarked upon to provide a detailed account to 'paint' a picture of the situation experienced by the participants – *Registered Nurse's experiences performing post mortem care in an Intensive Care Unit.*

3.2. The Research Design

From examining the limited literature pertinent to the research question, a qualitative research design utilising a descriptive method was the appropriate choice for this study. This approach is based on a 'perceived view of reality' implying that the person living the experiences is seen as the source of information (Grove, Burns & Gray, 2012:66). This then results in a comprehensive summary formulated from straight description of the event or phenomenon (Polit & Beck, 2004). The idea was not to penetrate the information for interpretive depth but to provide detailed descriptions of the participants first hand experiences. This was an important consideration when I selected this methodology and approach to be used.

At times descriptive, qualitative research may also aim to gather data for transformation of information needed to offer a new strategy (Grove, Burns & Gray, 2012). To fulfil the objective of this study it was also important to explore the educational and emotional needs of the participants in order to identify and recommend appropriate interventions that would benefit this sample of ICU nurses. This may be applicable to all health-care professionals who are exposed to the dying and deaths of patients.

3.3. Population

3.3.1. The Study Setting

A hospital from a consortium of private hospitals in Cape Town was selected as the research setting. The interviews were conducted in a seminar room within close proximity of the ICU. Being employed at this institution for 11 years facilitated negotiations for conducting my research in this area. Furthermore, as a clinical facilitator in the research setting, I had an established relationship with all of the participants.

Gaining access to the research setting occurred in two phases; formally and informally. Negotiating access consisted of the submission of the proposal to, and receiving approval from the Faculty of Health Science Human Research Ethics Committee (Appendix A). Approval for access was obtained from the private hospital's Research Operational Committee (Appendix B). Informal access was negotiated with the Unit Manager as well as the nursing personnel of the ICU.

3.3.2. The Sampling Method

In qualitative research designs, it is important to base sampling decisions on a 'systematic basis and on rational grounds' (Holloway & Wheeler, 2010:143). The rules of qualitative sampling are that the sample must be both appropriate and adequate for the study. This appropriateness refers to the fit of the sample to the study aim (Holloway & Wheeler, 2010). I employed a convenience sampling method and invited suitable participants whom were known to me. To avoid elitist bias, I ensured that the

participants were at different levels of experience in order to ensure all aspects of the phenomenon were fully described. I anticipated that these participants would provide me with honest, credible and detailed information of their experiences.

3.3.3. The Sampling Criteria

In convenient sampling, I invited participants who were 'conveniently available' and who were willing to participate in the study (Liamputtong, 2009:12). It was also important to select participants with various levels of experience in order to provide a further in-depth account of their experiences. This concept was applied by inviting ICU nurses who showed an interest in the research topic and a willingness to participate.

The participants invited were registered nurses currently in fulltime employment in the Intensive Care Unit. The invited participants were required to meet the following selection criteria:

1. The participants had to be working in the ICU at the research setting.
2. The participants had to have direct involvement in performing post mortem care following patient death.
3. The ICU nurse must be fluent in English as the interviews were conducted in English.

Although demographic information was collected during the interview process, it has been omitted to maintain the anonymity of those involved. The participant's years of experience working in an intensive care unit ranged from two to 44 years. The age range was 31 to 63 years and included two males and four females.

3.3.4. The Sample Size

Holloway and Wheeler (2010:145) motivated that 'the sample size may be large or small, depending on the type of research question, material, time resources and number of researchers.' They agreed that in general, qualitative sampling consists of a small sampling unit studied in depth (Holloway & Wheeler, 2010:145). Qualitative research dictates the

formulation of the research focus first, and thereafter the sampling takes place.

All of the ICU nurses who were currently working at the research setting were provided with the requirements expected of them. Information on the purpose of the study was also provided. Some of the participants showed a keen interest in the topic under study by asking questions and requesting more information. These identified participants formed the final selection for the study.

Holloway and Wheeler (2010) recommend six to eight 'data units' which are viewed as sufficient in qualitative research. The staffing contingent comprised of 11 registered nurses in this research setting. All of the registered nurses were invited to participate in this study. A convenient, heterogeneous sample of six registered nurses volunteered to participate in the study.

3.4. Ethical Considerations

Ethics for researchers is concerned with guiding professionals to protect and safeguard the interest of clients/individuals. The ethical principles elaborated in the Declaration of Helsinki (Brazil, 2013) guided my ethical principles to identify all possible predictable risks and burdens for the participants.

It is important for researchers to 'draw on these principles' and balance these in their research process (Holloway & Wheeler, 2010:54). Due to the nature of qualitative research, there are always concealed aspects within participant observation and at times it is difficult to predict in advance the emerging data due to its creative nature (Holloway & Wheeler, 2010). To ensure an ethical research process, I provided the best account of my intentions at each stage of the research process and, more importantly, attempted to maintain and ensure the confidentiality and anonymity of the participants.

3.4.1. Informed Consent

The process of informed consent is 'located within the principle of respect for autonomy' (Holloway & Wheeler, 2010: 59). This principle demands voluntary participation and the participants are equally aware of the possible benefits of the research and the potential personal and individual risks they take (Holloway & Wheeler, 2010).

An information sheet (Appendix C) explaining the information in the informed consent was provided to each participant. The participant information sheet provided clear and definitive information regarding the study. This information was written in simple English.

Signed consent (Appendix D) was obtained from each participant after the following information was provided in the information sheet:

1. The nature and purpose of the study.
2. Potential benefits of the research.
3. Assurance of confidentiality.
4. Implication of signing the consent form by the research participant.
5. The right to withdraw from the study at any time.
6. An opportunity to ask questions pertaining to the study (adapted from Fouché 2004:132).

However, informed consent in qualitative research remains complicated due to the natural flexibility and unexpected ideas that arise during information collection. Therefore, I was unable to inform the participants of the precise path of the research, an informed consent is not a once and forever agreement but is seen as an ongoing process of informing the participant (Holloway & Wheeler, 2010:59). This required of myself and the participants to re-consent for the feedback sessions and the participants written reflection on completion of the study.

3.4.2. Confidentiality and Anonymity

Due to the small sample size and the thick descriptions I worked with, it remained challenging to protect the participant's identities (Holloway & Wheeler, 2010). The personal information and details revealed by the

participants made confidentiality the most important ethical consideration. I had to convey a more sensitive nature and good communication skills due to the 'more intrusive nature' of qualitative research (Holloway & Wheeler, 2010:60). Anonymity remains an issue in qualitative research where I could possibly identify the participants especially in the use of interview guides to generate or validate data.

Strict confidentiality but limited anonymity was guaranteed. All the participants were informed of their right to refuse to take part in this study and that they could withdraw at any time without blame or prejudice.

Every attempt was made to ensure that this study represented the experiences described by the participants. In order to protect their identity, a fully transcribed interview has not been included as an example. In describing their experiences, the true identity of the participants was protected by the use of pseudonyms instead of the participant's real identity. I was the only person exposed to the participants' actual names and the audio-recordings of the participants. All of the transcriptions and audio-recordings were stored on an external flash drive (password protected) in a locked cupboard. The audio-recordings and transcribed interviews will be destroyed after five years.

3.4.3. Benefits and Risks/Vulnerable Participant Protection

The participants were informed that they would have no direct benefit from the study. This was clearly stated on the participant information sheet and consent form.

I was also aware that the study may induce emotional stress and the participants were informed of the formal referral system at the research setting should they require individual debriefing or counselling. I informed the participants of the potential emotional and psychological distress that may occur as a result of this study. Regular debriefing on feedback sessions were conducted to mitigate this risk.

3.4.4. Use of Transcribing Equipment

All of the participants agreed to the use of a digital audio-recorder for the duration of the interviews. The audio-recorder was switched on only after the participant had read the information sheet, understood the purpose of the study and had signed the consent form. Following the interviews, each individual's audio-file was removed from the audio-recorder, transferred onto my personalised computer, dated and named according to the pseudonym that the participant chosen.

A list of the participant's names and corresponding pseudonyms were stored in a separate area under lock and key. All follow-up feedback sessions with the participants were recorded with the participants' consent and saved in an electronic file labelled with the participants' pseudonym.

3.4.5. Research-Participant Relationship

Grove, Burns and Gray (2012:708) describe the researcher-participant relationship in qualitative research as 'specific interactions between the researcher and the study of the participants to accomplish the purpose of the study'. I had to adopt a non-judgemental stance towards the thoughts and words of the participants in order to gain access to their true thoughts and feelings (Holloway & Wheeler, 2010:8). This relationship needed to be built on mutual trust whereby the listener becomes the learner and the participant becomes the teacher. Every attempt was made by me to maintain an open, friendly, honest and flexible demeanour to achieve trustworthy, professional and personal engagement with the participant.

This required that I had to adopt an ethical rather than a methodological position regarding the thoughts, words and experiences of the participants. The participants were constantly reminded that there is no right or wrong answer. I booked individual appointment times with the participants that suited them, asking each participant to anticipate a 30 to 45 minute interview duration time. This allowed for preliminary introduction to allay their anxieties and to answer questions which might have been unanswered during the previous experiences of post mortem care.

3.5. Data Collection – Techniques and Strategies

In order to describe the experiences of the participants, I embarked on a process of interaction with the participants. Collection of information was facilitated in the following ways: (i) a semi-structured interview guide; (ii) the participant questionnaire and (iii) reflective journaling. Following the analysis of the transcriptions of the interviews, I thought it useful to validate the participant's narratives by completing a questionnaire (Appendix G).

3.5.1. Interview Guide

A semi-structured interview guide was designed for the participant's interviews. The interview guide comprised mostly of open-ended questions which allowed the participants to answer in their own words (Appendix E).

The interview guide was used to gather information from the six participants. This method of interviewing allows flexibility to create new and interesting responses to be explored further. The intention was to make it possible for me to follow the participants' thought processes (Holloway & Wheeler, 2010). Conversational prompts were used to keep the conversation flowing to answer the research question – *"Are ICU nurses prepared to perform post mortem care of patients who have died from various causes?"* - and to generate appropriate information related to the phenomenon under investigation. Furthermore the conversational prompts helped the participants and myself to gather appropriate information related to the phenomenon under investigation.

Following the initial transcribed interviews, theme-clusters, sub-themes and potential main themes began to emerge. I found it necessary to design a second semi-structured interview guide in order to authenticate these findings and to elaborate/discuss new information (Appendix F). This is in keeping with Holloway and Wheeler's stance that during the course of data collection, questions may be 'revised and added as new ideas arise' (Holloway & Wheeler 2010:90).

As a novice researcher I found the second semi-structured interview (participant feedback) to be useful as my inexperience proved that I had captured information that was irrelevant to the study (Holloway & Wheeler 2010).

The digital, audio-recorded interviews were planned carefully and the following strategies were employed:-

1. The participants were contacted in advance to establish an appropriate date and time and were reminded a few days before the date. The six participants were interviewed within a two week period. The participants preferred to be interviewed during the weekend (Saturday or Sunday) on-duty on both day and night shifts. Due to the 'busyness' factor during the week, the participants found it easier to commit to an interview over a weekend.
2. Ethical issues and access were considered. The participant information sheet and informed consent form were handed to the participants prior to the interviews, followed by an explanation about the nature and purpose of the study to assure confidentiality and anonymity.
3. The research setting was spacious and well ventilated and thus a private/comfortable environment was provided to the participants. The room was in close proximity to the ICU to facilitate the ease of movement into and out of the setting. Being near to the ICU was important for the participants as it felt less disruptive of their daily patient care.
4. From the outset, ground rules were established to create a sense for the proceedings of the interview process. These included cellular phones to be switched off and not on silent mode. This was to prevent any interruption or distraction during the interview process. The participants were informed that the interview may be suspended should they require a comfort break or feel awkward

answering the questions. At any given time, the participants could partake of the refreshments.

