NURSES' VIEWS OF FAMILY PRESENCE AT THE BEDSIDE DURING RESUSCITATION

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ABSTRACT

RESEARCH SUBJECT: Nurses’ Views of Family Presence at the Bedside during Resuscitation

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Family presence during resuscitation has been an ongoing issue in many hospitals across the nation and around the world. Nurses play a pivotal role in negotiating and supporting family presence during end-of-life crisis. Many hospitals do not have policies in place to guide nurses’ decision-making regarding family presence during resuscitation. Research suggests that nurses’ attitudes on the subject are varied, and reports of nurses’ perceptions are conflicting (Twibell et al., 2008). The purpose of this descriptive study was to extend what is known about the perceptions of registered nurses regarding family presence during cardiopulmonary resuscitation. This study used Wright and Leahey’s (1999) theory of family systems as an overarching framework and employed a grounded theory approach. The sample consisted of twelve nurses from various units of a midwestern hospital including the emergency department, intensive care unit, and cardiac cath lab. The data were obtained qualitatively using interview questions adapted from the Parkland Health and Hospital System (1997). Data were analyzed using constant comparative analysis. The results of this study provided information about nurses’ perceptions of family presence during resuscitation, which can guide nurses and nursing leaders who set policies and make decisions regarding the practice of family presence at the bedside during resuscitation.
Chapter I

Introduction

Healthcare is evolving quickly in the current era of history. Healthcare changes are not always guided by physicians or nurses, but rather by the consumers and patient populations that are served by the health care industry. Patients and their families are increasing in their knowledge on all subjects regarding healthcare, which has contributed to a shift in healthcare from a patient-centered approach to a family-centered approach.

Family-centered care is a system-wide approach to family healthcare that includes the delivery of safe, high quality healthcare while recognizing, focusing on, and adapting to both the physical and psychosocial needs of the patient and family (Hanson, Gedaly-Duff, & Kaakinen, 2005). The underlying premise of family-centered care is that each patient is an extension of a larger unit: his or her family. The goal in part is to meet the needs of patients’ families, including their needs for information, support, and the opportunity to be near loved ones during illness (Duran, Oman, Abel, Koziel, & Szymanski, 2007).

This shift toward family-centered care during acute illness and hospitalization has led to the controversial issue of family presence at the bedside during resuscitation and other invasive procedures. Healthcare teams worldwide are deliberating the risks and benefits of having family present in the room during a life-threatening resuscitation attempt. Research on family presence during resuscitation (FPDR) is limited but increasing, as healthcare professionals seek to make sound decisions for patients and
families (Meyers et al., 2000; Holzhauser & Finucane, 2007; Duran et al., 2007).

Research suggests a variety of perceived benefits associated with family presence at the bedside during resuscitation. Family presence can help sustain connectedness and bonding in the patient-family relationship, provide an opportunity to educate the patient’s family about the patient’s condition, facilitate the patient’s family in expressing their caring for the patient, allow patient’s family to support the patient and the staff, and reduce fear and anxiety among patient’s family members. Furthermore, research suggests that, if patients do not survive a resuscitation, FPDR can facilitate the family’s grieving process in the hospital and later at home because there is less doubt for the patient’s family about what happened to the patient and the family saw that everything possible was done. Families report that FPDR provides a sense of closure on lives shared together. In addition to holding benefits for families, benefits for staff include that FPDR encourages professional behavior of staff at the bedside and reminds staff of a patient’s personhood (Duran et al., 2007; Mian, Warchal, Whitney, Fitzmaurice, & Tancredi, 2007; McClement, Fallis, & Pereira, 2009).

There are also many risks perceived by nurses reported in the research on FPDR, such as insufficient space at the bedside and the challenge of finding sufficient staff to care for the patient and the family. There can be an increase in stress and performance anxiety for the staff due to worrying about the risk of litigation. Confidentiality and the patient’s privacy can also be violated. Healthcare professionals fear that some events might be too traumatic for family members. Families may lose emotional control and interfere with the patient’s care. Also, both family members and staff could find it difficult to discontinue resuscitation efforts.

The practice of FPDR is clearly becoming a more acceptable practice, despite a lack of strong evidence about the outcomes of FPDR and how to implement FPDR. Nurses are often the healthcare professionals who facilitate the process, communicate
with all stakeholders, and negotiate the specifics of inviting, supporting, and debriefing families. Research reveals that not all nurses are supportive of FPDR, and the risks and benefits of FPDR from nurses’ perspectives are still not clear (Twibell et al., 2008; McClement et al., 2009). Further examination of nurses’ perceptions of FPDR is needed in order to guide health care facilities in fully operationalizing family-centered care in general and FPDR in specific.

**Background and Significance**

This concept was first presented in the early 1980s when Foote Hospital in Michigan began a program to facilitate the practice of FPDR as a response to demands by families (Emergency Nurses Association, 2001). Traditionally, families of patients being resuscitated were secluded and placed in a private area while the healthcare team followed policies and procedures to try to reverse the patient’s life-threatening condition. With the movement to a family-centered approach, the Emergency Nurses Association (2005) endorsed the concept of family members remaining at the bedside of loved ones during resuscitation or invasive procedures. Additionally, the 2000 American Heart Association guidelines for emergency cardiovascular care and cardiopulmonary resuscitation recommended family-witnessed resuscitation. Shortly thereafter, the Code of Ethics for Nurses was published, which cited an obligation for nurses to advocate for the patient’s interests by meeting the comprehensive needs of patients and their families across the care continuum (American Nurses Association, 2001).

In about 2000, early attempts to conduct research on FPDR began. A flurry of descriptive studies addressed the opinions of all stakeholders, including nurses, physicians, families, and patients (McClement et al., 2009; Knott & Kee, 2005; Demir, 2008). The hospital staff surveyed most often included nurses and physicians from the emergency department and critical care units. A few tests of interventions were published (Holzhauser & Finucane, 2007; Mian et al., 2007). Qualitative researchers also
explored the lived experiences of family members present during resuscitation and, less commonly, the perspectives of patients and healthcare providers (Halm, 2005). The number of research studies on FPDR has been increasing steadily in the last few years and now totals nearly 75.

Research has shown that healthcare providers hold conflicting opinions about the presence of patients’ families during cardiopulmonary resuscitation. Nurses have responded more favorably than physicians and tended to agree with families who have claimed that family presence was a “right” of both the patient and family (Duran et al., 2007). Research with families has consisted primarily of retrospective reports, with little examination of long-term benefits. The little research that has been conducted with patients suggests that patients are positive about having families present.

Organizational statements in support of FPDR have been issued by such bodies as the Emergency Nurses Association (2005), American Association of Critical Care Nurses (2004), and European Federation of Critical Care Nursing Association (McClement et al., 2009). A key publication by the Society of Critical Care Medicine (Davidson et al., 2007), an organization of physicians and nurses, clearly recommended FPDR.

The practice of FPDR continues to gain momentum, indicating that more research is needed on all aspects of FPDR. This issue impacts patient and family satisfaction and nurse satisfaction, all variables that have an economic impact. Healthcare systems recognize that there may be legal implications of allowing families in and keeping families out. Since the attitudes of healthcare providers have been shown to affect the family member’s decision to stay or leave the room during various procedures on resuscitation, it is important to assess the attitudes, concerns, and beliefs of health care providers regarding FPDR (Basol, Ohman, Simones, & Skillings, 2009). Additional research and education in family presence are needed for the healthcare team. Education
regarding family presence that heightens awareness of the staff and addresses staff concerns is a necessity in promoting a change from the traditional view.

What is lacking from the research to date is sufficient qualitative approaches to the perceptions of healthcare providers about FPDR. Perceptions evaluated qualitatively may differ markedly from perceptions measured quantitatively. Furthermore, no conceptual underpinnings for FPDR have emerged. In particular, there has been a lack of qualitative research using the grounded theory approach to explore the perceptions of nurses related to FPDR indicating further research is needed in this area.

