**TRANSCRIPT ANALYSIS – Sudden Death in Emergency Department**

***Participant: CHRISTINE (pseudonym) (1N7)***

**INTRODUCTION (MOTIVATION AND VALUES)**

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| **Initial Codes** | **Transcript line and quote** | **Description of the code** |
| “**Individual traits**”  Passion  Excel  Personal example  Variety  Complexity  Mystery  “**Adrenaline rush**”  Solving a puzzle  Superior skills  Status | 26-28: I have quite a **caring** nature and I am a **caring** person, a **kind** person, I think all my individual traits worked well in my personal career  14-15: I **love** being a nurse. It is my **passion**.  22: I hope I **made her proud**.  24: she used to tell me these **weird and wonderful** stories  28-30: and it’s a **very broad area** to go into. It’s not like you go into nursing, and that’s it, that’s who you are, you have so many pathways to go into, so **it’s never a boring job** at all.  35-36: I have joined ED because it’s an area where **you can learn a little about a lot**  40-42: Every day is different in ED … you can **never know what comes through that front door**.  43: The **adrenaline rush**, especially when you work in Resus, when the red phone goes off  47: In ED, you have no idea, you are **working from scratch**  49-50: As an ED nurse you **gain skills** that a ward nurse will not even think to do at all  51: I mean what a **cool job** to do | Individual traits: personal characteristics, motivations and values  (The Schwartz (1992) Value Theory: Values are broad motivations that can serve as the basis for goals. For example, a person who values benevolence is likely to be motivated by benevolence values at home, at work, and with friends). |
| *Privileges*  Team  Different backgrounds  “**Comradery**”  Learning opportunity  Skills | 70-76: I love **the team**. The ED team is a solid bunch of people from **different backgrounds**, … and just learning how people are **working together**. Everyone has a very good **comradery**, very similar to the military. … Another thing I like about my job is just the amount of things I have the **chance to learn** and absorb and the **skills I am able to do** on a day-by-day basis | Privileges: things she like about the job |
| *Drawbacks*  Overcrowding  Unsafe  Staff pressures  Violence  “**Survival medicine**” | 77-91: The thing that I like the least about the job is the **overcrowding** and the **unsafe working** we have in ED because there is nothing we can do about the **massive influx of patients**, … the **pressures on the staff**, … pretty basic, it’s **survival medicine** is what is it called when you do what you can, in the **space and time, resources that you have**. … ED is a bit of a **dirty medicine**, … Other things that I dislike about the job is probably the **violence and aggression** … just obviously **do not appreciate** anything you are doing for them, … | Drawbacks: things she does not like about the job |