5. Light refreshments with snacks were provided as the participants were on duty and were interviewed in their lunch and tea breaks.
6. Each participant was given a copy of the interview guide to prevent deterioration of the interviews into an unclear and chaotic discussion.
7. A high quality digital audio-recorder was used in order to distinguish the voices for transcribing purposes. The audio-recorder was tested prior to interviewing the participants to ensure workability, to eliminate interview stress and anxiety.
8. A reflective journal entry was made after each interview, documenting unusual, interesting or contradictory ideas as well as gestures, pauses and body language.
9. Once the interview was transcribed, a copy was given to each participant to confirm and review the accuracy of their narratives and their experiences of performing post mortem care,

The repetitive process of most qualitative research methodologies became evident at this point: data collection, transcriptions, simultaneous analysis and description/interpretation and the need for further data collection.

The need for further sense-making of the clusters of formulated meanings and emergent themes became evident following validation by the individual participants. This process continued until consensus was achieved.

3.5.2. Questionnaires

Grove, Burns and Gray (2012:425) describe questionnaires as 'a printed, self-report form designed to elicit information that can be obtained from the participant's written response.' The information obtained is similar to that of interviewing but with less bias from the participant and interviewer (Burns, Grove & Gray, 2012). In order to verify information, evaluate the research process and generate recommendations for the research, a participant questionnaire was designed (Appendix G).

The questions were formulated with the help of the research supervisor. Each of the six participants received a hand delivered questionnaire in a sealed envelope from myself. The participants were requested to complete the questionnaire within a two week period and return them to my office in the envelope provided so that confidentiality was maintained.

3.5.3. Other Strategies

Journal entries were made immediately after each interview and feedback session. Reflective journaling mirrored my feelings about the interview process and if any problems had occurred during the research.

Journal Entry 25 October 2014

Another Interview completed. This topic is not easy for some of these nurses. Jemisco interviewed well and seemed to be emotional at times, teary and frustrated. Jemisco understood the questions and gave me a 'real' picture of what happens at the bed of the dead patient. The conversation felt real and genuine. Jemisco has a problem with the death documentation. Everytime I interview, I am faced with the trauma that the participants had experienced. I feel as if death is 'pouring out' of me with all of these interviews completed, but in some strange way the topic makes me feel focused.

3.6. Information Analysis

The purpose of information analysis is to make-sense or grasp the essential meaning of a phenomenon (Grove, Burns & Gray, 2012). In qualitative research, this means the reduction of a massive amount of information into categories and themes attached to a simultaneous process of data analysis and interpretation. The information analysis is directed by the methodology of the study. The work of Colaizzi (1978) was found to be appropriate for this study.

3.6.1. Transcription

The verbatim transcribing of interviews creates full, rich information for analysis (Holloway & Wheeler, 2010:282). It is important to transcribe

these conversations accurately to represent what was said and how it was said. I personally transcribed the first six interviews which proved to be very time consuming. This experience allowed me to interact with the information and was valuable in the research and learning process.

I then transcribed and summarised the interviews with the second round of interviews for all six participants. This was still time consuming but to a lesser degree, as the number of questions were limited to four.

3.6.2. Analysis and Interpretation of Information

All interviews with the participants were digitally audio-recorded and were listened to several times before the process of transcribing. All audio-recordings, field-notes and memoranda were named and dated. A wide margin was left on the transcription for coding and categorising of theme clusters and themes. The transcriptions included laughter, pauses and emphases voiced by the participants. Notes were made on the transcription of unusual, interesting or contradictory thoughts and ideas.

There are many steps involved in information analysis; firstly the information is transcribed into workable format from interviews to transcripts. Normally in qualitative research the researchers use a particular method which dictates a series of common steps to analyse the information (Brink, van der Walt & van Rensburg, 2012). The transcriptions in this study were analysed using Colaizzi's (1978) seven-steps of data analysis up to the point where groups of theme clusters, sub-themes and finally main themes emerged (Table 4). Colaizzi (1978:59) suggested that these steps must be seen as 'flexible and free in order for the researcher to modify steps' in whichever way appropriate.

These steps consisted of the following:

1. Firstly, I read all the participant's transcriptions a number of times to acquire a feeling and make sense of them. I then started coding, providing a word or phrase close to the meaning of the information. For example when a participant spoke of the dead body, the code was "the body." Each code was highlighted in a specific colour for

ease of tracking on the multiple transcriptions and to maintain consistency. Further codes were identified and the general ideas began to emerge.

2. I returned again to the transcriptions of each information set and extracted the phrases or sentences that were directly pertinent to the research question. This is known as extracting significant statements. In this second step, I wrote words and phrases, and quoted descriptive statements for example – Mystery Man says...

'Then we just close the whole body with a brand new sheet (clean) and we pull the curtains'...

and for example – Jemisco says...

'We have cleaned the body already and then we make sure that we cover the body nicely'...

At this point, the transcriptions were read numerous times and I again listened to the audio-files to remind myself of that participants particular reactions.

3. At this step, I set out to identify the meaning of each significant statement known as formulating meanings. I attempted to go beyond what was voiced in the interviews and come to a conclusion about what was meant or implied. Formulated meanings of the two significant statements in step two were seen as (a) 'The 'physical' 'appearance' of the body whilst performing post mortem care was highlighted by the participants. A clean sheet is used to cover the patient which may signify the purity of death' and (b) 'The ICU nurses highlighted that the physical appearance of the body was important and thought it important to keep the body 'clean and tidy.' At this point the participants were consistent in the care that they provided. The deduction made was that the detail of physical care when performing post mortem care is very important for the participants in this study.
4. I then organised the formulated meanings into theme clusters and thereafter condensed the theme clusters into sub-themes and later on the main themes. Once the sub-themes and the main themes

were extrapolated these were checked with my supervisor. I returned again to the transcriptions to check for any missed significant statements. I attempted not to ignore data or themes that did not fit. The identified themes clusters, sub-themes and main themes were validated by myself and the supervisor. Similarities and differences were discussed until agreement was reached.

5. I then integrated the results into an exhaustive description of the phenomenon under study. These descriptions were organised firstly in theme clusters and then sub-themes, for example the body must be 'clean and tidy.'
6. In the next step, I again formulated an exhaustive description of the investigated phenomenon into a single statement of identification. This was encapsulated as a main theme of the participants experiences of post mortem care:

Main Theme 1: Care of the dead body

Sub-themes identified: Physical, Psycho-social, spiritual and multi cultural aspects.

This process of analysis was followed to identify another two main themes. This is illustrated in Table 4.

Theme cluster(s)	Sub-themes	Main Theme
<ul style="list-style-type: none"> • Appearance • Comfort • The task of last offices • Respect and dignity • Rituals and beliefs 	Physical Psycho-social Spiritual and multi-cultural	Care of the dead body
<ul style="list-style-type: none"> • Saying goodbye • Letting go • Shared sadness • Professional • Personal 	Nurse-patient relationship Nurse-family relationship Self	Detachment
<ul style="list-style-type: none"> • Fear of dying • For their body to be treated as if they are still alive – ‘talk to me’ • No rough handling/respect and dignity of their body/ ‘close me or cover me’ • To die peacefully – at home or in a car crash. No lingering in a sick bed • Fear of dying • For their body to be treated as if they are still alive – ‘talk to me’ • Most believe in ‘spirits’ • Ghosts ‘have not seen them, so they are not real’ 	Ontological confrontation The Supernatural	Thanatophobia

Table 4. Theme clusters, sub-themes and main themes generated from the data.

7. Adhering to step number seven of Colaizzi's (1978) method of analysis – checking and validating. I returned to each participant with the sub-themes and the main themes. These were checked and confirmed with the participants individually for validation. My descriptions of their experiences of the ICU nurses performing post mortem care was discussed and confirmed with each participant.

3.7. The Scientific Rigour of the Study

Holloway and Wheeler (2010:341) define rigour as a systematic procedure in research which 'seeks detail, accuracy, trustworthiness and credibility'. The concept of trustworthiness is used to demonstrate validity in qualitative research. Trustworthiness can be defined as the accurate representation of experiences of the studied individuals (Speziale, 2007). The evaluation of trustworthiness exists within the information. Trustworthiness inspects the quality of the study and its findings, making it noteworthy to audiences. The identification of four aspects of trustworthiness namely credibility, transferability, dependability and confirmability, have been successfully used as criteria for qualitative researchers (Speziale, 2007)

3.7.1. Credibility

Credibility or truth-value refers to the confidence in the truth of the data and the interpretation thereof (Brink, van der Walt & van Rensburg, 2010). In qualitative research the concept is more complex and is related to the description and interpretation by the researcher and truth telling of the participant (Holloway & Wheeler, 2010:299).

Lincoln and Guba (1985) define credibility as the fit between the participant's view and the researcher's representation of them. Credibility does pose the question: 'Is it believable?' in other words, is the information 'true' to myself and the particular phenomenon/a under investigation?

It was shown in this study that credibility was achieved by the participant's confirmation of their experiences through the identified sub-themes and

main themes. Further credibility was attained through the feedback sessions with the participants.

Due to the sensitive nature of the research topic, it was important to be familiar with the participants in order to create a sense of trust and rapport. This intimate relationship augmented the research findings and led to the discovery of hidden facts as the participants volunteered more sensitive information than they would otherwise have done (Holloway & Wheeler, 2010). I also guarded against over involvement with the participants as this would complicate the separation of my own thoughts from those of the participants (Holloway & Wheeler, 2010). I did this through journaling, capturing my thoughts and feelings in relation to the participant experiences so that I remained focused on answering the research question.

Burns, Grove and Gray (2012) emphasise that the researcher's self-understanding is important in qualitative research, as this is an interactive process shaped by the researcher. Self-understanding allows the researcher 'to have insight into his or her potential biases related to the phenomenon and prevents these biases from interfering with voices of the participants' (Burns, Grove & Gray, 2012:59). While it was not possible to lose subjectivity, this self understanding and knowledge helped me to separate my personal thoughts and experiences from those of the participants. This assisted me to be less judgemental and more appreciative of the participants' experiences.

To establish credibility in this study, the following was adhered to:

1. I kept a reflective journal that documented the research process.
2. The analysed interviewed recordings and transcripts were discussed with each individual participant for validation. The participants acknowledged and recognised the formulated themes and meanings in relation to their verbal account. The participants also had the opportunity to elaborate and to further explain their conversations to substantiate the main themes and the sub-themes.

3. I also employed peer-reviewing. The study supervisor assisted with the information unravelling the participants' narratives and the emerging themes.

3.7.2. Transferability

Transferability or applicability can be defined as the probability that the study findings have meaning to others in similar situations (Speziale, 2007). The term transferability is not relevant to this descriptive, qualitative study as the aim is to describe the phenomenon at hand. The other term for transferability is 'fittingness' or the fit/match between research and other contexts (Speziale, 2007:49). I thought this to be more appropriate for this study. This means that the findings in one context may be transferred to similar situations or participants (Holloway & Wheeler, 2010). Furthermore, the findings of this study may fit in with or be similar to the findings of other related studies investigating this phenomenon.

In order to establish fittingness, I provided a thick and in-depth description of the information which follows in the next chapter.

3.7.3. Dependability

Dependability or consistency refers to the ability of the reader to follow the research process (Holloway & Wheeler, 2010). Dependability also relates to the transparency of the research process and the decision trail of the researcher (Gerish & Lacey, 2010:139). I attempted to ensure dependability and consistency by providing an in-depth description of the methodology and the use of a field journal and memoranda.

Holloway and Wheeler (2010) emphasise that the researcher is able to display dependability by providing an accurate decision trail which enables the reader to audit the events, influences and actions taken by the researcher from the beginning to the end of the study. An accurate decision trail was maintained and kept during the research process.

Excerpts from Reflective Journal

12 October 2014

I am finding it very difficult to keep the focus on the issue of post mortem care. They (Change and Flower) keep moving off to the family and how the family might experience this issue. Maybe the problem is with me. I am such a novice when it comes to this interviewing and research. The word 'it' is used often for the body. Maybe she has not personalised the issue as yet. I am so scared that I will wipe the data off from the recorder. I can see being close to the ICU is valuable, as she (Samantha) stays nice and calm. Now I realise this is a very emotional issue, maybe I have just skimmed the top of this. Care and dignity is very important to her.