**Statement of the Problem**

The practice of allowing FPDR has caused continuing controversy among health care professionals for decades. Nurses traditionally have been the healthcare professionals who facilitated the process, communicated with all stakeholders, and devoted energy and insight into inviting, supporting, and debriefing families who experienced FPDR. Research using quantitative methods has revealed that nurses could see both risks and benefits related to FPDR and have reported ambivalence about the intervention (Duran et al., 2007; Demir, 2008). Few research studies have queried nurses about their perspectives related to FPDR using qualitative methods; specifically, a grounded theory approach has not been utilized to explore the perceptions of nurses related to FPDR and to form a framework for explaining nurses’ perspectives. Since nurses often facilitate FPDR and negotiate decision-making regarding FPDR, more research using qualitative methods is needed about the practices, preferences, and perspectives of nurses involved with FPDR.
Purpose

The purpose of this grounded theory study was to explore qualitatively the perceptions of registered nurses about family presence during cardiopulmonary resuscitation. The target sample consisted of twelve nurses from various units of a mid-western hospital in the United States. The units included the emergency department, intensive care unit, and cardiac cath lab.

Research Question

The research question that guided the study was, “What are the perceptions of RNs who provide care to all ages of patients regarding family presence at the bedside during resuscitation?”

Conceptual Framework

No theoretical framework has been developed to ground the research on FPDR. Typically, grounded theory studies do not cite a theoretical basis before collecting data, in order to avoid bias in the interpretation of the data. However, the current study benefited from the general, overarching framework developed by Wright and Leahey (1999) that supported family-centered care. Wright and Leahey’s theory has not been tested in research, and published reports of its application in practice are limited. While this theory does not address FPDR specifically, its use in this study advanced the development of a theoretical basis for FPDR embedded within a theory of family-centered care.

Wright and Leahey's (1999) theory of family systems nursing viewed the family as a complex interrelated group that functioned as an organized whole. Individuals in the family were interdependent and derived meaning through interactions within and between the family and their world. Wright and Leahey’s theory was, in essence, a system theory. Systems theories viewed the world as one of interrelationships and recognized that the whole was greater than the sum of its parts. Wright and Leahey proposed that every
family system had features designed to maintain stability or homeostasis, although these features could be adaptive or maladaptive (Hanson et al., 2005). At the same time, the family changed constantly in response to stressors and strains from the external environment, as well as from the internal family environment. Thus, hospitalization of a family member had an impact on the whole family system and the system’s equilibrium (Eggenberger & Nelms, 2007). In the healthcare environment today, families expect to be involved with the care of their loved ones and to be actively engaged in care decisions. In this way, the family as a system tries to maintain stability when a family member is hospitalized and especially when a patient experiences an end-of-life crisis.

**Definition of terms**

Conceptual definitions help to clarify the focus of this research study and are presented in this section. Operational definitions were not appropriate for this study, since qualitative methods were used, and quantitative measurement of variables did not occur.

**Family.**

Conceptual Definition: those persons who are identified by the patient as providing familial support, whether or not they are biologically related (Canadian Nurses Association, 2005).

**Family presence during resuscitation.**

Conceptual Definition: The presence of family in the patient care area, in a location that affords visual or physical contact with the patient during invasive procedures or resuscitation events (Emergency Nurses Association, 2001).

**Resuscitation.**

Conceptual Definition: Life-saving interventions when either cardiopulmonary or respiratory arrest occurs (Fulbrook et al., 2007).
Perception.

Conceptual Definition: an attitude or understanding based on what is observed or thought (Encarta World English Dictionary, 2009).

Limitations

Limitations of this study included the following:

1. Data were collected at a single site in one geographical area.
2. The sample was not randomized, which could have created systematic bias.

Assumptions

The following assumptions guided the study:

1. Participants in the study responded honestly.
2. The sample represented the population being studied.
3. Respondents had awareness and knowledge of family presence during resuscitation.

Summary

Family presence at the bedside during resuscitation is an ongoing issue for health professionals. Research on family presence during resuscitation (FPDR) is limited but increasing, as healthcare professionals seek to make sound decisions for patients and families. Healthcare professionals report both benefits and risks of FPDR. Since nurses often facilitate FPDR and negotiate decision-making regarding FPDR, grounded theory studies are needed to explore the practices, preferences, and perspectives of nurses involved with FPDR. The purpose of this study was to explore qualitatively the perceptions of registered nurses about family presence during resuscitation.
Chapter II

Literature Review

This shift toward family-centered care during acute illness and hospitalization has led to the controversial issue of family presence at the bedside during resuscitation and other invasive procedures. Health care teams worldwide are deliberating the risks and benefits of having family present in the room during a life-threatening resuscitation attempt. Although research on family presence during resuscitation (FPDR) is limited, the practice of FPDR is clearly becoming a more acceptable practice.

Nurses are often the healthcare professionals who facilitate FPDR, communicate with all stakeholders, and negotiate the specifics of inviting, supporting, and debriefing families. Research reveals that not all nurses are supportive of FPDR, and the risks and benefits of FPDR from nurses’ perspectives are still not clear (Twibell, et al., 2008; McClement et al., 2009). There has been a lack of qualitative research to directly explore the perceptions of nurses related to FPDR. Further examination is needed in order to guide health care facilities in fully operationalizing family-centered care and FPDR.

Organization of Literature

The organization of literature in this chapter is divided into 4 sections:

1. Conceptual framework
2. Perspectives of Family toward Family Presence during Resuscitation
3. Perspectives of Healthcare Providers toward Family Presence during Resuscitation

4. Practices and Interventions related to Family Presence during Resuscitation

Conceptual Framework

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family member had an impact on the whole family system and the system’s equilibrium
(Eggenberger & Nelms, 2007).

This study will provide new knowledge about the conceptual underpinnings of nurses’ perceptions of FPDR. It will identify key concepts in FPDR and propose relationship statements for future testing.

**Perspectives of Family toward Family Presence during Resuscitation**

Traditionally, family members have been escorted to the family quiet room when a patient arrived in the trauma room of an emergency department. In 1995, the Emergency Nurses Association set national guidelines for family presence during invasive procedures and resuscitation. Unfortunately, there were no studies to describe the family presence experience during both invasive procedures and CPR using these guidelines until 2004. Meyers et al.’s study (2000) focused on examining the attitudes, benefits, and problems expressed by families and healthcare providers involved in family presence during invasive procedures or CPR and identifying demographic factors of the respondents that might explain differences in perceptions. This study was guided by a holistic framework that directed the caring activities of the health care provider in preserving the wholeness, dignity, and integrity of the family unit from birth to death. The protocol for this study was based on the Emergency Nurses Association Guidelines of Family Presence (2001).

This study was conducted in the emergency department of a 980-bed, university-affiliated, regional, level-1, trauma center in the Southwest. Family members, registered nurses, and physicians employed at the hospital were invited to participate in the study. Criteria for the family included the absence of combativeness, extreme emotional
instability, behaviors suggesting intoxication, or an altered mental state was required. Also, to be included, family participants had to be 18 years or older, able to speak English, and considered family members if they shared an established relationship with the patient. The convenience sample consisted of 39 family members and 96 healthcare providers involved in family presence. Cases studied (n = 43) consisted of 56% involving invasive procedures and 44% involving CPR. Of the 96 healthcare providers that responded to the survey, 60 were nurses and 36 were physicians. Informed consent was obtained from each participant prior to participation (Meyers et al., 2000).

The instrumentation for the study consisted of surveys containing a family presence attitude scale that was adapted for families and healthcare providers. The family survey consisted of 37 items. The 33-item healthcare provider survey was given to nurses and physicians. A 4-point Likert scale was used to measure participants’ agreement with statements about the problems and benefits of family presence. A low score indicated a highly positive attitude toward family presence. The surveys also had semi-structured questions that was used to gather quantitative and qualitative data about perceived benefits and problems of family presence. Five nurse experts and two physician experts rated the relevance of each item and the overall relevance of the surveys to support content validity. Any item not receiving 70% agreement was deleted from the survey. Internal consistency reliability was .92 and .91, indicating internal consistency for both surveys (Meyers et al., 2000).

Results of the family member survey revealed a positive attitude toward family presence at the bedside. Qualitative analysis showed that family members thought it was their right to and obligation to be present during treatment, providing the patient with
support and someone to trust. A large majority of family members (95%) said that being present at the bedside helped them to comprehend the seriousness of the patient’s condition and to know that every possible intervention had been done. Most families (95%) also believed that their presence was helping the patient, even if the patient was unconscious. Comments made included that family presence provided relief from wondering about what was happening to the patient, decreased worry, and helped them in facing reality of the situation, lessened helplessness, and facilitated grieving in later months. Family members perceived that they provided comfort and protection to a loved one who was in pain, afraid, or vulnerable. Family members described the experience as a spiritual experience, felt their presence had an effect on healthcare providers, and felt a patient-family member connectedness (Meyers et al., 2000).