**DEATH EXPERIENCE**

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| **Codes** | **Transcript line and quote** | **Description of the code** |
| Different understandings | 118-121: There are **different** ways in which people die, **different** environments in which people die, some people react **differently** to death, family, friends, colleagues. So I don’t really think there’s a clear description in my opinion but people could have a **different** understanding of it | Different: people could have a different understanding of death |
| Closure | 144-145: Spending 2 hours with her was actually nice, **seeing her having her last breath was nice**, quite upsetting at the time, quite emotional | Closure: seeing her last breath |
| Empathy | 149-150: I think it made me **empathize** more with patients who are dying or family members of patients who are dying because I know exactly what it’s like | Empathy: personal experience supports managing professional experience. |
| Not dignified | 164-165: dying in ED because it’s **not very** **dignified** … | Not dignified: a death that has no dignity characteristics |
| Better understanding | 166-168: Being more aware of the process of death by seeing it myself with a family member I am able to be there more for the patient, sitting by their side when we can, empathising with the family more and just having a **better understanding** of the processes.  432-437: Things that I have learned from certain events can help with similar events in the future. So if you see similar people with the same reason for death, you can bring back things that worked last time and help again with the next kind of situation. But there is nothing specifically that I have used, just trying not to affect you and being empathetic and passionate. Just keeping the similarities of how you deal with families. | Better understanding: personal death experience helps when processing death in professional life |
| Not ready | 221-223: but more for the unexpected, because we are **not mentally ready** for it. We are not prepared for it or the family I would say or colleagues. Sometimes we can’t mentally prepare  210-211: So if you are unexpected death, regardless of their age and regardless of what their future could have had, it’s *absolutely distressing* because you are **not expecting it**  216: it’s *emotionally devastating and upsetting* | Not ready: not mentally prepared for a death when it’s sudden and unexpected |
| Reflection | 233-236: There are times when patients who passed away you start thinking about like what have I done at the beginning, is there anything I could have done differently? There are times when you **reflect** on patients dying, especially during debriefs, you start thinking, would they have died anyway, regardless of what we did?  238-240: It’s very tricky isn’t it, because you’ve done everything you can but we are all humans, we’ve worked together, we’ve done everything we can, with the ability or knowledge that we have | Reflection: thinking about if there is anything that could have been done differently. Accepting limitations as a human, as a team, as knowledge possessed. |
| Debrief | 262-265: A worthwhile **debrief** is I think one that last about a half an hour. You have a very good sit down, everyone has their time to talk, express their feelings, what could they have done better, what we could have done differently but I think debriefs are really important because it gets people to reflect and let people having an understanding of the ways in which they did things and why.  270-275: In a **group** you can listen to everyone’s opinions, worries and successes so you can kind of all listen, however the problem with that is that there is a risk of blame sometimes. So for example if someone says, a certain individual did it this way, but the others didn’t agree with that but they couldn’t challenge it at the time, in the debrief there is a risk of these individuals speaking up and some sort of blame culture coming out of it. | Debrief: people have their time to talk  Group debrief: listen to everyone’s opinion. Risk of blame sometimes. |
| Family support | 251-252: kind of we have done everything we can and there is nothing else we can do, is taking on a role with the family, **family support,** colleague support.  291-294: I normally try to close the curtains and sit with them, put my hand on their shoulder and say, look “I am Eva”, I introduce myself and say, “I am your point of contact”. I always apologize and say, “I am so sorry that this is happening at the moment” and then basically, being there for the family as much as they need you to be.  328-329: We wouldn’t do our jobs well, we wouldn’t be able to offer **support for the family** … for whoever needs it, especially as a senior band 7 | Family support: being there for the family |
| Colleague support | 252: taking on a role with the family, family support, **colleague support**  329-332: We need to be there for the band 5’s, *we can’t be the one’s crying in the corner* unfortunately, not just because of the patients and relatives but our juniors, who may not be used to see so many patients dying. | Colleague support: being there for junior colleagues |
| Not enough | 258-261: But if I am honest, we are not very good in doing debriefs in our Department and probably most ED’s would probably agree. There is **not enough** time or resources to cover a whole Resus Team to go off the shop floor and have a debrief  257-258: Unfortunately with ED we have patients coming through the door all the time  310-311: we show compassion, but we only give so much, because we have other patients. We want to get more time than we do, but unless we do, but unless we have more staff and resources for that, | Not enough: limited time and resources |
| Carry on | 319-320: that was the first time I’ve seen a dead body and I was very upset. **I carried on** with everything, | Carry on: continue to do the job after a death experience |
| No feelings | 321-322: But, then after 6 years working in ED I have **no feelings** at all anymore seeing a dead person. | No feelings: no impact of seeing a dead person |
| Part of the job | 322-323: There is nothing. It has become so, normal for me as a nurse and probably as an ED nurse, that it’s **part of the job** | Part of the job: normal to see a dead body |
| Age and situation | 338-341: For example there’s been a few in the past, because of what brought them in, their **age and the situation**, it makes it feel like, ohh that is awful, but not so much that I would not be able to go to work or start crying. It’s more just a shock of the situation, how they died, rather than the emotion of it.  399-402: Yes, so if the young girl wasn’t young, if it would have been older, male or female, doesn’t matter what gender, it wouldn’t have shocked me as much. Same with the young gentleman, if it was older, male or female again, who would have had their life, it wouldn’t shocked me either. | Age and situation: factors that make a death shocking |
| Shocking | 355-356: It was just **shocking**, once it was called RIP, the family haven’t even arrived yet. This is what is horrible about ED death  389-392: He had no past medical history other than obese, in it’s thirtees, so relatively young, male. Another thing **shocking** about him was that his wife was at home, Covid positive, couldn’t even come in to see him because she was Covid positive, which was so upsetting. | Shocking: a death case that has features that stand out from the many deaths seen |
| Talk | 414-418: I ring my mum quite often, I don’t mention anything confidential but I **tell** her the situation in which I was in and she’s great because she listens and empathizes, even though she was never for herself. So, I think support network is really important for me. I also tell my fiancée, he just listens, doesn’t really get involved. My mum is my go to if I have anything shocking, I ring her and I tell her “Guess what?”  468-471: Getting people **talking** about it. Because as I said earlier, people don’t like to talk about it. Whether it upsets them, they don’t want to be involved with it so whether or not we need to **talk** about death more. It’s normal sometimes. But not so much in ED.  491-494: First thing to know that death is normal and **talk** about it because it’s not going to go away and as nurses we are going to see it more, so those people who get upset about seeing death, what do they expect from ED, death is going to happen. It’s about coping with it rather than denying that is not going to happen | Talk: coping mechanism in dealing with a shocking death |
| Sleep | 419-420: I sleep. **Sleep** helps. I don’t lose sleep. Which is good, because I am quite strong minded. If I wouldn’t be I would probably loose sleep. But I cope with sleep and try not to think about it | Sleep: coping mechanism in dealing with a shocking death |
| Exercise | 422-423: I do like to **exercise**, I go for runs as the exercise kind of clears the mind | Exercise: coping mechanism in dealing with a shocking death |
| Stay in ED | 441-442: I know it’s definitely ED where I am going to stay. So seeing death in ED, did not made me not want to stay in ED, | Stay in ED: continue a career in ED despite seeing death experiences |
| Life is short | 452-459: Working in ED and seeing such amount of sudden death, it makes me realize that **life is too short** and life can be over in an instant. We see it all the time and you absolutely need to live life to the full, don’t hold back because you can never know when something happens and you’ll be in ED and potentially die. It made me really value my family and just those little conversations with your family, saying that you love them, or like not taking risks sometimes. People often come in with awful head injuries and die when don’t wear a helmet on their bike, so this really made me think about safety when riding bikes and things. So realistically, **life is too short**, make the most of everything | Life is short: seeing sudden death makes her realize life is too short |
| Studies and resources | 468: **study sessions** about death  475-476: Maybe some **resources** of things that we can do, to make patient’s experiences better in ED, what pathways do we have, because I know that we don’t have much really.  482-484: potentially more information about things in what to do. Because as a band 5, normally you have the things to do such as paperwork with the family. Knowing things about NOK, valuables, belongings knowing more information about that prior of doing it. | Studies and resources: sessions about death and resources of things that can be done |
| Detach | 504-507: Also try to take a step back, quite a lot of people tend to become too involved with it and that’s sometimes people do, get very emotional and that’s when you get really attached. So my advice would be to try and **detach** yourself from it. Like I said I don’t get upset anymore seeing a dead person, probably because I have detached myself from it too much.  501-502: . Try not to take home with them and especially the traumatic deaths, which stick with you sometime | Detach: not getting too involved with the death of a patient |