26 October 2014

I completed all the interviews yesterday. What a challenging experience – you are continuously confronted with this feeling of doubt: not doing enough and if what you are doing is the right thing. I did it just the way Ms Nicola Fouchè said I had to do it. By now I feel death is pouring out of me, but in a strange way this makes me focused. I can see that they work a lot of hours, they can't see what they are doing in post mortem care but it just comes so naturally to them. They appreciated the time and effort I took to come and see them on my days off and they see me differently in my informal non work, clothes. Some anger came out at times towards people who treat the body disrespectful. Now the long transcribing awaits me.

3.7.4. Confirmability

Holloway and Wheeler (2010:301) explain the meaning of this concept in qualitative research as research that is 'free from biases and relatively value neutral'. Speziale (2007:49) stated that the objective of this is to 'illustrate as clearly as possible the evidence and thought process that led to the conclusions'. There are two major techniques for ensuring confirmability; these are triangulation of the data and the audit trail. The latter has already been discussed.

Triangulation refers to the combination of different methods of research, data collection approaches, investigators or theoretical perspectives in the study of one phenomenon (Holloway & Wheeler, 2010:342). In triangulation, I look at the same phenomenon in different ways or from different angles.

In this study, limited triangulation, but validation was achieved by returning all documented information to the participants to confirm that the transcribed narratives captured their own experiences. This is known as member checking or participant feedback. The participants were encouraged to clarify issues and add or remove information.

3.8. Summary

This qualitative research design using descriptive method explores the experiences of the ICU nurse performing post mortem care. A convenience sampling method was used to invite six registered nurses. The information was collected by semi-structure interview guides and a participant questionnaire. The information was transcribed verbatim and analysed using Colaizzi's (1978) seven-step data analysis approach.

In the following chapter, I will present the findings of this study.

Chapter Four

Description of the Themes

4. Introduction

In this chapter, I present the themes that emerged from the analysis of the data. I aim to provide the reader with an understanding and insight into the registered nurses' experience of performing post mortem care in the intensive care unit (ICU).

The participants' voices are incorporated as quotes and are illustrated in colour. This is to highlight and bring to attention their 'voice' which is often unheard. Only the most illustrative quotes were used.

4.1. The Emergence of the Themes

Three main themes were generated from the data obtained from the individual interviews: (i) post mortem care of the body; (i) detachment and (iii) thanatophobia.

Theme clusters, sub-themes and main themes are presented in Table 4.

Theme cluster(s)	Sub-themes	Main Theme
<ul style="list-style-type: none"> • Appearance • Comfort • The task of last offices • Respect and dignity • Rituals and beliefs 	Physical Psycho-social Spiritual and multi-cultural	Care of the dead body
<ul style="list-style-type: none"> • Saying goodbye • Letting go • Shared sadness • Professional • Personal 	Nurse-patient relationship Nurse-family relationship Self	Detachment
<ul style="list-style-type: none"> • Fear of dying • For their body to be treated as if they are still alive – ‘talk to me’ • No rough handling/respect and dignity of their body/ ‘close me or cover me’ • To die peacefully – at home or in a car crash. No lingering in a sick bed • Fear of dying • For their body to be treated as if they are still alive – ‘talk to me’ • Most believe in ‘spirits’ • Ghosts ‘have not seen them, so they are not real’ 	Ontological confrontation The Supernatural	Thanatophobia

Table 4. Theme clusters, sub-themes and main themes generated from the data.

4.2. Theme 1. Care of the Dead Body

Post mortem care of the body is described within the sub-themes of:

- physical
- psycho-social
- spiritual and multi-cultural

Further theme clusters have been highlighted from the sub-themes.

Physical care

The physical care of the dead body was illustrated by the following theme clusters:

- appearance
- comfort
- the task of last offices

Appearance

The physical appearance of the dead body whilst performing post mortem care was highlighted by all of the participants. Closing or covering up of the body appeared to signify the purity of death. Examples of these:

... 'With a clean sheet, we just close it with a clean sheet over the patient'
... ♦Jemisco.

... 'I cover the patient with a sheet. We use a white sheet [clean]'...
♦Samantha.

Another aspect of appearance was that of the face of the dead patient:

... 'For the face, I clean and if the patient's eyes are wide open I try to close it. The mouth I close with the pillow under the chin'... ♦Anne.

... 'I make sure that the mouth is close and I make sure I push the bottom lips to be closed together'... ♦Samantha.

... 'I see that the mouth is not hanging open'... ♦Flower.

An interesting concept of the care of the dead body was that the ICU nurses were very attentive to keeping the dead body clean and tidy:

... 'I make sure the patient looks clean and tidy when the family comes'...

◆Samantha.

... 'I have cleaned the body already and then I make sure that I cover the body nicely'... ◆Jemisco.

... 'Behind that door is dignity, patient's dignity. I close the door and then care physically. Then the lay-out of the patient. The patient must lie on the bed flat and if possible must be straight and one must cover the patient. You must then put the patient like in peace'... ◆Anne.

Comfort

The physical comfort of both the dead body and the nurse was alluded to. Post mortem care was easier and more comfortable when two nurses in the room performed this care:

... 'Now normally we are two persons. It is not easy to handle a dead body, so you help with the turning and washing'... ◆Mystery man.

... 'Cleaning the patient, this is so difficult to be doing alone. I always want to be with somebody [in the room]'... ◆Jemisco.

... 'It is not because there is no life. No it is still the same for the nurse. One of us is on the one side of the bed; the other one on the other side'... ◆Anne.

Knowing that the body was made and looked to be comfortable illustrates the importance of caring even after death. For the nurses this was evident when the patient's death was lengthy and traumatic:

... 'I must make sure that the patient looks comfortable. Straighten the limbs'... ◆Samantha.

... 'It makes you feel comfortable to know that there is someone who cares for that person and is not just doing it because it is their job to do it'... ♦ Flower.

The physical component of comfort care, of washing the dead body, was common practice for the ICU nurse. The ICU nurse's felt that this portrayed a level of respect which maintained the dead body's (the patient) dignity:

... 'You must wash the patient and treat the patient as if the patient is alive'... ♦ Anne.

... 'I then wash the patient and take everything out [tubes, drips] and cover with a dressing. You handle the patient with respect'... ♦ Change.

Finally, it was well illustrated that talking to the body as if the patient was still alive, served as a comforting gesture by the ICU nurses:

... 'I even speak to the body, saying I am doing this now;'... ♦ Jemisco.

... 'This was a patient whether for ten minutes, ten days. It is still like we treat all patients'... ♦ Change.

The Task of Last Offices

Performing last offices consists of basic care to prepare the body for the mortuary. One of the basic tasks is removing 'pipes,' 'lines,' 'cables' and the 'ET tube' [breathing tube]. This task was experienced with difficulty by most of the participants.

... 'The critically ill patient will be having invasive lines and all the stuff like that. I don't want to say it is scary; it is not a nice feeling. It is something that is not nice. I will say that it is not easy'.... ♦ Samantha.

... 'Most often pulling out everything when the patient passes away, if on ventilator, taking out the ET tube, pulling out all those lines just makes me feel bad. Taking out everything and you are looking at this person. This person is not waking up again. It is not easy at all'... ♦ Jemisco.

For the ICU nurses it was important to lay the body 'straight' as this may portray a picture of normality for easier family viewing:

... 'The patient must lay on the bed flat and straight, if it is possible the arms must be straight'... ♦ Anne.

... 'Yes, the body must be kept straight, arms must lie straight'... ♦ Flower.

The ICU nurses found it very important to close the eyes and mouth of the body; to create a picture of the body 'sleeping'. At times this task was seen as uncomfortable and difficult to perform:

The mouth

... 'To close the mouth. Especially, to close the mouth, that part I really don't like'... ♦ Samantha.

... 'See that the mouth is not hanging open so we shall position the patient in a decent way'... ♦ Flower.

... 'The mouth stays open and you put the pillow underneath the chin and eventually the mouth closes'... ♦ Anne.

The eyes

... 'We try to keep the eyes and mouth closed. So we normally put a pillow underneath the chin just to lift it up'... ♦ Mystery man.

... 'If the patient's eyes are wide open, we try to close it and sometimes you do close the eyes and several times the eyes open again. But you keep trying and eventually they close'... ♦ Anne.

The limbs

... 'Because when the patient is cold it is not easy to straighten those limbs and not easy to close the mouth'... ♦ Samantha.

Lastly, some ICU nurses experienced rough handling of the dead body and had been exposed to this uncaring behaviour at least once during their nursing career. This experience was found to be distressing and created a feeling of distrust and anger towards other nurses:

... 'You do get people who don't care. You will see them acting rough and saying "Ag man there is no life. Why should we now be so gentle. He is dead, he is dead." There are people who have no feelings'... ♦Anne.

... 'I've seen in my early nursing years. I think it is very important to have respect for the dead person. I mean we can just take it from ourselves that if you had to die you would like somebody to treat you with respect'... ♦Flower.

... 'Yes unfortunately I will tell them [colleagues] that I am not happy. If this was my patient, or if this was my family member and you handle them like this... and I have reported them to their managers. You feel this is our patient and look how they handle the body'... ♦Change.

Psycho-social

Psycho-social is defined as a person's psychological development in relation to his social environment (Freshwater & Maslin-Prothero, 2005:491). Within this context, this may involve the feelings and emotions of the ICU nurse towards the dead body.

Respect and Dignity

Branford and Thompson define respect in two ways

1. Deferential esteem felt or shown towards a person or quality
2. To avoid interfering with or harming (Branford & Thompson, 1994:822).
3. Dignity is defined as 'the state or quality of being worthy of honour or respect' (Branford & Thompson, 1994:256).

This was illustrated by the ICU nurses in handling the dead body with respect and care:

... 'We do this but we do not think about it. This care, we are supposed to do it. It is part of the care and we must realise it and we must teach ourselves this. Although there is no life you must care for your patient in many ways; psychologically, physically, emotionally. Sometimes people just don't talk they just do it. Although there is no life there is still the body and those parts [nursing care] you still have to go through'... ♦Anne.

... 'A body you handle with respect and with care as if the person is still there'... ♦Change.

... 'I think it is very important to have respect for the dead person. I can just take it for myself that if you had to die you would like somebody to treat you with respect. So I think just out of that point of view, if this person would see what you were doing, this person would expect you to do the best'... ♦Flower.

The 'soft' touching of the dead body also emphasised the respect and dignity of the dead body which is central to the nurturing and caring work of nursing:

... 'I make sure that the body is handled in a correct way [softly]. I am in charge of that body. You cannot handle this body bad because this person is alive although we know this is a dead body'... ♦Samantha.

... 'We don't just pull out the drip; we handle the patient as if the patient is still alive, just for his respect and dignity. Most of the times it is people who are very careful [doing post mortem care]'... ♦Mystery man.

... 'Then handle that body as you would like your family to be handled. Softly and with respect'... ♦Change.

At times, the ICU nurse was faced with the daunting task of touching the dead body that had gone cold. Some of the participants were almost repulsed by having to touch the cold and lifeless body:

... 'I cannot take the coldness of the body. It affects me. Not that I am afraid it is just a phobia you know'... ♦Mystery man.

The ICU nurses confirmed that the physical tidying and cleaning of the dead patient's room was seen as a sign of maintaining the patient's dignity as well as that of the family:

... 'Clean [the room] and take all the dirty linen away. Then place chairs for the family and remove all the attachments [pipes, lines]. You remove all the machines from the room'... ♦Anne.

... 'We clean the room; we take out everything. When the family members view the patient, it will serve as comfort and it's the best for them also, rather than coming in a room that is filthy, things are still hanging around. This would not show any good care from the nursing staff. When the family walk in the room and the room is airy and clean, it will make them feel better. It will also show respect to the patient. It serves as last offices, which we perform for the patient. We make sure the patient goes with dignity'... ♦Jemisco.