Problems that were addressed from the family members’ view included that 17% said the experience was not what they had expected, 29% stated that they did not know what to expect, and 8% worried they might be unable to cope with what was going on at the bedside, even though 95% found that the experience was not upsetting for them. Qualitative findings showed family felt concern about the patient’s pain, fear, and survival. Family members also were concerned with physician competence, patient safety, staff inexperience, and cost of care. Families did state that there was an appropriate need for the screening tool that was used to evaluate an individual’s ability to remain calm and controlled at the bedside (Meyers et al., 2000).

Healthcare providers had a mean score of 1.91 in favor of family presence at the bedside, with 1 being most positive and 4 being least positive. Nurses (mean = 1.69) did report a more positive attitude than physicians (mean = 2.06). Healthcare providers (80%)
reported the experience was important to families, while 78% felt it helped meet family members’ and patients’ emotional and spiritual needs. Healthcare providers (89%) also felt that it assisted family members in understanding the patient’s condition. During qualitative analysis, nurses commented on family presence giving family members a chance to witness and know the efforts that had been made for their loved ones, gave increasing peace of mind among family members, and gave staff an opportunity to educate families about patient’s condition. Nurses reported that they believed that family members’ increased knowledge lowered the risk of potential lawsuits. Nurses also noted that there was a chance for closure when the patient was dying, and 64% believed that family presence encouraged more professional behavior and modified staff conversations at the bedside (Meyers et al., 2000).

Potential problems that were identified by healthcare providers were that that families might interrupt CPR or invasive provisions (38%) and family members might initiate future litigation (29%). About half of the healthcare providers (57%) expressed concern that the family might misinterpret the team’s activities. Healthcare providers were concerned with cost-benefit ratio of continued CPR in terms of staffing, medication cost, and additional therapies. Qualitative data showed that nurses and physicians were concerned about maintaining an environment that focused on treating the patient and was free from overcrowding. Like family members, healthcare providers thought screening to identify appropriate family presence candidates was essential. Residents also reported concern about being watched during the event (Meyers et al., 2000).

In conclusion, Meyers et al. (2000) found that family presence was a beneficial experience for participating family members and was viewed as a right, obligation, and
natural event. Most healthcare providers had positive attitudes toward family presence and most supported the practice and believed it should continue. The writers suggested adding the family presence candidate screening criteria that the researchers developed. Suggestions for further research were to focus on outcomes with different populations in different settings and include longer-term family follow-up. Future studies should also determine whether family presence affects the activities, length, and cost of invasive procedures or CPR.

As noted by Meyers et al. (2000), family members consistently express a need to be with loved ones during serious crisis; however, most hospitals lack a family presence policy. The purpose of McGahey-Oakland, Lieder, Young, and Jefferson’s (2007) study was to facilitate development and implementation of a family presence during resuscitation policy. Specifically, they wanted to describe the experiences of family members whose children underwent resuscitation attempts in a children’s hospital emergency department, recognize family members as experts in the child as a person, identify critical information about family experiences to improve circumstances for future families, and assess the mental and health functioning of family members.

This study took place in Houston, Texas in the emergency department of Texas Children’s Hospital, a large pediatric tertiary hospital. The study sample was identified through a performance improvement activity of the hospital’s CPR committee. Participants included both English- and Spanish-speaking adult family members of children undergoing resuscitation initiated prior to arrival at the emergency department. A total of ten family members were asked to participate in the study. Family members included seven mothers, two fathers, and one great-grandmother. Seven out of ten were
present at the bedside. Three of the children had chronic illnesses, while seven experienced acute life threatening events. All ten children died after the resuscitation event (McGahey-Oakland et al., 2007).

Instruments used in this study included the previously validated and reliable Parkland Family Presence during Resuscitation/Invasive Procedures Unabridged Family Survey (Meyers et al., 2000), which included a Family Presence Attitude Scale consisting of 15 items rated on a 4-point Likert scale. The items assessed attitudes, problems, and benefits of family presence. For the three family members in the sample who were not present for the resuscitation, a modified attitude survey was developed and approved by a panel of family members and health care providers. The Short Form Health Survey version 2 (Ware, Kosinski, Turner-Bowker, & Gandek, 2002) is a 12-item scale measuring health status across physical and emotional domains to assess mental and physical functioning. Also a seven-item symptom screen for post-traumatic stress disorder derived from the National Institute of Mental Health Diagnostic Screening Interview for the Diagnostic and Statistical Manual – IV was used. The authors noted that reliability and validity of each of these scales had been established previously. A family survey featuring 32 items containing 10 demographic questions and 22 open-ended questions regarding family presence was also used to obtain qualitative data. Open-ended items were reviewed for relevance by a panel of family members and health care providers and received an endorsement of 70% or greater, with the exception of three items that had to be modified for clarity (McGahey-Oakland et al., 2007).

Findings from the quantitative analysis were, whether present or not, all family members expressed the importance of the option to be present during resuscitation.
Family members had a mean Family Presence Attitude Scale score of 24.1 (Median = 24; SD = 4.9), with a possible score range of 15 to 60 on the Parkland Family Presence during Resuscitation/Invasive Procedures Unabridged Family Survey. Low scores indicated support for family presence (McGahey-Oakland et al., 2007).

Five themes regarding parent reactions and concerns emerged from this study’s qualitative interviews. The first was “it’s my right to be there.” All ten members indicated FPDR was an unequivocal right. They felt their presence was critical to their child during every life transition, and crisis and resuscitation was no different. The second was “connection and comfort makes a difference.” Caregivers believed that their children wanted them there and believed they provided them with strength so children were less afraid. The third theme was “seeing is believing.” FPDR helped parents to believe that all possible options had been exhausted. “Getting in” was the fourth theme. Data showed that actual physical location during resuscitation occurred through several mechanisms. Some were already in the room and never were asked to leave; some asked to be in the room; some were invited; and some were asked to wait outside. The last theme to emerge was “information giving.” The timing for information giving by the health care team was critical. Family members did not want to be delayed from the children’s side, but they also needed to be prepared and aware of what was going on at the same time (McGahey-Oakland et al., 2007).

McGahey-Oakland et al.’s (2007) study revealed several inconsistencies in mechanisms for family presence: the timing for family entry into the room and family needs for sensitivity. Without a formal family presence policy, family member presence was left to the staff’s discretion, which resulted in inconsistent treatment of family
members. The writers suggested that future research focus on family presence policy
development and implementation outcomes.

In a third study that included an exploration of family perceptions, Morse and
Pooler (2002) sought to describe interactions among nurses, patients, and patient’s family
members. This description was done by examining the behavioral responses of family
members and their interactions with nurses and patients in the trauma room. A model of
suffering (Morse & Carter, 1995) was used for the framework. The model of suffering
described the interrelationship between enduring and emotional suffering. Concepts of
the model guided the coding of responses of the family members in the trauma room and
the caregiver’s interaction with family visitors (Morse & Pooler, 2002).

Videotapes were collected from three different sites. All three sites were
emergency departments at level 1 trauma centers in North America. Of the 193 tapes
collected, 88 had family members present. Some tapes (n = 332) were erased due to an
informed consent not being obtained. Only 55 were used to show a range of patients’
ages and acuities, times of entry to the resuscitation room, time spent at the bedside,
family composition, and site. There were a total of 32 male and 23 female participants.
Participants in the convenience sample included a total of 41 adults and 14 children.
Length of time at the bedside varied from 20 seconds to over 5 hours, with a mean time
of 46 minutes (Morse & Pooler, 2002).

Data were obtained by using a video camera fixed on the wall that was activated
by a nurse researcher when a patient first entered the room. Taping ceased when the
patient left the trauma room. Reliability was checked by research assistants coding the
videos initially and then one of the writers of the study watching the video segments and
verifying the coding. Any discrepancies led to discussion between the writers until 100% agreement was reached (Morse & Pooler, 2002).

Findings from observing the video allowed the researchers to classify people who were enduring by exhibiting behaviors of being verbally silent, using only words or short sentences, failing to initiate conversation, speaking in a monotonic voice, standing erect, maintaining a gap between them and the patient, and standing with upper extremities crossed. Staff refrained from touching, conversations, and eye contact with all family members exhibiting these behaviors (Morse & Pooler, 2002).