**FINAL CODES EMERGING THEMES**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| 1 | Individual traits |  | 1 | Motivation for the job |
| 2 | Adrenaline rush |  | 2 | Pros of the job |
| 3 | Privileges |  | 3 | Cons of the job |
| 4 | Drawbacks |  | 4 | Meanings of death |
| 5 | Different understandings |  | 5 | Closure |
| 6 | Closure |  | 6 | Empathy |
| 7 | Empathy |  | 7 | Dignity |
| 8 | Not dignified |  | 8 | Understanding death |
| 9 | Better understanding |  | 9 | Readiness for death |
| 10 | Not ready |  | 10 | Blame and reflection |
| 11 | Reflection |  | 11 | Talking about death |
| 12 | Debrief |  | 12 | Family support |
| 13 | Family support |  | 13 | Colleague support |
| 14 | Colleague support |  | 14 | Limitations |
| 15 | Not enough |  | 15 | Duty of care |
| 16 | Carry on |  | 16 | Numbness to death |
| 17 | No feelings |  | 17 | Part of the job |
| 18 | Part of the job |  | 18 | Age and situation |
| 19 | Age and situation |  | 19 | Shocking death |
| 20 | Shocking |  | 20 | Coping with death |
| 21 | Talk |  | 21 | Career plans |
| 22 | Sleep |  | 22 | Influence on self |
| 23 | Exercise |  | 23 | Prepared for death |
| 24 | Stay in ED |  | 24 | Detachment |
| 25 | Life is short |  |  |  |
| 26 | Studies and resources |  |  |  |
| 27 | Detach |  |  |  |

**SUPERORDINATE THEMES**

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| --- | --- |
| **WORKING IN ED** | Motivation for the job |
| Pros of the job |
| Cons of the job |
| **A DIFFERENT DEATH** | Meanings of death |
| Readiness for death |
| Age and situation |
| Shocking death |
| Dignity |
| **LIVING WITH DEATH** | Blame and reflection |
| Duty of care |
| Numbness to death |
| Part of the job |
| Detachment |
| **LEARNING FROM DEATH** | Closure |
| Empathy |
| Understanding death |
| Talking about death |
| Coping with death |
| Influence on self |
| Prepared for death |
| **LIFE AFTER DEATH** | Family support |
| Colleague support |
| Limitations |
| Career plans |