Experiencing the patient's death and ending care after the completion of post mortem care was traumatic for the ICU nurses. The ICU nurses tried to cope with this disconnection by attaching meaning in comparing with the nurse's own family member:

... 'I think it is a sense of uneasiness because it is still a loved one of somebody that you're dealing with. You don't always realise how special that is, because it is not your person. But once you think: this could be my father or my mother; you automatically change your attitude. You feel that the way you treat this person, even if it is a dead body and nobody sees you, it could be your family' ... ♦Change.

... 'When I touch that dead body, sometimes I do get emotional. Thinking, what if this was my family member. I think if this is my family member, this is not nice. I wonder how the family of this patient is feeling at the moment about their family member that has gone. They are going to be with them again. But I make sure that patient looks clean and tidy when the family comes. They must see her or him in a good position although he is gone'... ♦Samantha.

... 'I lost my father and I was not there to do the last ritual. I can see how people go through the loss of a family member and what you can do from your side. One of my things that I tell people the first time they lose a family member is that we all go through this and it happens to all of us. You share your personal experiences with the family'... ♦Mystery man.

Spiritual and Multi-cultural care aspects

Whilst the ICU nurse was performing the tedious task of post mortem care, the consideration of the spiritual and cultural needs of the patient and the family was mentioned by the participants.

Rituals and Beliefs

Considering and respecting patients and the family religion was seen as a sign of respect. Most of the participants were resolute in considering the religion and culture of the dead person as this restricted their own act of post mortem care. Mention was made that at times this aspect of post mortem care was forgotten/omitted by the ICU nurse:

... 'In Islamic religion, they bring their things and do their things themselves –prayers. The Buddhists also want to do things themselves. I can only check and see what they are doing and I can't intervene [hand touching table]'... ♦Anne.

... 'It just depends on the religion of the patient that passed away. Like with Jewish people there are certain things that you are allowed and not allowed to do'... ♦Flower.

... 'The first thing that we are supposed to do, but most often we really do not do, is to see which religion this patient belongs to. That is the first thing we are supposed to do. Then we know who to phone to perform the last rituals/rites. We must establish if the patient is Jewish, a Muslim or Christian. There are the things we are supposed to do but at times we tend to forget these things. We don't do it'... ♦Jemisco.

The act of praying after post mortem care was a common occurrence for the participants. The family was given the choice to pray alone or with the ICU nurse present at the bed side. For the participants and the family, this 'prayer time' provides the last private moment with the deceased:

... 'The soul is going to God now and we have to pray and let them go. I just pray, other people don't believe in prayer'... ♦Anne.

... 'I ask the family's permission to do a prayer for them. To make them calm and know that the soul has been taken care of'... ♦Change.

... 'Sometimes if someone wants to do a prayer we close the curtains.'... ♦Mystery man.

The participants commented and confirmed that ICU nurses' professional status dictates the way the body is handled. They implied that the neglect of post mortem care is an indicator of professional attitude; no respect for the body was extrapolated to no respect for the nursing profession:

... 'My status right now, professional status, I make sure that the body is handled in a correct way. Whoever is helping me, I am in charge of that body. You cannot handle this body badly because it is still treated as if this is a patient. This person is alive although we know this is a dead body'... ♦Samantha.

... 'Sometimes, they [other colleagues] just walk away. I think it is also from shock. No compassion for the deceased patient. I think your attitude

towards your profession dictates you, and how you are going to handle this type of thing'... ♦Change.

4.3. Theme 2: Detachment

Detachment is defined as 'unfasten or disengage and remove' (Hawker & Waite, 2007:83). In performing post mortem care the ICU nurse was forced to detach him/herself from various aspects of relationships formed with the patient and the family. The process of removing him/herself from the death scene was also illustrated as challenging and difficult. These detachment experiences evolved from the sub-themes of:

- nurse-patient relationship
- nurse-family relationship
- self

Nurse-patient Relationship

Due to the amount of time that the nurse spends with the patient (and the family) a bond develops between these role players. When this bond is broken or terminated there is a palpable sense of detachment.

Saying Goodbye

The first theme-cluster for this relationship detachment was the act of saying 'goodbye.' The participants expressed that post mortem care may provide the time to say their 'good byes':

... 'If the patient goes let it be, it is better'... ♦Anne.

... 'It gives you time which you use to say goodbye to this person and to show your last care'... ♦Mystery man.

... 'I prayed with the patient before he goes and see that the Lord takes care of his soul. I'm done!'... ♦Change.

The participants also experienced saying their goodbyes assisted with the closing of a bond formed with the patient. The ICU nurses felt a sense of closure whilst performing post mortem care:

... 'Closure that you feel that you did something or that you spent time with this person'... ♦Mystery man.

... 'Did you conclude a box [put a lid on a box] or a relationship? Yes, probably a relationship'... ♦Change.

... 'Things go through your mind when you are busy washing the patient, but may your soul rest in peace, that is how you close [say good bye] now'... ♦Anne.

Keeping the body in the ICU for an extended period of time after performing post mortem care was a concern for the ICU nurse:

... 'The mortuary that we are using, we are using come immediately when we phone them. We do not have to sit with the body for long'... ♦Samantha.

... 'Sometimes you wait very long and then they [undertaker and police] tell you that they were busy. Especially if it is a police case. You know it is all like six to ten hours that you wait'... ♦Change.

Letting Go

Another theme-cluster for the detachment of the nurse-patient relationship was the process of letting go by the ICU nurse of the patient. In some ways post mortem care provided separation time once a close nurse-patient relationship was established:

... 'If the patient was here for almost a month then you build that relationship with the patient. You sometimes get very close to a patient, especially if it is a young patient. You get used to that person and if something happens to that person you feel like your tears are also running. You just have to turn your back and cry silently and carry on'... ♦Mystery man.

... 'When you get too close to the patients, when they are gone it is like your family is gone. I feel part and parcel of that family and that patient. You think of all the positive things, all the good things although he was suffering pain but the personality shone through'... ♦Anne.

Whilst letting go of the relationship built between the patient and the ICU nurse they continue to strive to do the best for the patient:

... 'It feels like at least you are doing your last duties for this person. For some nurses the care stops when the patient dies but I feel that you must still give your best. You must still treat the patient with respect and dignity'... ♦Mystery man.

... 'The reward is that I did my work, I did my best. I now believe he is in a better place and he had good quality of life'... ♦Anne.

... 'I think it is also experience that makes it easier'... ♦Change.

For those participants who had more nursing experience, post mortem care and handling of the dead body was easier for them:

... 'I think being a nurse for so long, having worked with so many dead people. It is no longer a problem for me'... ♦Flower.

Nurse-family Relationship

Another very dynamic relationship is that of the nurse-family relationship. This theme emerged from the shared sadness that the nurse and the family experience in dying and the death of the patient.

Shared Sadness

The shared sadness was well illustrated by the following anecdote:

... 'At times I even go to the toilet, just shed some tears and I go back again. Most often if you have a close bond with the patient, seeing the patient passing away in front of you and watching the family members crying, it is so difficult to hold my tears back. You cannot show it in front

of the family. If you also cry it is not going to be a good reaction as I am the person who is supposed to support them [family]'... ♦Jemisco.

The participants remarked that the death of the patient is disturbing for both the nurse and the family. This stressful time was brought about because the nursing care of the dead patient remained the responsibility of the nurse and not the doctor:

... 'This person is not waking up again. Just, it is not easy [teary]'... ♦Jemisco.

... 'Sometimes you don't know what to say to the family or how to explain this. But most of the times the families are teary eyed but at the end they do come to terms with the death and they do understand'... ♦Mystery man.

The ICU nurse as well as the family experienced some anxiety when the body was released to the mortuary or funeral home. One participant shared her 'separation' anxiety:

... 'They [the family] cry when the body leaves. I got no control over it. I can do whatever I can. But there is nothing I can do [fisting of hands]'... ♦Change

It was evident throughout the participant's conversations that the nursing staff and family members experienced minimal emotional support:

... 'I can tell you it is really one of the worst situations if someone died. You can never get used to it. Sometimes twenty to thirty family members come at one time and you must be the spokesperson. You have to tell them what went wrong. You feel so that it is your fault because the doctor is not there to explain. Sometimes they ask you these funny questions and you cannot answer all of them. It feels as if you did not do enough to prevent this from happening. But after a few days you say to yourself that it was not your fault and there is nothing that you could have done. We all go through this'... ♦Mystery man.

... *'We do not always have the resources to refer to when the patient's family does not cope well'...* ♦ Flower.

... *'I think there is a lack of emotional support for the nursing staff. I also feel there is a lack of support for the family. They walk out and they've been part of the ICU or part of the hospital for months or maybe a few days. But if you keep contact with them you are the emotional support'...*
♦ Change.

... *'We do need that emotional support. I don't want to say I get too attached to the patients but I really do feel something'...* ♦ Samantha.

The participants confirmed and highlighted that the unpreparedness of the patient's family influences post mortem care. It was mentioned that if the patient's family was not prepared for the death, the care of the family during the post mortem process was emotionally burdensome for the ICU nurse:

... *'When the patient passes away most of the time the family is there. This depends on how prepared the family was for the news and how the family deals with it. The most intimidating thing is when the family is very emotional, it makes you also emotional. If the family didn't come to terms with what happened to that person, it is very difficult to explain.'...*
♦ Flower.

Finally, it was mentioned that the nurse-family relationship changes after the patient has died. The nurses' role changed from the primary caregiver of the patient to the caregiver of the family:

... *'I just check and see what they [the family] are doing with the patient. I can't intervene'...* ♦ Anne.

... *'It is not just the patient. It is also the family. You continue to care for the patient until the patient is gone'...* ♦ Anne.

... 'You can help them by giving that emotional support before and after the death. The family will rather come to somebody that was kind to them at that stage, that is what they remember. They might not remember your name, but they remember the emotional support for them afterwards'...

◆Change.

Detachment of Self

The third and last detachment process that occurs is that of the ICU nurse and the dead patient. The theme clusters that were evident:

- professional
- personal detachment.

Professional Detachment

The professional detachment of the ICU nurse from the dead patient was seen as a difficult concept to process emotionally. The detachment process for the ICU nurse was delayed because they continued to care for the dead body as 'their' patient:

... 'I am in charge of that body. I treat this patient as if this person is alive although we know this is a dead body'... ◆Samantha.

... 'Maybe for some nurses the care stops when the patient dies. But I feel that you must still give your best' ... ◆Mystery man.

... 'At the end of the day it is still my patient until the patient is out of my sight or out of the site'... ◆Anne.

... 'Yes we are there until they go out the door'... ◆Flower.

Most of the ICU nurses' conversations implied that the attitude of the nurse towards the nursing profession dictates the attitude that may influence their behaviour towards death and the dead body. This was illustrated by the following:

... 'My status right now, professional status, I make sure that body is handled in a correct way. This shows my respect for death. I am respecting the dead although the patient is gone but I am still respecting him or her and the family'... ♦Samantha.

... 'I think your attitude towards your profession dictates you how you are going to handle this type of thing'... ♦Change.

The process of self examination and blame as to the cause of death was clearly evident in their conversations:

... 'We feel that we are going to be prosecuted. I used to feel as if maybe I am the cause of this patient death. We don't give up until the last moment.'... ♦Jemisco.

... 'Sometimes you feel that it is your fault because the doctor is not there. Sometimes it feels as if you did not do enough to prevent this from happening' ... ♦Mystery man.

... 'What did I do for this patient? The patient is dead now. Did I do something wrong to this patient? You feel that emotion. The guilt and blaming but still the patient was suffering'... ♦Anne.

... 'I used to feel that my patient is passing over because there is something that I should have done that I did not do. It makes me feel bad'... ♦Jemisco.