Family members who were categorized as emotionally suffering exhibited more emotional behaviors, such as repeating phrases, crying, standing in hunched positions with their heads down, and signaling to others the need for comforting. During emotional suffering, family members stood close to one another, stood away from patients, and even turned away to conceal uncontrolled tears. These family members were more distraught, and staff assumed a more comforting role (Morse & Pooler, 2002).

There were two exceptions that the observers reported. When a family member was familiar with the hospital environment, whether it was due to being a health professional or because of a patient’s previous admissions and course of illness, the family member went and stood with the staff, even if they were not known to the staff. These family members touched equipment, leaned on the counter, and answered questions for the patient. The second exception was when the nurses’ interactions caught the family members unaware, resulting in loss of endurance and was referred to as “sideswiping.” The nurse’s comment broke through their emotions, and their emotions could no longer be controlled, interrupting their ability to endure (Morse & Pooler, 2002).
Morse and Pooler (2002) concluded from their study that most family members demonstrated enduring behaviors at the bedside, which were supported by nurses. They suggested future research should focus on predicting which members of a patient’s family should be admitted or excluded.

**Perspectives of Healthcare Providers toward Family Presence during Resuscitation**

Family presence supports family-centered care, but some healthcare providers still hesitate to allow family at the bedside during resuscitation and/or invasive procedures. Duran et al. (2007) conducted a study to describe and compare the beliefs about and attitudes toward family presence of clinicians, patients’ families, and patients. This study used a descriptive survey design. The conceptual framework was based on healthcare providers, patients’ families, and patient’s beliefs regarding family presence at the bedside.

This study was done at the University of Colorado Hospital, which is a 300-bed academic hospital in Denver, Colorado. The emergency department, neonatal intensive care unit, and medical, surgical, neurosurgical, and burn/trauma intensive care units were used to collect the data. A total of 202 healthcare providers responded, which included physicians, nurses, and respiratory therapists. Family members and patients were approached individually and excluded if they were younger than 18 years, non-English speaking, confused, emotionally distraught, or unable to make decisions as assessed by the bedside nurse. Also, patients who were unstable hemodynamically were not invited (Duran et al., 2007).

The survey for the study was adapted from the Parkland Health and Hospital System (Meyers et al., 2000). This survey collected both qualitative and quantitative date
by using open-ended questions and scale items. The healthcare providers’ survey had a total of 74 items; the family survey had a total of 58 items; and the patient survey had a total of 54 items. Validity was supported by a review of nursing faculty, a nurse research scientist, pastoral care team member, physicians from the emergency department, and nurses from the emergency department, adult intensive care unit (ICU) and neonatal intensive care unit (NICU). The internal consistency reliability value for the revised survey was .97 for the healthcare provider survey, .93 for the family survey, and .89 for the patient survey (Duran et al., 2007).

Findings from the Duran et al. (2007) study were that healthcare providers had an overall positive attitude about family presence. The range of possible scores was 1 (strongly disagree) to 4 (strongly agree). Higher scores meant a more positive attitude. Respiratory therapists (x = 2.89, SD = 0.48) had the highest scores, and nurses (x = 2.79, SD = 0.38) had more positive attitudes toward family presence than physicians (x = 2.37, SD = 0.47). There were several themes reflective of poor outcomes found in the qualitative data from healthcare providers, including “fainting”, “getting in the way”, and causing “disruption”. Another theme was the concern about the emotional response from patients’ family members.

The mean score for family members on the survey was 2.9 (SD 0.41) with a range of 1 to 4. The higher the score meant a more positive attitude toward family presence. Qualitative analysis suggested that family members felt it was their right to witness their loved ones procedures or resuscitation. Families felt that they had a better understanding of the patient’s condition, and that it was helpful to the patient for them to be in the room.
After being present at beside for a procedure or resuscitation, 95% said they would do it again in a similar situation (Duran et al., 2007).

The mean scores for patients were 2.65 (SD = 0.45) for family presence. A range of 1 to 4 was possible, with higher scores illustrating a positive attitude towards family presence. Patients had similar views as the family members in that they felt it was their family’s right to be there and they should have that option. Patients also reported it was comforting to have family members present (Duran et al., 2007).

Duran et al. (2007) concluded that family presence held potential benefit for both patients and their family members. Also, the authors stated that, among healthcare providers, family presence was becoming a more acceptable practice and healthcare providers should be aware that family presence was an option because every situation was different. The authors recommended policy development since families believe strongly that FPDR is beneficial. The authors called for more research on the emotional well-being of family members, patient safety, and healthcare providers experiencing performance anxiety due to having an audience.

Traditionally, healthcare team members have not been receptive to family presence at the bedside during cardiopulmonary resuscitation (CPR). Few studies have been done that reflect the cultural differences in the opinions of healthcare professionals. Demir’s (2008) study focused on determining the opinions of physicians and nurses who worked in a university hospital intensive care unit and emergency department about the presence of patients’ families during CPR on these units in Turkey.

A descriptive study design was followed and conducted with staff in the emergency department and the cardiology and the anesthesia intensive care units of an
1811 bed, university-affiliated hospital in western Turkey. There were 102 nurses and 79 physicians working in the combined departments at the time this study was conducted. A response rate of 79% was achieved; of the 144 participants, 82 were nurses and 62 were physicians. Participants worked in the emergency department (n = 25), cardiology (n = 41), and anesthesia intensive care unit (n = 78). Two-thirds of the participants were under the age of 30 years, and 73.6% were female (Demir, 2008).

The survey questionnaire was developed by the researcher based on the literature and given to those who agreed to participate in the study. There were 4 open-ended questions and 17 multiple choice items on the questionnaire. Open-ended questions asked why it was necessary for family members to be present or not present, who should make the decision, what kind of reaction family members had when witnessing the resuscitation event, and a general question where healthcare professionals could add any thoughts that they wanted to. Content validity and reliability of this questionnaire were not discussed (Demir, 2008).

Findings from this study showed that 82.6% of physicians and nurses did not think that it was appropriate for family members to be at the bedside during resuscitation. Several reasons were given as to why this was the belief. Reasons given were that families would interfere with the team’s activities (56.3%), procedures were extremely traumatic (43.6%), the team would be under pressure and would have a negative effect on their performance (22.6%), family would incorrectly interpret the CPR procedure (21.8%), the practice is not appropriate for the cultural background and educational level of the Turkish public (15.9%), family members might become ill or faint (15.9%), it would lengthen the time of resuscitation (2.5%), there were no national guidelines in
Turkey on this topic (1.6%), there might be litigation against them (0.8%), and there was not enough space for the patient’s family in the work environment (0.8%). A small percentage (3.3%) did respond that family members who are also healthcare personnel should be given permission (Demir, 2008).

Only 13 of the 144 respondents thought that it was appropriate for the families to be present during CPR. Reasons stated were families could see how much effort was made (76.9%), that they would be able to accept the situation more easily (69.2%), that it was the family’s right (46.1%), that it increased families’ confidence in the physician (15.3%), and that it improved professional behavior (7.6%) (Demir, 2008).

In response to the fixed questionnaire section, 93.8% did not have any written policy that permitted the presence of the patient’s family; 93.8% had never received education about a family’s presence during CPR; and 97.9% did not know the international guidelines have specific recommendations on this subject. Only 13.9% had ever read any articles/research about the family presence during resuscitation, and 91.7% had never even given permission to a family member to observe CPR (Demir, 2008).

In this study, very few respondents found it appropriate for patients’ families to be present during CPR. This was very low compared to recent research that has been conducted elsewhere. Demir (2008) suggested that this difference in acceptance level may arise from cultural differences, but there has been no research in Turkey on how physicians’ or nurses’ assumptions about patients’ cultural and educational backgrounds affect their decisions. It was suggested that it would be beneficial to deal with the conflicting information provided by healthcare professionals through continuing education programs, by developing written policies, starting national guideline
development projects in Turkey, and following international publications and guidelines. Future research should also focus on what public education was needed to facilitate implementation of such policies.

Nurses’ personal opinions have been varied on the subject of family presence at the bedside during resuscitation. Regardless, the traditional practice has been to sequester grieving families during resuscitation efforts. The purpose of Knott’s and Kee’s (2005) qualitative study was to explore the beliefs and experiences of RNs providing care to patients of all ages in various acute care settings, including the emergency department, cardiac step down unit, intensive care (adult, pediatric, and neonatal), and labor and delivery. This study followed the previously published guidelines from the Emergency Nurses Association (ENA) (2001) and the American Heart Association (2000), which promoted the option of family presence.