At times the ICU nurse acknowledged that they were exposed to 'blame shifting' between the nurses and doctor(s) regarding the responsibility for the death of the patient. This created anger for both these parties in an already emotionally charged environment:

... 'I get cross with the doctor if he is cross with me because I could not save this patient. You can't save all the patients unfortunately [hands folded open on table]. You have to make peace with yourself that whatever you did for the patient you did as good as you could. They [doctors] shift the blame on us. Saying we didn't give proper nursing care or we didn't call them [anger in voice]. It is a matter for them to accept that they [doctors] made a mistake that it is not my mistake'... ♦Change.

... 'At times they [the doctors] want to blame us [nurses]. Why would they do this? We can't be blamed for this [patient death][agitated voice]'... ♦Anne.

Personal Detachment

The personal detachment of the ICU nurse in performing post mortem care was seen to be complicated. Firstly the ICU nurse referred to the patient as their own family member, personalising their death experience and that of post mortem care:

... 'Seeing someone lay there dead it always feels that if it was a family member'... ♦Jemisco.

... 'I am touching that dead body sometimes I do get emotional. I take it as this is my family member, this is not nice'... ♦Samantha.

... 'This can be your own parent; it can be your own family member'... ♦Mystery man.

... 'When you get too close to the patients when they are gone, it is like your family because I feel part and parcel of that family and that patient. You think of all the positive things, all the good things although he was suffering pain but the personality shone through'... ♦Anne.

Secondly, a 'grieving time' for the ICU nurse to personally detach themselves was identified through their conversations:

... 'It makes me feel bad and at times I even cry, but I cry in silence. At times I even go to the toilet, just shed some tears and I come outside again'... ♦Jemisco.

... 'Then you get used to that person so if something happens to that person you feel like your tears are also running. You just have to turn your back and cry silently. Yes, I do get emotional in some cases'... ♦Mystery man.

... 'Before the family comes then all the emotions come back again. The crying, the sadness, you feel for them'... ♦Anne.

... 'There is always a sense of sadness when someone dies. I think it is just a normal thing that we feel sad when someone dies'... ♦Flower.

There appeared to be an overlap of professional and personal detachment which I thought needed to be mentioned.

This overlap of detachment between the professional and personal self (the ICU nurse), appears as a confrontation and/or conflict with their professional obligation of doing the 'right thing' versus 'doing enough':

... 'You think about it, how was the patient an hour before, how did it happen? Was I there? Did I do anything physically to help this patient because the patient is suffering? You have that thing called continuity that the patient must live: 'the patient must live, must live' maybe I did something wrong, maybe it is my fault the patient died. All those things go through your mind when you are busy washing the patient but may your Soul rest in peace that is how you close now'... ♦Anne.

... 'I don't like working in this place [ICU]. The death is too much at times'... ♦Flower

... 'You did all you can do for the patient and you still lose the patient. That is unexpected. That is the only thing which I am struggling with'...
♦Anne.

... 'You have to do intervention, cannot just leave and just go... You feel so useless and helpless'... ♦Anne.

4.4. Theme 3. Thanatophobia

Thanatophobia is defined as: 'the abnormal fear of death.' ("The Encyclopaedia of Death and Dying", 2015)

The two theme-clusters that emerged from the main theme of thanatophobia were:

- ontological confrontation
- supernatural

Ontological Confrontation

Ontological confrontation is described as:

'Human beings have a degree of awareness of personal existence not found among other species. This awareness, the province of ordinary people as much as philosophers and theologians, encompasses the finitude of life, the personal existence of others, the possibility of other worlds, and the questions of when people came into the world, why they are on Earth, and what happens when they die.' ("The Encyclopaedia of Death and Dying", 2015)

The ICU nurses admitted that they never thought of their own death:

... 'You plan everything but you do not think of your own death. It is so unknown. I am scared when it comes to that part'... ♦Jemisco.

Most of the participants shared their fears about their own death. The fear of the unknown was the most challenging aspect of death for the ICU nurses:

... 'I am scared to leave my family behind especially my children [hands touching forehead]. Who will take care of them? I want to be around until they grow up'... ♦Samantha.

... 'Yes of course I am scared of dying. If we are believers we should not be scared of death but we are human beings'... ♦Mystery man.

... 'Yes, I fear dying because I do not know where dead people go to [sweat on forehead]'... ♦Jemisco.

... 'Yes, I fear dying [soft voice]. We do not know the feeling of death'...
♦Anne.

The ICU nurses' explained in their conversations that they do not want to die, but admitted to having no choice in death:

... 'No one wants to die because of the fear of the unknown'... ♦Jemisco.

... 'I really do not want to die. But if I have a choice it will be better to die in an accident'... ♦Samantha.

... 'Nobody wants to die'... ♦Mystery man.

The noise and involuntary movement from the dead body during post mortem care was seen as stressful and anxiety provoking:

... 'You never know when there is a last movement going to be and when you are going to jump. Those last breaths or a noise that comes out'...
♦Flower.

... 'Any movement, like the mouth opening suddenly, makes me scared [hands clasped]'... ♦Samantha

When I questioned the participants about how they would like post mortem care performed on their dead body, some of their responses were:

... 'I will love to be handled in a proper way. Act as if I am still alive. I am not a thing [hand fling]; I am still a human being'... ♦Samantha.

... 'The same way as handling a live person. Speak to me. Must be approached as they approach a living body'... ♦Jemisco.

... 'Must handle me as if I am still alive'... ♦Mystery man.

The second most important request in performing post mortem care on the ICU nurses' dead body was the avoidance of rough handling:

... 'No roughness. Because you are a dead body, they must not push me like a bag of cement. Handle me with care, softly'... ♦Jemisco.

... 'Don't handle me roughly. Move me softly and slowly [softer voice]'... ♦Mystery man.

Of the six participants five verbalized that if there was a choice of how they may die they choose to die peacefully in their own home or instantly in a car crash. This choice was motivated to eliminate a prolonged sick bed in an ICU environment:

... 'Accident is a better way to die. You do not suffer so much, than being sick for a long time [short sigh]'... ♦Samantha.

... 'I want to lay in my bed and die. No suffering. Peacefully in my sleep. Not in an ICU'... ♦Jemisco.

... 'I want to go in my sleep, peacefully. I do not want to struggle, no pain, no ICU [eyebrows drawn together]'... ♦Anne.

... 'I never want to die on a ventilator or having cancer. I want to go in a car crash, fast and quick. I just want to go from one place to the other place'... ♦Change.

... 'If you can choose, I would like to die at home with my family or suddenly in a motor accident or a heart attack [serious voice]'... ♦Anne.

Post mortem care performed with respect and dignity for their dead body was important to most of the ICU nurses:

... 'They must respect me, the way they would love someone to respect them when they are dead'... ♦Samantha.

... 'Treat me with care and dignity. People that are caring and have respect for the dead must handle me'... ♦Mystery man.

... 'Handle me with respect and dignity according to my culture'... ♦Anne.

... 'Handle me with dignity and respect. Treat me with respect as if I belong to them [strict, insistent voice]'... ♦Change.

The participants felt it important that their own bodies must be covered whilst performing post mortem care:

... 'They must make sure to close me and cover me [finger tapping on table]'... ♦Change.

... 'No nakedness. You cover my head and you put on my panties, socks, and petticoat, according to my culture'... ♦Anne.

Lastly, the ICU nurses expressed that the physical appearance of their own body was important:

... 'Wash me and then put on something [clothing] I like. Take care of my face, for me to look good and smell nice [giggling and smiling]'... ♦Mystery man.

... 'My face must be right, my hair must be right. I must look as if I am sleeping. I must be neat and straight'... ♦Anne.

The Supernatural

The term supernatural is defined as 'not attributable to, or explicable by, the laws of nature; magical; mystical' (Branford & Thompson, 1994:972).

Within this study of performing post mortem care, the supernatural was referred to as ghosts, spirits and the devil. The ICU nurses were questioned about their perceptions of these supernatural concepts.

Most of the participants believed in the presence of spirits:

... 'I believe in spirits'... ♦ Samantha.

... 'I do believe in spirits'... ♦ Jemisco.

... 'Spirits, yes I believe in the Holy Spirit'... ♦ Anne.

... 'I believe in spirits. They give warning of something. You just pray and the Holy Spirit guides you [hands folded]'... ♦ Change.

They also explained that spirits may be felt:

... 'I feel spirits. Their presence can be felt, at times you get goose bumps [rubbing arms]'... ♦ Mystery man.

... 'You can feel somebody [spirit] is around'... ♦ Anne.

The ICU nurses also expressed their scepticism in the existence of ghosts even during post mortem care:

... 'I don't believe in ghosts and the devil [shaking head]'... ♦ Samantha.

... 'I never seen one, different cultures, people tell different stories. If you have not seen, I do not know if it exists'... ♦ Jemisco.

... 'Never seen a ghost [slight pulling of nose]'... ♦ Mystery man.

... 'I don't believe in ghosts'... ♦ Change.

4.5. Summary of Findings

Surprisingly, for the participants in this study, performing post mortem care was far more than a simple act of care. For them, it involved caring for their patient until the end, detaching themselves from relationships and facing their own personal issues regarding death. This care is performed with a great reverence for the body and also entails comfort care of the family.

Facing death almost on a daily basis is a reality in ICU nursing. The findings in this study may suggest that coping with personal fears of death remains a problem for the ICU nurse.

In describing the three themes, I have used the participants' own words to describe their experiences of post mortem care in an ICU. In the last chapter, I will discuss the theme findings and relate these to the literature.

Chapter Five

Discussion and Conclusion

5. Introduction

The themes that emerged from the ICU nurses' experiences of performing post mortem care are discussed in relation to the literature reviewed. I conclude this chapter by highlighting the limitations and strengths of the study and make recommendations for future research.

5.1. Discussion of the Three Main Themes

In this research setting, the ICU nurses' experiences of performing post mortem care revealed three concepts: (i) care of the dead body; (ii) the process of detachment by the nurse and (iii) the fear for their own death.

5.1.1. Care of the Dead Body

This study illustrates the importance of post mortem care consisting of three different aspects: (i) physical care of the body; (ii) the psycho-social aspect of caring for the body and (iii) lastly the spiritual care and multi-cultural aspects whilst caring for the dead body. The care of the dead body was seen by all of the participants as the most important aspect of care. Within this theme, the sub-theme of physical care of the dead body was considered extremely important for the participants.

Physical care of the Dead Body

The appearance of the dead body, for the participants, was seen as a significant part of care and caring. A clean sheet must be used to cover the body which in a way may symbolise the purity of death. Wolf confirms that nurses are committed to making the patient look presentable (Wolf, 1991:84). The appearance of the face was seen as a vital part of the care of the dead body. Wolf endorses this and explains that the face is seen as the 'most cleaned area' of the body (Wolf, 1986:31).

The nurses expressed further, that the appearance of the entire dead body must be that of cleanliness and tidiness. This cleaning ritual is seen as 'imposing order' by the nurse (Wolf, 1986:66).

The word comfort was used by all the participants in the study. This is a difficult concept to grasp as the patient is dead and therefore does not feel discomfort. As the patient has died, it is questionable how the nurse will ensure comfort. In this study the word 'comfort' was interpreted in different ways.

The first aspect of comfort was that of the nurse handling the dead body caringly. Within this aspect it was noted that a feeling of personal comfort was preferred. At times, the ICU nurses explained that they felt more comfortable when there were two people in the room performing post mortem care. Hadders (2007) study of nurses' experiences working in the ICU on interventions and dealings with the deceased confirmed that post mortem care must always be done by two or more nurses working together (depending on the size of the body). This is appropriate to 'safeguard a humane' body and to ensure careful handling of the dead body (Hadders, 2007:214).

Another aspect of comfort highlighted by the ICU nurses was that post mortem care should ensure that the dead body is made to look comfortable. Wolf emphasised that in providing comfort the ICU nurse ensures that suffering decreases (Wolf, 1991:73).

A part of post mortem care is that of washing the dead body. The participants described that a sense of cleansing both physically and spiritually was realised. Wolf proposed that this may be seen as a way of 'washing away traces of suffering' (Wolf, 1991:75).

The aspect of talking to the dead body helped the participants to continue to provide comfort. This is in keeping with Hadders who explains that this practice helps the nurses with the maintenance of the 'relational aspect' of the care rendered (Hadders, 2007:211). Furthermore Hadders explains

that this may assist the nurse to cope with the exposure to death (Hadders, 2007).

The last aspect of physical care of the dead body was described by the participants as the actual task of last offices. All of the participants place the dead body in a straight, flat position ensuring that the eyes and the mouth are kept closed. Blum's, historical perceptions (1850-2004) of the nurses' role of the care of the dead verifies this practice and explains that nurse procedures rest on the knowledge of the physiological changes after death (Blum, 2006). This includes understanding the process of algor mortis, livor mortis and rigor mortis.

This is in keeping with Pennington where she asserts that the task of last offices is 'more than ritual' (Pennington, 1978:846). Pennington clarifies that the actions of post mortem care is not only to show respect for the body, but is related to physiological changes as 'somatic death' occurs (Pennington, 1978:846).

The process of removing lines, pipes, cables and tubes from the body was described as a difficult experience. Quested and Rudge (2002) confirm and explain this difficulty as being a sign of withdrawing medical science. The participants found this task difficult as they considered this as giving up on the patient.

The rough handling of the body was seen as a distressing factor for the participants. When this was done by other colleagues, the participants corrected this inappropriate behaviour immediately. This behaviour was seen as disrespectful to the dead body and the family. Hadders (2007) explains that all nurses are responsible to address demeaning behaviour. Blum has similar thinking to that of Hadders, that protection of the body is central to post mortem care and rough handling is emotionally disturbing for the nurses (Blum, 2006).

The psycho-social aspect of caring for the dead body

In this sub-theme, the aspects of respect and dignity for the dead body were highlighted. Hadders (2007:219) emphasised that the 'focus and locus' of the dead body is to safeguard the integrity of the dead body during post mortem care. Respect emerged from the participants conversations which overlapped with psycho-social, spiritual and multi-cultural care of the body.

The participants used the words 'respect' and 'dignity' throughout their interviews. They related respect and dignity in the manner that the body was handled. Lawler (1991) affirms that respect is deeply embedded in the culture of nursing. Care of the body also incorporates the preparation of the body for transportation to the mortuary or undertaker.

The 'soft handling' and the moving of the dead body is well documented in the limited literature. Hadders (2007:211) describes the careful moving and supporting of the body whilst being washed as a sign of 'respect and reverence towards the deceased.' Hadders comments further, that the general attitude of respect paid to the dead patient is no different to that of a living patient. Understanding the physiological changes when algor mortis takes place, may alleviate anxiety for the participants. The anxiety brought upon the participants by the general coolness of the dead body had a significant effect on one of the participants:

'It is so cold I cannot take the coldness of the body, it affects me'

◆Mystery man.

The participants commented that cleaning and tidying up of the dead patient's room demonstrated a sign of respect for the family. Blum comments that when the family views the dead body, the room is seen as the 'patient's sacred space' (Blum, 2006:60). Blum endorses this practice of the participants stating that the tidiness in the room portrays to the family a peaceful death. This further provides 'a way for the nurse to comfort those who come to visit' (Blum, 2006:60).

The last aspect of respect and dignity is the meaning which the participants attach to post mortem care. The participants stated that whilst performing post mortem care, they often think of their own family member who has passed away, or, 'imagined' one of their own family members lying in the bed. Blum states that this reaction is common when performing post mortem care and explains this as the nurse personalising the event. It may be concluded that respect and attention for the dead body together with his or her sacred space is seen as an act of caring to others (Blum, 2006).

The Spiritual and Multi-cultural care aspects

The participants commented that they acknowledged and respected religion and culture but had little or no education of the specific rituals applicable to dead patients in general. However, the participants made sure that there was a safe space for the family to provide any rituals they deemed necessary. Due to the complicated and personal nature of cultural and spiritual care of the dead body, this aspect may be overlooked by the ICU nurse at times.

Pattison supports nurses' respect for religion and explains that sensitivity to the individual, cultural, religious or personal needs is vital to minimise grief. This respect for religion helps facilitate closure for the nurse at the end of a person's life (Pattison, 2008b).

For the ICU nurses in this study, prayer is a common practice. The ICU nurse explained that they say their own prayers when alone with the dead body. Pattison (2008b) acknowledges that religious behaviour is seen at death, for example prayers, but no specifications are made about prayers. The presence of prayers can be seen as hidden in post mortem care and preference may be dictated by the family.

The issue of professional nursing conduct was raised by the participants. The participants implied that the neglect of post mortem care is an indicator of your professional attitude; no respect for the dead body was interpreted as no respect for the nursing profession. Hadders supports this

by commenting that the personal integrity be safeguarded at post mortem care in two ways; the integrity of the body and the integrity of the nurses themselves (Hadders, 2007). Therefore, the treatment of the body portrays the professional norms and values of the nurse:

'Your profession dictates you and how you are going to handle this type of thing' ♦ Change.

5.1.2. Detachment

The second main theme for this study was detachment. The participants highlighted that after death, there was an overwhelming need to detach themselves from various relationships developed with the patient before death. This required that the participants physically and emotionally detach themselves from the patient and family relationship.

Nurse-patient Relationship

The sub-theme of saying 'goodbye' provided the opportunity for the participants to say their own goodbyes whilst performing post mortem care. Performing this task gave them time to 'close' the bond formed with the patient. This is in keeping with Pattison's statement, that preparing a patient that has died may be a way of achieving closure at the end of a care episode and can be seen as the 'final act in caring' (Pattison, 2008b:55). Wolf (1991) also confirms that post mortem care assists nurses to achieve closure after their patient's death.

Within this study, the aspect of keeping the dead body for long periods of time after post mortem care appears to be a problem for the participants. It is evident that the closure process appears to have taken place, but the presence of the dead body reminds the participants of the relationship, thus making the 'letting go' process longer. This study offers a new perspective of detachment although I found no supporting literature specific to ICU nursing.

The task of performing post mortem care allowed time for the participants to 'separate' themselves from the patient after death. This separation time was imperative especially if the study participant had formed a special and close relationship with the patient prior to death. Green and Green share this view, describing post mortem care as a 'fitting conclusion to a special relationship' (Green & Green, 2006:182). Wolf adds that ICU nurses view post mortem care as a way to end their 'care giving association' (Wolf, 1991:85).

The participants also expressed that they experienced a heightened feeling of needing to do the best for the dead body. Green and Green (2006) emphasised that post mortem care can be seen as the last act of service to the deceased. This heightened feeling of doing their (the participants) best, may be seen as a compensatory option for their inability to do anymore at the end of life:

'For some nurses the care stops when the patient dies but I feel that you must still give your best' ♦Mystery man.

Again this study offers another new perspective of detachment although there was no evidence in the literature pertaining to ICU nursing.

Lastly, three of the six participants who had on average of 15 years of ICU nursing experience, verbalised that the letting go process and handling of the dead body was less stressful. Hadders admits that nurses 'sway between poles of nearness and distance' to the deceased to manage their exposure to death, although this does not omit the stress element (Hadders, 2007:207). The participants in this study, and to a lesser extent the family, experienced separation anxiety when releasing the dead body to the mortuary or funeral home.

Nurse-family Relationship

Another aspect of detachment for the nurse is that of separating themselves from the family. Despite the participants having said their personal goodbyes to the dead patient, the participants expressed

difficulty in relinquishing this relationship. This was primarily based on the shared sadness of the nurse and the family.

The participants made it clear that family care and support remained a significant aspect of nursing care. All the participants found family care difficult and recommended that education in this area was needed to better equip them in attending to family care.

For the participants, the preparedness of the family for the death and post mortem care of the patient influenced the nurse-family relationship. It was felt by the participants that a well informed family accepts this stressful event of death better. Pattison advises that the management of this situation requires of the nurse to maintain a high degree of sensitivity (Pattison, 2008a).

Following the death of the patient, the participants voiced that they entered into a different nurse-family relationship. This change is in keeping with Pattison (2008a) who explains that the nurse provides information on the process and procedures of after death care. In this study it was apparent that the participants employed more of an advisory role to the family after caring for the dead patient.

'I offer the family some tea and I asked them if I can do anything from our side to help them. I also explain the things [process] of the funeral home and the death certificate' ♦ Mystery Man.

The participants also identified that providing post mortem care expressed their compassion to provide family care. Quested and Rudge (2002) confirmed that nurses are responsible for presenting the deceased to the patient's relatives in preparing the body for burial. Further on, Pattison (2008b) acknowledges that post mortem care enables the family to see that their loved one was respected and cared for even after death. This compassionate act of care is very important for the family and may be remembered long after the death of the patient.

All the participants acknowledged that there is a lack of support for the family and nursing staff in this setting. It was identified by the participants that bereavement counselling was needed. Çelik et al. (2008) conducted a study of nurses to identify the critical care nurses' knowledge about the care of deceased adult patients. In Çelik et al. study nurses were asked whether or not they gave emotional support to the deceased patient's family, (15/61) 24% stated they did not. Nurses who did provide emotional support reported that they offered a suitable environment for the family to be left alone and to say good bye. It may be extrapolated that the poor emotional support given to the ICU nurse is reflected in the lack of family care after the patient has died.

Detachment of Self

The theme of detachment of self comprised of two sub-themes:

- professional and
- personal.

From the literature reviewed it appears that there is a dearth of information regarding these subthemes.

Professional Detachment

It was important to note that the body, although the patient was deceased, was still treated as the ICU nurse's patient. According to Hadders, treating the patient as alive can be explained as maintaining the relational aspect of the care given (Hadders, 2007). Hadders also clarifies this behaviour as a coping mechanism for the ICU nurses when exposed to patient's death (Hadders, 2007). A sense of ownership of the body is portrayed in this statement making the letting go process difficult.

The participants indicated that the cause of death and the resulting blame thereof, was a difficult process to endure. There is often a situation of blame between the doctors and the nurses. The doctor(s) have the need to keep the patient alive, versus, the nurse who has to care for the dying patient:

'We feel that we are going to be prosecuted. I used to feel as if maybe I am the cause of this patient death. We don't give up until the last moment' ♦ Jemisco.

Overall, the ICU nurses exhibited fear for the blame of the patient's death. This fear sparked self-examination of the nursing care provided to the patient before death. Çelik et al. (2008) supports this feeling of guilt and inadequacy of the ICU nurse in providing end-of-life care. Added to this, the ICU nurse also has to provide respectful and honourable post mortem care and share in the grief of the dead patient's relatives.

The participants stated, that their professional attitude towards the nursing profession would dictate the attitude they may have towards death and the dead body. Hadders (2007) confirms respect for the integrity of the personal body as an essential part of any nursing care in general. This professional guarding of the body is in essence the objective of post mortem care.

Personal Detachment

The personal impact of post mortem care is evident to the reference of the body with the ICU nurses own families. These references of the ICU nurses own family, is an aspect of personalising the death experience. Blum (2006:59) elaborates that identifying with the patient as 'one of their family' when performing post mortem care, the nurse personalises this event. This personalisation makes this event real and demands the acceptance of the reality of death. The association of the dead body with that of a family member may create a more mindful and tender post mortem care.

In order for the ICU nurse to personally detach herself from the patient, allowances must be made to experience personal grief. The literature acknowledges that the death of a patient may be upsetting for nurses especially if they had a caring relationship with the patient (Pattison, 2008b). Instead, during the training of the student nurse, the student nurse is taught to 'exhibit a degree of control of his/her emotions' (Blum,

2006:59). At times, the nurses 'block' their emotions in order to deal with the patient's death and post mortem care (Wolf, 1991:84). More practically, in the current ICU situation in South Africa, the ICU nurse is allocated to care for another critically ill patient and consequently he/she is denied the opportunity to grieve.