Ten RNs with a minimum of 4 years of clinical experience working in diverse acute care units provided data for the study. Of the ten nurses, nine were female, one was male, and the age range was between 31 and 41 years. Several different units were represented; one nurse worked in labor and delivery, one in the neonatal intensive care unit, two in the emergency department, one pediatric cardiac intensive care unit, and five from various adult health units (Knott & Kee, 2005).

The questionnaire contained open-ended questions that were adapted from the previously developed questionnaire used by the Parkland Health and Hospital System (1997). This format allowed for an interview format (Knott & Kee, 2005).

Findings from this study showed that four themes emerged: conditions under which family presence was an option, using family presence to force family decision
making, the staff’s feelings of “being watched”, and the impact of family presence on the family. The first theme to emerge was conditions under which family presence was or was not a viable option. Nurses reported concerns, including family behavior at the bedside and the potential interference that a grieving family might present during resuscitation. Nurses considered family presence an important option but remain committed to caring for patients without interference from family members. The second theme was bringing family members to the bedside so they could have an understanding of the gravity of the situation, which could lead to terminating efforts. These nurses felt that educating families to the reality of the situation would help to enable them to make an informed decision regarding the patient’s care. The third theme was the feeling staff had of being watched by family members and how it affected the staff’s behaviors. Nurses reported an increase in anxiety and noted that having family members present maintained professionalism among staff. The last theme involved the impact resuscitation efforts had on the family. Nurses voiced concerned that unpleasant memories of resuscitation would obscure happy memories and would hinder the family’s grieving process (Knott & Kee, 2005).

Knott and Kee (2005) found in their study that nurses remained committed to providing individualized patient care. Since family presence at the bedside during resuscitation had not been traditionally practiced, the writers urged that attention of the nursing staff be committed to creating and changing the family presence during resuscitation policies.

Nurses have both personal and professional experiences with family presence during resuscitation. McClement et al. (2009) conducted a study to examine the practice
and preference of Canadian critical care nurses regarding family presence during resuscitation. This was a descriptive, qualitative study. The conceptual framework selected for this study was based on nurses’ practices related to family presence at the bedside during resuscitation.

There were 450 nurses that were members of the Canadian Association of Critical Care Nurses who completed the survey electronically. The majority were female, between the ages of 40 and 49 years, who worked full time as a staff nurse with adult patients. Most had been practicing in a teaching hospital as a critical care nurse for more than 15 years. Also, the majority of Canadian provinces and territories were represented in the sample (McClement et al., 2009).

The survey was distributed online and was a modified version of the survey used by MacLean et al. (2003). There were 18 questions that collected demographic data, nurses’ practices, preferences, and hospital/professional organization policies that were related to family presence during resuscitation. There was also an area where nurses could write descriptions of their experiences in a dialogue box to respond to the question, “Is there anything you would like to share with us about family presence during resuscitation related to your unit, or on a professional or personal note?” (McClement et al., 2009).

Findings from the online survey had several themes. Perceived benefits for family members included seeing things firsthand, providing a comforting presence, and being present to say good-bye. The risks for family members cited were psychological trauma and the possibility of physical harm. Perceived benefits for the healthcare team were seeing the person behind the patient and family acceptance of decisions to discontinue
resuscitative efforts. Several potential risks for healthcare team members were mentioned, such as feelings of clinical inadequacy, liability concerns, and constraints on the use of usual coping mechanisms. To some respondents, family presence was viewed as a disruption of and distraction from staff duties (McClement et al., 2009).

McClement et al. (2009) concluded that the decision to participate in family presence during resuscitation was varied and complex. The impact on both family members and healthcare providers should be evaluated before a decision is made. The writers suggested that cross-cultural research be examined as well.

Another study that focused on the nurses’ perceptions of family presence at the bedside during resuscitation was done by Twibell et al. (2008). The purpose was to address three gaps in the literature about family presence during hospitalization: to test instruments used to measure nurses’ perceptions of family presence; to explore demographic variables and nurses’ perceptions of self-confidence, risks, and benefits related to family presence in a sample of nurses from multiple hospital units; and to examine differences in perceptions of nurses who have and who have not invited patients’ families to be present during resuscitations. This study was based on Rogers’ theory of diffusion of innovation (1995) and Bandura’s theory of self-efficacy (1991).

The sample consisted of registered nurses and licensed practical nurses employed at one hospital in the Midwestern United States. Ball Memorial Hospital was a regional medical center in Muncie, Indiana. Inclusion criteria for the nurses in this study consisted of participants being 18 years or older, able to read English, and holding a nursing license in Indiana. A total of 375 nurses participated, with more than 95% being women, more than 90% being white, and more than 75% had at least 6 years of nursing experience.
Half of the sample had a baccalaureate degree in nursing. Respondents represented several different units. A total of 44% worked on inpatient, non-critical care units, 6% worked in the emergency department, and 7% worked in the outpatient setting. Most cared for adults (80%) and 10% cared only for infants. There were 10% of the nurses from the pediatric unit that also cared for adult surgical patients also. Of the nurses who responded, 254 had never invited the family of a patient to be present during resuscitation; 83 had invited family presence at least once but fewer than five times; and 28 had invited family presence during resuscitation 5 times or more (Twibell et al., 2008).

Two instruments were created to measure the variables. The Family Presence Risk-Benefit Scale was used to measure nurses’ perceptions of the risks and benefits of family presence to the family, patient, and resuscitation team. The Family Presence Self-confidence Scale was used to measure nurses’ self-confidence related to managing resuscitation with patients’ families present. Both scales were developed from a review of the literature and interviews from expert nurses from different clinical areas. Both scales used a 5-point Likert response with 1 being strongly disagree to 5 representing strongly agree. A content review was done by clinical experts in family presence, academicians, and statistical experts. A pilot of the scales was conducted on 20 nurses representing different clinical areas. After review, 26 of the original 30 items were used on the Family Presence Risk-Benefit Scale, and 17 of the original 19 items were used on the Family Presence Self-confidence Scale. The reliability of the Family Presence Risk-Benefit Scale was reported as .96, and the reliability of the Family Presence Self-confidence Scale was .95 (Twibell et al., 2008).
Results related to the Family Presence Risk-Benefit Scale showed that the correlation between nurses’ perceptions of risks and benefits and self-confidence was significant (p < .001). This finding showed that nurses who perceived more benefits and fewer risks also perceived more self-confidence when managing family presence. More than half of the sample agreed that family presence was a “right” of patients and families, which was related to perceptions of fewer risks and more benefits (p = .008). This scale also showed that certified nurses and members of professional organizations perceived more benefits and fewer risks than did nonmembers and noncertified nurses. Perceptions did not differ between RNs with an associate degree, a baccalaureate degree, or an advanced nursing degree. LPNs did perceive fewer benefits and more risks (p < .001). The number of years of experience or the nurse’s age was not related to perceptions of family presence. Emergency nurses did perceive significantly fewer risks and more benefits (p < .001) than did nurses who worked in all other units. Nurses in outpatient ambulatory settings reported more risks and fewer benefits than did nurses from other units (p < .001). Scores varied significantly between nurses who had never invited family presence (mean = 2.99), nurses who invited fewer than 5 times (mean = 3.38), and nurses who had invited family presence 5 times or more (mean = 4.00) (p < .001). These findings showed the more times nurses invited family presence, the more benefits they perceived (Twibell et al., 2008).

Results related to the Family Presence Self-confidence Scale showed that certified nurses (p < .001) and members of professional organizations (p < .001) perceived greater self-confidence than did noncertified nurses and nonmembers. LPNs reported less self-confidence than did RNs with a baccalaureate degree (p = .04), but results were not a
significant difference between LPNs and RNs with an associate degree or an advanced practice degree. Number of years of experience and the nurse’s age showed no significant association with study variables. Scores varied significantly between nurses who had never invited family presence (mean = 3.47), nurses who invited fewer than five times (mean = 3.93), and nurses who invited family presence 5 times or more (mean = 4.43), with higher scores reflecting more times family presence had been invited. These findings showed the more times nurses invited family presence, the greater their self-confidence (Twibell et al., 2008).

In Twibell’s et al. (2008) study, the writers suggested that nurses held widely divergent perceptions of risks, benefits, and their own self-confidence related to family presence. Perceptions of risks, benefits, and confidence in managing family presence were associated with decisions nurses make about inviting family presence. The writers believed that further testing was needed on both of the scales used in this study to develop a high reliability and validity in diverse samples.

**Practices and Interventions related to Family Presence during Resuscitation**

The lack of a standard of practice in regards to family presence at the bedside is a problem that must be remedied, as our healthcare practice shifts from a patient-centered to a family-centered approach. The purpose of the research study by MacLean et al. (2003) was to identify the policies, preferences, and practices of critical care and emergency nurses for having patients’ families present during resuscitation and invasive procedures.

The study was a survey design in which the survey was mailed to a random sample of 1,500 critical nurses who were members of the American Association of
Critical Care Nurses and 1,500 emergency nurses who were members of the Emergency Nurses Association. The sample included only registered nurses who practiced in all 50 states and the District of Columbia. Out of the 3,000 surveys sent, a total of 984 (33%) were returned, 473 by critical care nurses, 456 emergency nurses, and 55 who worked in both areas or did not disclose their specialty. Also, of the nurses responding 90% were women and 50% had attained a baccalaureate degree (MacLean et al., 2003).

The family presence practice survey used was developed for this study and consisted of 30 items that included questions about the demographic characteristics of the respondents, respondents’ practices and preferences, and hospital policies regarding family presence. There was also one item that offered the option to share any comments about the respondent’s personal or professional experiences with family presence. The content validity of the tool was conducted by a national panel of experts consisting of 3 critical care nurses, 3 emergency nurses, and 1 physician. The experts rated 100% of the items and the overall survey relevant in measuring family presence practices. This survey has been tested on 4 separate occasions with a total of 113 critical care and emergency nurses (MacLean et al., 2003).

Results of the survey concerning family presence policies showed that only 5% of the respondents worked on units that had written policies allowing the option of family presence during CPR and invasive procedures. However, 45% of the respondents stated that, although there was no written policy for these situations, their units allowed family presence during CPR, and 51% stated that their units allowed family presence during invasive procedures. Of the nurses who responded, 37% preferred that a written policy be established in their institutions allowing the option of family presence during CPR, and
35% preferred a written policy for family presence during invasive procedures. Yet, 39%, regarding CPR, and 41%, in regards to invasive procedures, were against having written policies in place for family presence (MacLean et al., 2003).

In MacLean et al.’s study (2003), 36% of the nurses reported that they brought a member of the patient’s family to the bedside during CPR, and a total of 21% said they had not taken family members to the bedside during CPR but would do so in the future if the opportunity arose. For invasive procedures, 44% of the responding nurses had taken a family member to the bedside, and 18% said that they had not taken families to the bedside during invasive procedures but would do so if the opportunity arose. Of the nurses surveyed, 31% reported being asked by the family to be present during CPR, and 61% asked to be present during invasive procedures (MacLean et al.).

At the end of the survey, 44% of the responding nurses provided additional comments about family presence. A summary of the comments about the benefits of family presence at the bedside were that it provides emotional support for patients and patients’ families, provides a positive experience for patients’ families, patients, and staff, provides guidance and increases family understanding of the patient’s situation, provides guidance and increases family understanding of the patient’s situation, helps patients’ families make decisions about resuscitation, helps patients’ families know that everything was done to save their loved one, and facilitates closure and healing (MacLean et al., 2003).

Several nurses did express concern about family presence due to patient-related issues such as privacy and limited benefits, family-related issues such as family behaviors, lack of education and understanding, emotional reactions, and family-staff
relationships such as staff stress and discomfort, impeding work, extra work and burden, and inadequate staffing. Environmental issues that were a concern included limited space and staff, chaos and confusion, and lack of privacy. There were also concerns about legal issues, such as lawsuits and family complaints (MacLean et al., 2003).

The authors concluded that there should be written policies in place in every institution, as more consumers and professional organizations join to support this effort to have family presence at the bedside. Formal policies would give nurses guidance in these situations and help to alleviate some concerns they have voiced. Further research would be suggested comparing institutions with and without formal written policies to determine differences in provider support, how often patients’ families are brought to the bedside, and desired outcomes of family presence such as uninterrupted care of patients and meeting the needs of patient’s families (MacLean et al., 2003).

There have been few studies that focused on the different attitudes between nurses and physicians about changing the practice of family presence at the bedside during resuscitation. Mian et al. (2007) used retrospective surveys of staff to design and implement a family presence program in the emergency department and to evaluate attitudes and behaviors of nurses and physicians toward family presence before and after implementation of the program. This purpose was accomplished by using a pretest and a posttest.

This study was conducted in an 898-bed urban academic medical center in the northeastern United States. The emergency department was a level 1 adult and pediatric trauma center with 50 beds that treated more than 770,000 patients per year. The hospital was awarded Magnet status in 2003 and had an affiliation with an emergency medicine
residency program. The convenience sample included all nurses and physicians working in the emergency department during January 2002 and May 2003 who consented to participate. The first survey was completed by 86 nurses and 35 physicians. The follow up survey was completed by 89 nurses and 14 physicians (Mian et al., 2007).

The same survey was given anonymously in the pretest and the posttest. The survey had three different parts. The first part was based on professional attitudes, values, and behaviors. It consisted of 30-items measured by a Likert scale with five potential responses. The second part was based on personal and professional experience. There were twelve questions that addressed the participant’s personal and professional experience with family presence, but four questions were added in the follow-up survey about the practice and educational sessions provided. The third part was questions pertaining to participant demographics. Questions included age, sex, educational level, years of practice, and experience in the emergency department. Content validity of the survey was supported by an expert panel that consisted of twelve former emergency department nurses. The study reported that internal reliability was acceptable for the total items as well as for the subscales (Mian et al., 2007).

The initial survey showed that 71% of nurses were supportive of the right for family members to be present but were less supportive of family presence during invasive procedures and trauma resuscitations. Nurses were also less supportive of the belief that family presence helped patients’ families. Physicians showed a 51% support in favor of the patient’s right to have a family member present during a medical resuscitation. Physicians were less enthusiastic about family presence during invasive procedures, the belief that family presence helped families, and family presence during trauma
resuscitation, just like nurses. According to the pretest, concerns of both nurses and physicians were about the patients’ families being upset at watching residents, concerns with interfering with the teaching of residents, and concerns about increased anxiety among staff when families were present. Both populations were least concerned with confidentiality and malpractice lawsuits and family presence being too traumatic for family members (Mian et al., 2007).

The follow up survey showed that nurses’ support of family presence during medical resuscitations, invasive procedures, and trauma resuscitations had increased. Beliefs about benefits of family presence to patients and their families were still low. Smaller percentages of nurses were concerned about interference in the teaching of residents, changes in medical decisions, malpractice and liability issues, and anxiety about family presence. Questions regarding the evaluation of the educational program showed that 39% of nurses reported having a more positive attitude toward family presence after the program, and 36% of nurses felt more positive about family presence after the program was actually implemented (Mian et al., 2007).

Mian et al. (2007) reported that fewer physicians responded to the follow up survey and therefore results may have been skewed. Physicians who responded showed less support for family presence and more concerns about practice issues. Physicians did show more support for the idea suggesting that family presence was beneficial to patients’ families. The questions regarding the educational program showed that only one physician out of fourteen attended the educational program, and 92% of the physicians reported no change after program implementation.
The writers of this study concluded that their findings were consistent with other studies showing increasing support among nurses after experience with family presence. They believed that family presence was a nurse-driven practice. The writers also concluded that there was a great need for ongoing educational programs for family presence. There were suggestions of using educational posters and nursing rounds for reinforcement. They also suggested that ongoing support and validation for staff was a successful strategy when implementing family presence (Mian et al., 2007).

As the debate about FPDR spread, researchers in Australia began to raise questions about the effect of FPDR on multiple stakeholders. Most emergency departments in Australia excluded the relatives of critically ill patients during resuscitation. There was little known about what Australian relatives perceived about family presence at the bedside during resuscitation. The purpose of Holzhauser, Finucane, and De Vries's study (2006) was to report part of the findings of a research project, specifically relatives' attitudes after being present during resuscitation. A randomized, controlled trial method was used as the design for this study. The control group continued the usual practice of sitting in the quiet waiting room, and the experimental group was invited to be present at the bedside during the resuscitation event.

The setting of the study was the emergency department of a major tertiary referral teaching hospital in Queensland, Australia. Inclusion criteria for the sample included that patients were triaged as a Category 1 or 2, with or without an altered level of consciousness; hypotension; respiratory distress or the need for cardiopulmonary resuscitation (Holzhauser et al., 2006). Patients that were excluded from this study were
trauma cases. Relatives and significant others were included in this study if they were over 18 years of age, immediate family or significant other, written consent had been obtained, and the presence of a trained support person and the relative would not be disruptive to the treatment of the patient. Randomization happened after relatives and patients fit the criteria. They were randomly assigned to either the experimental group or the control group. The final sample size contained 30 family members for the control group and 58 family members for the experimental group. The experimental group was made up of 55.2% spouses or partners and 50.9% were over the age of 50. In the control group were family members who were primarily over the age of 50 (64.3%) and half of whom were spouses or partners (Holzhauser et al., 2006).

A survey tool of 10 open-ended questions was used. The questions were based upon experiences of clinical staff and the review of the literature. For content validity, the survey was analyzed by the research team after piloting the tool on the first 10 relatives participating in the project. To ensure inter-rater reliability, education was done on how to collect the data with the research team and research assistant. For consistency, when possible, the same research assistant was used (Holzhauser et al., 2006).

The most common responses made by relatives about being present at the bedside were: "I preferred to be present”, "I was very scared and emotional", and "I was worried about being in the way." The control group reported 67% would have preferred to be at the bedside and 100% of family members present at the bedside during resuscitation were glad they were present. Both the control and the experimental groups reported that staff communicated effectively with them during the resuscitation event. The control group was informed of the condition on arrival, allowed to see the patient, and given a complete
update after the event. The experimental group always had someone with them to explain things, to offer support, and to answer any questions that family had (Holzhauser et al., 2006).

Relatives who were present in the resuscitation room were asked additional questions about what they remembered and how they felt about being present. The experimental group (85%) reported that it was beneficial to recovery for them to be there. A strong majority (92%) reported that they received adequate support, and 96% felt their presence assisted them to come to terms with the patient's outcome. Over half (58%) of the experimental group stated that they received follow up support even though they felt they did not need it. Only two negative comments were made that concerned general administrative issues with the department (Holzhauser et al., 2006).

When reviewing this part of the study, the writers concluded that many family members were grateful for the ability to be present during the resuscitation of their relative. The research also supported the important need for the support person in the overall care of the patient and their relatives in the emergency department. This study did suggest that further research should be conducted related to the psychological effects of relative presence during resuscitation and relative follow up support (Holzhauser et al., 2006).

In a report from a second part of their research program in Australia, Holzhauser and Finucane (2007) further evaluated outcomes from implementing a FPDR intervention. In this second aspect of the work, they sought to know if there was a difference in staff attitudes regarding relatives’ presence in resuscitation after the implementation of the intervention. The intervention consisted of a randomized
controlled trial of family presence during resuscitation. The setting was an emergency department in Queensland, Australia that treated approximately 45,000 patients per year. Participating staff was from nursing, medical, social work, and pastoral areas. Participants completed a pre-test that assessed staff opinions about having relatives present during resuscitation and what they perceived as advantages and disadvantages prior to the start of the study. The majority of the respondents were nurses, followed by medical staff. Most had five years or less experience and were between the ages of 20 and 30 years. The post-test majority of respondents were again nurses, followed by medical staff with ten years or less experience. The ages were between 26 and 35 years in the post-test (Holzhauser & Finucane, 2007).

The survey tool was developed based on a review of the literature by a panel of expert clinical staff. Questions were dichotomous, multiple choice, open-ended, or Likert scale questions. The survey tool was taken by seven staff members initially to review content and context. Minor changes were made to the language and were reviewed by the same staff members for approval before distributing (Holzhauser & Finucane, 2007).

Between the pre-test and the post-test, staff was provided with education that included peer-support, debriefing, and dealing with grieving relatives (Holzhauser & Finucane, 2007).

Findings in this study showed 11% of staff strongly agreed that they felt comfortable working with grieving relatives in the pre-test and 28% felt comfortable with the post-test. During the pre-test 18% of staff strongly agreed that relatives should be give the opportunity to be present in the resuscitation room. The percentage increased to 39% during the post-test (Holzhauser & Finucane, 2007).
Participants were asked why relatives should or should not be present during resuscitation in open-ended questions. Multiple reasons were reported. Reasons relatives should not be present were that staff performance suffers, relatives would not be able to cope, the hospital will leave itself open to litigation, and it was too personal for staff. The amount of staff supporting all of these reasons decreased from the time the pre-test was taken to the post-test. Reasons given as to why relatives should be included were to assist relatives with the grieving process, to include them as part of the team, to aid in adjusting to the illness, and to keep relatives close when patients are dying. All reasons were seen as positive and increased from the pre-test to the post-test except keeping relatives close to patients when they are dying. Pre-test scores for being close while dying were 78% agreement; during the post-test only 72% agreed (Holzhauser & Finucane, 2007).

Holzhauser and Finucane (2007) concluded that, when comparing staff experiences after implementation of the intervention, staff had overall positive comments. There was a suggestion from staff to focus on how to prepare relatives before they arrive in the resuscitation room and what to expect.

Summary of the Literature

In this literature review, there was an overview of twelve studies on FPDR. Results of the studies regarding families show that families strongly request FPDR, find it to be beneficial, and report it to hold few if any risks (McGahey-Oakland et al., 2007). The few studies on physicians reported a low level of support and many reported risks with few benefits (Duran et. al., 2007). Nurses in general were more supportive than physicians (Duran et al.).
Several studies examined variables related to nurses’ perceptions of FPDR. For example, the more nurses invited FPDR, the more benefits they perceived. Nurses with an associate degree, a baccalaureate degree, or an advanced nursing degree did not have a difference in their perceptions related to family presence (Twibell et al., 2008). Number of years of experience in nursing and nurses’ age did not significantly relate to nurses’ perceptions of risks, benefits, or self-confidence related to family presence (Twibell et al.).

Three studies measured variables of interest before and after implementation of FPDR. Nurses and family members responded more favorably to FPDR than did physicians, although sample sizes of physicians were not large.

Other than the three intervention studies, most research was descriptive or correlational in design. Sample sizes varied widely, with the largest samples consisting of nurses. No samples were randomized into the study, while one sample in one study was randomly assigned to groups. Most samples were from the United States of America, although two studies were conducted in Australia and one in Turkey.

Both qualitative and quantitative methods were used, yet surveys were the most common method of data collection. The qualitative data primarily originated from written comments on surveys. Few studies interviewed participants. One study by Knot and Kee (2005) explored the experiences of nurses solely through in-person interviews. Replication of this study in different samples may illuminate what is known about nurses’ perceptions and provide a framework for the factors nurses’ process when experiencing and making decisions about FPDR.
Eight of the studies were descriptive. Several sampled families, healthcare providers, and sometimes patients. Patients reported wanting the option of having a family member with them during CPR or invasive procedures and felt that it would be important for family members to be there with them (Duran et al., 2007). Family members have also reported that being present at the bedside helps them to understand the seriousness of a patient’s condition, facilitated grieving, and showed the family that healthcare providers did everything possible to help the patient (Duran et al.).

It is important that we examine the past experiences of nurses with FPDR and how does that affect staff members’ attitudes toward FPDR. Also, studies are needed to test the effectiveness of various approaches to develop and prepare staff effectively to facilitate FPDR and produce the best outcomes for healthcare providers, family members, and patients.
Chapter Three

Methodology and Procedures

Family presence at the bedside during resuscitation is a controversial subject that affects the patients, family members, and healthcare members. The practice of FPDR is clearly becoming a more acceptable practice, despite a lack of strong evidence about the outcomes of FPDR and how to implement FPDR. Nurses are often the health care professionals who facilitate the process. Yet research reveals that not all nurses are supportive of FPDR, and the risks of benefits of FPDR from nurses’ perspectives is still not clear (Twibell et al., 2008; McClement et al., 2009). Few studies have examined nurses’ perceptions through interview methodology and none of have used a grounded theory approach. Further examination of nurses’ perceptions of FPDR is needed in order to guide health care facilities in fully operationalizing family-centered care in general and FPDR in specific.

The purpose of this partial replication study (Knott & Kee, 2005) was to explore the beliefs and experiences of RNs providing care to all ages of patients in various acute care settings. This chapter presents the population, sample, setting, methodology, and procedures that were utilized for this study.
Research Question

The research question that guided the study was, “What are the perceptions of RNs who provide care to all ages of patients regarding family presence at the bedside during resuscitation?”

Population, Sample and Setting

This study took place in a mid-western, 190-bed hospital that recently obtained Magnet designation. The population for the study was experienced registered nurses who worked in critical care areas. The sample included nurses from the emergency department (ED), intensive care unit (ICU), and cardiac cath lab. The target hospital had a Level 2 Emergency Department and a 12-bed ICU.

To be included in the sample, participants had to be Registered Nurses with a minimum of four years nursing experience and employed at the target hospital. There were no exclusion criteria based on age, gender, or ethnicity. The sample consisted of 12 nurses: five nurses from the emergency department, four nurses from the intensive care unit, and three nurses from the cardiac cath lab. The actual sample size was determined when the data were saturated, per grounded theory methodology.

Protection of Human Subjects

This study was approved by the Institutional Review Boards of Ball State University and the hospital where the study was conducted. The research study was announced in multiple nursing venues in the institution, including at nursing meetings and in newsletters. Study packets were made available in areas of the facility where nurses gathered, such as lounges and meeting rooms. Signs were posted inviting nurses to take a study packet. In the packet were an invitation to participate in the study, the
informed consent document, and a return inner-hospital envelope marked “Confidential” to the researcher. The informed consent form included an agreement to have the interviews audio recorded.

Participants who provided the researcher with their contact information in the return envelop were contacted and a time was set to meet. The researcher explained the study and participants who wished to participate signed the consent forms after all their questions were addressed. The interview took place immediately or at a time and date convenient for the participant. The interview was audio recorded. Participants’ names were not used during the interview. Interviews were transcribed verbatim into electronic files.

The only risk in the study was that the participants were not anonymous. Their identity was known to the interviewer. However, confidentiality of the data and protection of the identity of the respondents were guaranteed. Precautions were taken to protect the non-anonymous data in the study. For example, the respondents had a choice whether or not to participate and could cease participation in the study at any time without any ill effect. The interviews were conducted in a private office in the hospital where the study took place. Audiotapes of the interviews were kept in a locked filing cabinet in a hospital office to which only the researcher had access. Demographic data forms were kept in a separate locked file drawer, apart from the signed consents and the interview data. Demographic data forms were not coded in any way and were not associated with interview data. Signed informed consents were kept in a third locked file drawer, separate from other study materials. The transcriptionists who transcribed the interviews did not know the identity of participants. Transcribed interviews were kept in
a computerized file on a password protected computer to which only the researcher had access. When results of the study are fully disseminated, all data was destroyed by shredding hard copies and erasing all electronic files.

There were no benefits to the participants in the study. However, the participants may have had an opportunity to self-reflect on feelings regarding family presence at the bedside during resuscitation. Knowledge gained was valuable to the discipline of nursing, and only participants who met the study criteria could provide the information. Therefore, the risk-to-benefit ratio was considered acceptable.

Procedure

After the Institutional Review Boards’ approval, the research study was announced in multiple nursing venues in the institution, including at nursing meetings and in newsletters. Study packets were made available in areas of the facility where nurses gathered, such as lounges and meeting rooms. Signs were posted inviting nurses to take a study packet. In the packet were the sample criteria, an invitation to participate in the study, the informed consent document, and a return inner-hospital envelope marked “Confidential” to the researcher. The informed consent form included an agreement to have the interviews audio recorded.

Participants who provided the researcher with their contact information in the return envelop were contacted and a time was set to meet. The researcher explained the study and verified that the nurse met the sampling criteria. Participants who wished to participate signed the consent forms. The interview took place immediately or at a time and date convenient for the participant.
In this grounded theory approach, data analysis occurred parallel to data collection. Two researchers listened to the recording of the first interview and read the transcript. Text related to FPDR was identified and highlighted in the first interview data, before any other interviews occurred. Open coding followed by axial coding and matrix development of conceptual schema followed. Members of the research team agreed on the schema analysis from the first interview and made decisions about any modification of questions or new questions that might be appropriate for the second interview, in order to expand upon the schema or enlighten understanding of the schema. The second interview was then conducted, and the data were analyzed in the same fashion. The original schema was modified by the analysis of the second set of data. Subsequently remaining interviews were conducted, and the data were analyzed by constant comparative analysis.

Interviews lasted approximately one hour and were audio taped. Interviews consisted of a series of questions about family presence taken from an established interview tool (Parkland Health and Hospital System, 1997). At the end of the interview, demographic data were collected, including age, gender, nursing education, unit worked, certifications, years of experience, and ethnicity. Then nurses were given an opportunity to add any additional comments before the interview concluded. The interviews were conducted in a private office in the hospital where the study took place. Nurses were not paid to be in the study.

Audiotapes of the interviews were kept in a locked filing cabinet in a hospital office to which only the researcher will have access. Demographic data were kept in a separate locked file drawer. Signed informed consents were kept in a third locked file
drawer, separate from other study materials. Transcribed interviews were kept in a computerized file on a password protected computer to which only the researcher had access. When results of the study were fully disseminated, all data was destroyed by shredding hard copies and erasing all electronic files.

**Design**

A descriptive design with grounded theory methods was chosen for the study (Knott & Kee, 2005). A descriptive design with grounded theory methods may be used for the purpose of developing theory, identifying problems with current practice, justifying current practice, making judgments, or determining what others in similar situations are doing (Burns & Grove, 2009). The present study intended to describe nurses’ perceptions related to family presence during resuscitation through an in-person, open-ended interview that allowed participants to voice their feelings, thoughts, decision-making processes, and experiences.

**Instrumentation**

The data were obtained using interview questions adapted from the Parkland Health and Hospital System (1997). The questionnaire was selected because it was brief, contained open-ended questions intended for hospital staff, and allowed for an interview format (Knott & Kee, 2005). The interview questions have been used in other studies such as Duran et al.’s (2007) study and also McGahey-Oakland et al.’s (2007) study. Sample interview questions included: tell me your beliefs regarding family presence during resuscitation, were you comfortable or uncomfortable with family presence, and was your performance affected in any manner by family presence? Probing questions
followed to clarify and draw out stories and examples, thus providing the detailed data required for a grounded theory approach.

Participants also provided demographic data including age, gender, nursing education, unit worked, certifications, years of experience, and ethnicity. Demographic data were recorded on a written form. The forms were not coded in any way. Rather the information was used to describe the sample when disseminating the findings.

**Data Analysis**

Demographic data on age, gender, nursing education, unit worked, certifications, years of experience, and ethnicity were categorized and summarized in table form to describe the sample (Knott & Kee, 2005). Responses to interview questions were analyzed by using the constant comparative method of data analysis, which entailed comparing elements present in one interview with those identified in another subsequent interview (Strauss & Corbin, 1998). Data analysis occurred parallel to data collection in the constant comparative approach. Two researchers listened to the recordings of the interviews and read transcripts, comparing the transcript to the recordings for accuracy and to detect subtle nuances or voice intonations. Interview text related to FPDR was identified and highlighted in the first interview data, before any other interviews occurred. Open coding followed by axial coding and matrix development of conceptual schema followed. Members of the research team agreed on the schema analysis from the first interview and made decisions about any modification of questions or new questions that might be appropriate for the second interview, in order to expand upon the schema or enlighten understanding of the schema. The second interview was then conducted, and
the data were analyzed in the same fashion. The original schema was modified by the analysis of the second set of data.

With each new interview and subsequent analysis, codes and categories were compared to see if further modification was required to represent all existing data. A core concept and stable conceptual structure emerged. After 12 interviews were conducted and no new categories or elements of schema emerged from the data, the researchers declared that the data were saturated and data collection ceased. The schema was finalized and presented to two of the study participants who were randomly selected. They read the final analysis and agreed that the analysis represented a cogent view of FPDR from their perspective.

Quality assurance procedures were used to ensure credibility and trustworthiness. Biases were declared and bracketed. This assessment process was documented through an audit trail (Knott & Kee, 2005).

**Summary**

In this chapter, the methods and procedures for the partial replication of the study by Knott and Kee (2005) were discussed. A descriptive design with grounded theory methods was used with an anticipated sample of approximately 12 experienced nurses. The data were collected by interview using a modified version of The Parkland Health Survey (1997). These data were analyzed using constant comparative analysis (Strauss & Corbin, 1998). Findings add to nurses’ knowledge about family presence at the bedside during resuscitation and contributed conceptual map of nurses’ perceptions. Connections between concepts are proposed for further testing.
References