5.1.3. Thanatophobia

Thanatophobia is defined 'as a feeling of dread, apprehension or solicitude when one thinks of the process of dying, or ceasing to be or what happens after death' (Foyle & Hostad, 2004:74).

Thanatophobia is also known as a fear of death or death anxiety. Lehto and Stein differentiate between these two interpretations of thanatophobia (Lehto & Stein, 2009).

Death anxiety refers to a 'dread of complete annihilation' whereas fear of death is more a 'concrete belief that death is frightening' (Lehto & Stein, 2009:31). Lehto and Stein explain that death anxiety is related 'broadly to mental or spiritual awareness of the loss of existence whereas fear of death is related to the physical awareness of loss of existence' (Lehto & Stein, 2009:31). The literature reveals no consistency in using these two aspects of thanatophobia separately, but rather using these concepts interchangeably.

Most of the literature is focused on the death anxiety experiences of the hospice nurse, although Lehto and Stein refer to a study by Mallett, Price, Jurs and Slenker in 1991, that showed that critical care nurses reported significantly more death anxiety, burnout and stress compared with hospice nurses. Furthermore, Lehto and Stein acknowledged that death anxiety is not a new concept in nursing, but research on this topic has 'not kept pace with the enormous spectrum of nursing influence' in both preventative and acute settings (Lehto & Stein, 2009:36). These authors recognised that most research has been generated by palliative care and hospice practice and confirms that death anxiety may need more critical attention in the acute care setting (Lehto & Stein, 2009).

Thanatophobia was identified in this study as a 'real' experience for the ICU nurse. In this theme, the following two sub-themes emerged; ontological confrontation and the supernatural. The literature was minimal supporting these two sub-themes specifically pertaining to the ICU nurse.

Ontological Confrontation

'Ontological Confrontation' is defined as the degree of awareness of personal existence and death ("The Encyclopaedia of Death and Dying", 2015). The most compelling ontological confrontation occurs when facing the inevitability of one's own death whether as an immediate reality or as an imagined, distant eventuality ("The Encyclopaedia of Death and Dying", 2015). Kauffman in *'Awareness of Death'* admits that this ontological confrontation with death leads to a number of emotional responses that may have positive and negative effects (Kauffman, 1995).

In this study, a degree of anxiety and fear was experienced by the participants. Most of the participants were scared of the process of dying as there is no scientific proof of what happens with the soul after death:

'Nobody can answer where we going as nobody came back from the other side to tell us' ♦Mystery man.

According to Castles and Murray, the psychoanalytic theory is that 'the unconscious (mind) cannot conceive death because there is no direct experience with it' (Castles & Murray, 1979:156).

This fear and anxiety created a general feeling of 'not wanting to die' amongst the participants. This is in keeping with the nursing and medical outcome of the goal in the ICU: the preservation of life (Castles & Murray, 1979). In this study, exploring the ICU nurses thoughts about their own death and handling of their own body, it was important for the ICU nurses to be treated as if they were still alive:

'They must talk to me' ♦Mystery man.

It was also important for the participants that their body must be handled with care:

'They must not push me like a bag of cement' ♦ Jemisco.

Perceived rough handling of the participant's dead body was seen as an unacceptable practice. Ethical standards of respect and dignity were important for the participants own post mortem care. The covering of their body and their physical appearance was a high priority in their own post mortem care.

Admittedly, the participants explained that they have never thought of their own death and that this study made them think about this inevitable event. Detailed preferences were shared by the participants in their choice of how they would like to die. Two options for their own deaths were highlighted: dying peacefully at home 'in my own bed' or, 'dying suddenly in a motor vehicle accident' thus avoiding a 'long sick bed.' The details on how post mortem care must be performed on their own body, correlates with their own experiences described in performing post mortem care on a patient following death.

Lastly, some of the participants expressed a sense of fear towards the dead regarding the noise and involuntary movement(s) after patient death. The participants stated further that this creates uncertainty:

'Is the patient really dead?' ♦ Samantha.

Peters, Cant, Payne and colleagues (2013) proposed a reason for this degree of apprehension be related to 'the unknowable - what really happens beyond death.' Post mortem care creates a sense fear for the ICU nurse and creates some individual spiritual or supernatural encounters (Peters et al., 2013:14).

In order to address the ICU nurses' death anxiety, Dunn, Otten and Stephens (2005) recommend the development of a continuing education programme that teaches effective coping strategies to prevent death anxiety. Peters et al. (2013:20) also supports this notion by adding that

this 'emotional demanding work' requires nursing skill and also force nurses to have insight into their personal beliefs about death (Peters et al., 2013:20). Peters et al. supports death education in the workplace as a form of providing support to the nurse (Peters et al., 2013). Lehto and Stein reinforces further the importance for nurses to find 'therapeutic motivational avenues' for expressing death anxiety in the workplace (Lehto & Stein, 2009:36).

The Supernatural

For the participants in this study, an element of supernatural encounters were described. Most of the ICU nurses mentioned that they believed in the spiritual realm and that spirits may be felt physically:

'You can feel something is around' ♦ Anne.

Ghosts were also seen as 'make believe' in that they cannot be seen.

Reference was also made to some cultures who experience the presence of ghosts and spirits differently. Lehto and Stein commented on the supernatural reality of death stating that the relationship 'between religiosity and death concerns vary depending on age, gender and devoutness' (Lehto & Stein, 2009:27).

Lehto and Stein also acknowledged that committed religious beliefs and practices do decrease death anxiety of the individual (Lehto & Stein, 2009). Peters et al. describe that the impact of death anxiety on caring for patients at the end of life also reiterate that the 'cultural background and the depth of nurses' belief in a higher being (a God) appeared to influence beliefs about death and dying' (Peters et al, 2013:20). The literature consulted offered no explanation how the supernatural may influence thanatophobia. This sub-theme cluster of the supernatural was viewed by the participants as an unspoken and private aspect of post mortem care.

Whilst reviewing the literature on post mortem care, I wrote up a journal entry.

Journal Entry 15 March 2014

This is such a frightening topic. What is on the other side of death, do we really know? Will we ever know? Death is real – there is a time that we depart from this earth to live in another world. Maybe death is not a curtain lifting, but rather a veil softly lifted from our faces. The only way to find peace in death and to stop this fear is to believe in what lies ahead. This topic has pushed me into religion without me knowing, searching and finding the true answer in my personal faith. I have learnt through this study that death is the final stage of growth. When you are dying you get your final chance to grow, to become more truly who you really are, to become more fully human. If you can begin to see death as an invisible, but friendly, companion on your life's journey then you can learn to live your life rather than simply passing through it.

Managerial/Educational Detachment

The participants admitted that the educational aspects of dying and death have been neglected. All of the participants expressed a need for death education and further educational support on the topic of post mortem care. The participants indicated that they required guidance and confirmation that they were performing post mortem care correctly despite there not being a policy/guidelines available.

The completion of documentation after the death of the patient was identified as challenging and cumbersome especially when the patient's death was classified as unnatural.

A need for debriefing and counselling skills was identified by some of the participants so that they may improve on the management of the death event. The participants identified emotional support and debriefing interventions to manage the nurse-patient detachment process. It was also noted by the participants that managerial support after the death of the patient was minimal.

In a study by Hinderer (2012), exploring critical care nurses' reactions to patient death, it was noted that there may be inadequate support systems in place to care for the critical care nurse who experiences death on a daily basis. Hinderer comments that the critical care nurse would benefit from continuing education in healthy ways to cope with death and the emotions it presents (Hinderer, 2012). Furthermore, Hinderer states that learning to process patient death in a 'healthy manner', ICU nurses could improve the care they provide to patients and families (Hinderer, 2012:258). It was recommended that formal and informal support systems in the work environment may assist the critical care nurses in coping with patient loss. This support may promote healthier work relationships and work environments (Hinderer, 2012).

5.2. Strengths and Limitations of the study

As I reflect on my personal journey, it seems I have learnt an equal amount about post mortem care and the research process. In this sense, then, I have achieved my own personal objectives but it does not mean that the aim of the study has been achieved in every aspect.

Strength of this study was my involvement in teaching and learning with the participants in the study setting. This enabled me to establish a rapport and relationship of trust and confidence with the participants. This had a positive effect on the quality of the interviews and data that was generated.

The participants' thoughts and experiences were specific and personal only to those who participated, therefore applying the results of my study to other groups of ICU nurses may be difficult. Although not perceived as a limitation, transferability of these study participants (ICU nurses) experiences of post mortem care, may differ from future studies in this area. It must also be considered that the transferability of the findings to other research settings may be a limitation as the study was conducted in one academic hospital. However, other ICU nurses may see a similarity with the resulting descriptions of post mortem care.

5.3. Recommendations for Further Research

The following recommendations, as derived from the study findings, are related to nursing management, education and research.

Nursing Management

For unit and nursing managers, finding ways to work together in supporting the ICU nurses through formal and informal systems would be beneficial and rewarding to nursing interpersonal relationships and the ICU working environment.

A greater sensitivity towards the ICU nurse and their individual experiences of patient death may assist in building a better understanding of death.

Regular formal and informal debriefing sessions with the ICU team (at least once in a six month period) may be used to reflect upon the deaths of the patients.

A standard operating procedure (guideline or policy) on the provision of post mortem care, should be designed and implemented to ensure care of the dead body. Within this Standard operating procedure, the legal documentation required for the deceased may prove to be beneficial to both nursing and medical personnel.

Nursing Education

Continuing education of the after death process and related nursing interventions, should be provided to create certainty amongst all nurses in performing post mortem care, such as seminars and short lunch time meetings.

A short course on death and dying for the ICU nurses may facilitate a better understanding of death. This may require a professional in the area of end-of-life care and thanatology. This teaching and learning of death should include cultural and religious aspects of death.

An intervention on trauma debriefing skills would be beneficial to all ICU nurses to improve the interactions with the family of the deceased. General debriefing skills would also be helpful in understanding emotions experienced by the ICU nurses. A program that teaches effective coping strategies to prevent death anxiety may also benefit nurses. Learning to process patient death in a healthy manner may improve the care ICU nurses give to their future patients and families.

Short courses on different cultural and religious death practices will create a greater sensitivity for the ICU nurses towards various cultural beliefs and thus improve post mortem care.

Continuing professional development program on the completion of the legal death documentation may assist the ICU nurses to better understand the legal process of death.

Nursing Research

The concept of debriefing in South African ICU's appears to be seldom considered and opens an area of research for the future.

Future studies may investigate other nursing categories experiences of death in general wards, trauma units and the operating theatres.

Further research in the coping strategies employed by the ICU nurse when dealing with dying and death may be valuable. Understanding the emotions experienced by the ICU nurse may be helpful in providing support.

5.4. Conclusion

In a technological society, where answers to many questions can be pursued through science, understanding the experience of death, as opposed to dying, may be logically incomprehensible. Death remains one of the most traumatic events experienced by the patient and their family. Society has no way of knowing what happens after death unless this fear is alleviated, even partly, on the premise of religious conviction.

Safeguarding the integrity of the dead body was the major finding and utmost priority for the participants in this study. Regardless of how the ICU nurses felt about death, providing professional and quality care to dead patients and their families was seen as most important.

The post mortem care of patients is a complex and involved procedure that can be varied according to different cultural and religious practices. Intensive Care Unit nurses continue to have close contact with their dead patients. They are witnesses and participants with patients and their family's at the most private events of human experience.

The physical appearance, comfort of the dead body and the task of last offices was seen as vital for the ICU nurses. It was important for all the participants to care for the dead body with dignity and respect.

The ICU nurses, during post mortem care, experienced detachment from various relationships. This included the detachment from the nurse-patient relationship, nurse-family relationship and the detachment of the nurse own self from the death experience. The unspoken experience of thanatophobia was also revealed by the ICU nurses when confronted by the reality of their own death.

This study contributed to the knowledge of post mortem care and the experiences of the ICU nurses.

Washed away, all washed away,

"Presented faultless" in cloudless day;

Suffering over and sorrow ceased,

Limitless – endless - *perfect* peace!

- ode to V.G.A. Oliver Wendell Holmes 1890

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APPENDIX A

	<p style="text-align: center;">UNIVERSITY OF CAPE TOWN Faculty of Health Sciences Human Research Ethics Committee</p>	
<p>Room E52-24 Old Main Building Groote Schuur Hospital Observatory 7925 Telephone (021) 404 7682 • Facsimile (021) 406 6412 Email: pos.bsama@uct.ac.za Website: www.health.uct.ac.za/research/humanethics/forms</p>		
<hr/>		
<p>08 September 2014</p>		
<p>HREC REF: 664/2014</p>		
<p>Ms N Fouché Health & Rehab Sciences F56.71, Old Main Building</p>		
<p>Dear Ms Fouché</p>		
<p>PROJECT TITLE: "WHAT HAPPENS BEHIND THE CURTAINS?" AN EXPLORATION OF ICU NURSES' EXPERIENCES OF POST MORTEM CARE (MSc candidate- Ms C de Swardt)</p>		
<p>Thank you for submitting your study to the Faculty of Health Sciences Human Research Ethics Committee for review.</p>		
<p>It is a pleasure to inform you that the HREC has formally approved the above-mentioned study.</p>		
<p>Approval is granted for one year until the 30th September 2015.</p>		
<p>Please submit a progress form, using the standardised Annual Report Form if the study continues beyond the approval period. Please submit a Standard Closure form if the study is completed within the approval period. (Forms can be found on our website: www.health.uct.ac.za/research/humanethics/forms)</p>		
<p>We also acknowledge the MSc student, Ms Carien de Swardt is also involved in this study.</p>		
<p>Please note that the ongoing ethical conduct of the study remains the responsibility of the principal investigator.</p>		
<p>Please quote the HREC reference no. in all your correspondence.</p>		
<p>Yours sincerely</p>		
<p> PROFESSOR M BLOCKMAN CHAIRPERSON, FHS HUMAN ETHICS Federal Wide Assurance Number: FWA00001637. Institutional Review Board (IRB) number: IRB00001938</p>		
<p>This serves to confirm that the University of Cape Town Human Research Ethics Committee complies to the Ethics Standards for Clinical Research with a new drug in patients, based on the Medical Research Council (MRC-SA), Food and Drug Administration (FDA-USA), International Convention on Harmonisation Good Clinical Practice (ICH GCP) and Declaration of Helsinki guidelines. The Human Research Ethics Committee granting this approval is in compliance with the ICH Harmonised Tripartite Guidelines E6: Note for Guidance on Good Clinical Practice (CPMP/ICH/135/95) and FDA Code Federal Regulation Part 50, 56 and 312.</p>		

APPENDIX B



Netcare Management (Pty) Limited

Tel: + 27 (0)11 301 0000
Fax: Corporate +27 (0)11 301 0499
76 Maude Street, Corner West Street, Sandton, South Africa
Private Bag X34, Benmore, 2010, South Africa

RESEARCH OPERATIONS COMMITTEE FINAL APPROVAL OF RESEARCH

Approval number: UNIV-2014-0041

Ms Carien de Swardt

E mail: Carien.DeSwardt@netcare.co.za

Dear Ms De Swardt

RE: WHAT HAPPENS BEHIND THE CURTAINS" AN EXPLORATION OF ICU NURSES' EXPERIENCE OF POST MORTEM CARE


The above-mentioned research was reviewed by the Netcare Research Operations Committee's delegated members and it is with pleasure that we inform you that your application to conduct this research at Netcare UCT Private Academic Hospital, has been approved, subject to the following:

- i) Research may now commence with this FINAL APPROVAL from the Netcare Research Operations Committee.
- ii) All information regarding Netcare will be treated as legally privileged and confidential.
- iii) Netcare's name will not be mentioned without written consent from the Netcare Research Operations Committee.
- iv) All legal requirements with regards to participants' rights and confidentiality will be complied with.
- v) Netcare must be furnished with a STATUS REPORT on the progress of the study at least annually on 30th September irrespective of the date of approval from the Netcare Research Operations Committee as well as a FINAL REPORT with reference to intention to publish and probable journals for publication, on completion of the study.
- vi) A copy of the research report will be provided to the Netcare Research Operations Committee once it is finally approved by the relevant primary party or tertiary institution, or once complete or if discontinued for any reason whatsoever prior to the expected completion date..
- vii) Netcare has the right to implement any recommendations from the research.

- viii) Netcare reserves the right to withdraw the approval for research at any time during the process, should the research prove to be detrimental to the subjects/Netcare or should the researcher not comply with the conditions of approval.
- ix) APPROVAL IS VALID FOR A PERIOD OF 36 MONTHS FROM DATE OF THIS LETTER OR COMPLETION OR DISCONTINUATION OF THE STUDY, WHICHEVER IS THE FIRST.

We wish you success in your research.

Yours faithfully

 21/9/2014
Prof Dion du Plessis
Full member: Netcare Research Operations Committee & Medical Practitioner evaluating research applications as per Management and Governance Policy


Shannon Neil
Chairperson: Netcare Research Operations Committee
Network Healthcare Holdings Limited (Netcare)
Date: 23/9/2014

APPENDIX C

Participant Pseudonym:

Date:

Nurse Researcher: C de Swardt

Address: UCT Private Academic Hospital,
D-level L Block GSH, Anzio Road, Observatory

Telephone N^o (021) 442 9246

Supervisor: Dr N Fouché UCT Health and Rehabilitation Science

Information Sheet

The nurses' experience of post mortem care differs from that of other occupational groups (ambulance officers, medical practitioners and police). Intensive Care (ICU) nurses are faced daily with performing post mortem care when critically ill patients die. Post mortem care is performed behind closed doors, thus creating an aura of mystery as to what happens to the dead body.

The ICU nurse is ideally placed to provide experiences encountered whilst performing post mortem care.

The purpose of this study is to explore the experiences of ICU nurses while performing post mortem care.

In doing so, information about experiences of post mortem care will be obtained.

These experiences will be used to identify challenges in post mortem care and the need for educational/emotional support for the ICU nurses.

Registered nurses currently working in an ICU environment will be invited to take part in the study.

The research will consist of a conversation between the researcher and the registered nurse, which will last between 45 - 60 minutes. The conversation will be recorded on audiotape only (no videotaping). Your permission to audiotape the conversation will be requested. All information will remain confidential (i.e. your name will not be mentioned in the study

however a pseudonym will be used). Participation in the research will consist of one session with feedback at a later date.

UCT Private Academic Hospital will be the venue for this conversation. These sessions will be held in a private and secure room in near proximity to the ICU.

Access to information will be restricted to the researcher and study supervisor only and the conversation will be transcribed by the researcher. The recorded conversations will be saved on a disc and kept in a safe when not being used. By law the data must be retained for five years after which it will be destroyed.

Participation in the research will not necessarily benefit you directly.

This is a very sensitive research area, and we will be exploring aspects of care that may be uncomfortable or distressing. The interview process can be stopped at any time if you do not want to answer any questions. If you experience any discomfort, upset, or distress during the interview, there will be a debriefing session with the researcher. The debriefing session would be held immediately and if necessary you may be referred to Independent Counselling and Advisory Services (ICAS).

Participation in this study is voluntary based and no participant is under any obligation to participate in the study other than voluntarily. You have the right to withdraw from the study at any point in time.

If you wish to contact anyone for further information regarding this study, please feel free to contact my Supervisor. Ms N Fouche email nicki.fouche@uc.ac.za.

The UCT Human research Ethics Committee can be contacted on 021 406 6338 in case participants have any questions regarding their rights and welfare as research subjects on the study.

APPENDIX D

Participant Pseudonym:

Date:

Nurse Researcher: C de Swardt

Address: UCT Private Academic Hospital,
D-level L Block GSH, Anzio Road, Observatory

Telephone N^o (021) 442 9246

Supervisor: Dr N Fouché UCT Health and Rehabilitation Science

CONSENT FORM FOR STUDY INTERVIEW AND FEEDBACK

SESSIONS.

Registered nurses currently working in an ICU environment will be invited to take part in the study.

The research will consist of a conversation between the researcher and the registered nurse, which will last between 45 – 60 minutes. The conversation will be recorded on audiotape only, (no videotaping). Your permission to audiotape the conversation will be requested. All information will remain confidential (i.e. your name will not be mentioned in the study or in the study findings; however a pseudonym will be used). Participation in the research will consist of one session with feedback at a later date.

6 – 8 Participants will be required to participate in the study.

The duration consisting of the conversation and feedback session will be 4 weeks in the month of October 2014.

If you wish to participate in this study, you must be a permanent staff member working in ICU.

Should you decide to take part in this study, you will be required to sign this consent form.

UCT Private Academic Hospital will be the venue for this conversation.

These sessions will be held in a private and secure room in near proximity to the ICU.

Access to information will be restricted to the researcher and study supervisor only and the conversation will be transcribed by the researcher.

The recorded conversations will be saved on a disc and kept in a safe when not being used. By law the data must be retained for five years after which it will be destroyed.

After the study has been completed the findings will be made available to the ICU Unit.

Participation in the research will not necessarily benefit you directly (no financial or other benefits).

This is a very sensitive research area, and we will be exploring aspects of care that may be uncomfortable or distressing. The interview process can be stopped at any time if you do not want to answer any questions. If you experience any discomfort, upset, or distress during the interview, there will be a debriefing session with the researcher. The debriefing session would be held immediately and if necessary you may be referred to Independent Counselling and Advisory Services (ICAS).

Participation in this study is voluntary based and no participant is under any obligation to participate in the study other than voluntarily. You have the right to withdraw from the study at any point in time.

If you wish to contact anyone for further information regarding this study, please feel free to contact the study supervisor, Ms N Fouche email nicki.fouche@uct.ac.za.

The UCT Human Research Ethics Committee can be contacted on 021 4066338 in case participants have any questions regarding their rights and welfare as research subjects on the study.

I have read the Information Sheet. I understand what is required of me and I have had all my questions answered. I do not feel that I am forced to take part in this study and I am doing so of my own free will. I know that I can withdraw at any time.

I hereby agree to the audio-recording of my individual interview.

Signed:

.....
Participant

.....
Date and place

.....
Researcher

.....
Date and place

Notes

.....
.....
.....
.....
.....
.....
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.....

APPENDIX E

DATA COLLECTION TOOL

Participant Pseudonym:

Date:

Nurse Researcher: C de Swardt

Address: UCT Private Academic Hospital,
D-level L Block GSH, Anzio Road, Observatory

Telephone N^o (021) 442 9246

Supervisor: Dr N Fouché UCT Health and Rehabilitation Science

INTERVIEW GUIDE 1.

The leading question to the interview with the participants:

Please describe your patient experiences in performing post mortem care.

The interview prompts:

1. What actions do you find difficult or dislike doing whilst caring for the dead? And why?
2. Have you experience the rough handling of the dead? How did this make you feel?
3. What emotional and spiritual experiences do you encounter whilst performing post mortem care?
4. Are there any personal death rituals that you follow in doing post mortem care?
5. Is there any 'rewards' (positive results) in performing post mortem care?
6. Are there any educational interventions that you think would help you to be more prepared to do post mortem care?

All participants will be asked the same questions.

NOTES:

APPENDIX G



Dear

As this study concludes, I would be very grateful if you can complete this short questionnaire. Your input into the study is invaluable.

What has this study taught you about post-mortem care?

.....
.....

What have you learnt about death?

.....
.....

Describe one good thing that you have experienced in this study?

.....
.....

Describe one difficult thing that you have experiences in this study?

.....
.....

Do you think that there should be death education even after graduate level?

.....
.....

If so, what would you like to know more about?

.....
.....

It is with sincere gratitude that I thank you for your time and willingness to participate in this study.

Signature:

Date: