NURSES’ PERCEPTIONS OF FAMILY PRESENCE DURING RESUSCITATION

A RESEARCH PAPER

SUBMITTED TO THE GRADUATE SCHOOL

IN PARTIAL FULFILLMENT OF THE REQUIREMENTS

FOR THE DEGREE

MASTERS OF SCIENCE

by

LUELLA L. WIRTHWEIN

DR. KATHRYN RENEE TWIBELL-ADVISOR

BALL STATE UNIVERSITY

MUNCIE, INDIANA

JULY 2011
TABLE OF CONTENTS

Table of Contents ................................................................. i-ii
Abstract ................................................................. iii

Chapter I: Introduction ................................................................. 1-13
  Introduction ................................................................. 1-2
  Background and Significance .............................................. 2-8
    Cardiopulmonary Resuscitation ........................................ 3-4
    Families and Resuscitation ............................................ 4-5
    Perceptions of Health Care Professionals ............................ 5-7
    Responses of Professional Organizations and Acute Care Facilities ...7-9
  Statement of the Problem .................................................. 9
  Purpose ................................................................. 9
  Research Questions .......................................................... 9
  Theoretical Framework .................................................... 9-11
  Definition of Terms ....................................................... 11-12
  Limitations .............................................................. 12
  Assumptions .............................................................. 13
  Summary ................................................................. 13

Chapter II: Review of Literature ............................................. 14-56
  Introduction ............................................................. 14-15
  Purpose ................................................................. 15
  Research Question ........................................................ 15
<table>
<thead>
<tr>
<th>Section</th>
<th>Pages</th>
</tr>
</thead>
<tbody>
<tr>
<td>Organization of Literature</td>
<td>15</td>
</tr>
<tr>
<td>Theoretical Framework</td>
<td>16-20</td>
</tr>
<tr>
<td>Family Perspectives</td>
<td>20-31</td>
</tr>
<tr>
<td>Health Care Professional Perspectives</td>
<td>31-53</td>
</tr>
<tr>
<td>Summary</td>
<td>53-56</td>
</tr>
<tr>
<td>Chapter III: Methodology and Procedures</td>
<td>57-62</td>
</tr>
<tr>
<td>Introduction</td>
<td>57</td>
</tr>
<tr>
<td>Research Questions</td>
<td>58</td>
</tr>
<tr>
<td>Population, Sample, Setting</td>
<td>58</td>
</tr>
<tr>
<td>Protection of Human Subjects</td>
<td>58-59</td>
</tr>
<tr>
<td>Procedures</td>
<td>60</td>
</tr>
<tr>
<td>Instruments and Methods of Measurement</td>
<td>60-61</td>
</tr>
<tr>
<td>Data Analysis</td>
<td>61-62</td>
</tr>
<tr>
<td>Summary</td>
<td>62</td>
</tr>
<tr>
<td>References</td>
<td>63-70</td>
</tr>
<tr>
<td>Literature Table</td>
<td>71-88</td>
</tr>
</tbody>
</table>
ABSTRACT

RESEARCH SUBJECT: Nurses' Perceptions of Family Presence During Resuscitation

STUDENT: Luella Wirthwein

DEGREE: Masters of Science

COLLEGE: College of Applied Science and Technology

DATE: July 2011

The issue of family presence during resuscitation (FPDR) creates an ongoing controversy among nurses. FPDR has been promoted by nursing organizations including the American Association of Critical Care Nurses and Emergency Nurses Association. However, many clinicians do not support or value FPDR. To clarify the controversy, more information is needed on nurses’ perceptions of FPDR. The purpose of this study was to explore nurses' perceptions of FPDR and the relationships of these perceptions to selected demographic variables. This study was a partial replication of a study by Twibell, Siela, Riwitis, Wheatley, Riegle, Bousman, et al. (2008). Guided by family system theory data were collected from 150 registered nurses working in a Midwestern hospital. Nurses completed a survey that measured a variety of perceptions related to FPDR, including risks, benefits and self-confidence. Findings provide information to nurse leaders, managers, and direct care providers regarding needs for further education and factors that influence staff nurses’ decision-making related to FPDR.
Chapter 1

Introduction

The presence of family during resuscitation of loved ones has been the subject of ongoing controversy among health care professionals. Multiple stakeholders in the debate have varying opinions and perspectives. Families overwhelmingly report the desire to be present at the bedside during resuscitation of a loved one. Health care professionals have resisted this practice, with nurses being somewhat more favorable than physicians (Doyle, Post, Burney, Maino, Keefe, & Rhee, 1987; Ellison, 2003; Hanson & Strawser, 1992). The resolution of the matter is important, as health care systems strive to increase patient and family satisfaction with policies and services while also creating healthy work conditions for professionals. Research has not yet clarified the perspective of all stakeholders in this global, and at times intense, debate.

In 1982, Foote Hospital in Michigan began allowing family members to be present during resuscitation. Since then, studies of families that have or have not been allowed to be present at the bedside during resuscitation have indicated that families felt it was their right to be there and that they benefited from being present (McGahey-Oakland, Lieder, Young, & Jefferson, 2007). Three studies found that over 75% of families
believed that grieving was made easier due to having been present during resuscitation (Doyle et al., 1987; Belanger and Reed, 1997; Robinson, Mackenzie-Ross, Campbell-Hewston, Egleston, & Prevost, 1998). Prevailing practice in most hospitals has historically been to exclude families from being present during resuscitation of a loved one in an effort to let the resuscitation team concentrate and to avoid trauma to the family.

Numerous professional organizations have officially given support to family presence during resuscitation (FPDR) through position statements and guidelines. The Emergency Nurses Association (ENA), American Heart Association (AHA), and the American Association of Critical-Care Nurses (AACN) have urged offering the option of FPDR (Tamekia, 2008). Organizations have recommended the development of a formal policy addressing FPDR although few hospitals have a policy supporting FPDR at present (Twedell, 2008).

A dearth of strong research evidence contributes to the lack of consensus and continuing debate regarding FPDR. Research on FPDR has primarily consisted of descriptive studies of opinions of stakeholders. While some clarity has emerged on the perspectives of families, the perspectives of health care providers remain ill-defined. In specific, more research is needed on health care professionals' perceived risks, benefits and self-confidence related to FPDR.

**Background and Significance**

Resuscitation of a human being whose life is threatened by inadequate circulation or breathing often occurs as a crisis situation. Multiple health team members are present, lending expertise to attempt to save the patient's life. The question of whether or not the
patient's family members have a place in the room during the critical activities is the focus of a global debate in health care settings.

**Cardiopulmonary resuscitation.**

About every 90 seconds someone in the United States suffers from a cardiopulmonary arrest. In many cases, resuscitation efforts ensue. The history of cardiopulmonary resuscitation (CPR) can be traced back to the sixth century when a hole was made in the neck of an animal suffering from a neck injury resulting in a tracheostomy. Over the centuries various practices were attempted to revive humans from drowning. These included hanging the individual upside down and rolling them over a barrel. Eventually endotracheal intubation evolved (Cooper, Cooper, & Cooper, 2006; Fitzgerald, 2008).

Similar advances in supporting breathing and circulation for a dying person can be traced for hundreds of years. At one time, bellows were used to reproduce breathing. Cardiac compressions initially were done on animals through an open thorax. From this, it was believed for years that cardiac arrest could only be treated in an operating room or urgent hospital setting. In the mid-1900's, it was accidentally discovered that pressing on the chest of an animal resulted in a rise in arterial pressure. This led to external cardiac massage, which became known as chest compressions and became widely taught (Cooper et al., 2006).

Since the inception of the modern era of resuscitation, continuing advances have included use of defibrillation, concurrent supportive medications, and invasive techniques used in attempts to restore spontaneous circulation and treat the causes of the cardiopulmonary arrest. Despite these advances, successful resuscitation rates have
remained low and ways to improve outcomes have continues to be explored (Cooper et al., 2006).

With the advent of modern resuscitation efforts and advancing medical technology, it became common practice for the patient suffering a cardiopulmonary arrest to be removed from the presence of the family. However, societal trends in the early 2000s have been toward family cohesiveness in times of crises and openness and shared information among health care consumers. Thus, the outcry for FPDR has been growing (Fell, 2009; Man & Chair, 2006).

**Families and resuscitation.**

Throughout history, ill or dying individuals were cared for by the family at home until death. When the patient died the family and doctor(s) were present at the bedside. Rarely were life-saving measures instituted, in part because medical science did not have end-of-life or resuscitative care. As medical technology advanced over time, the patients were cared for in the hospital environment and often isolated from their families. With the advent of modern resuscitation options and resources, resuscitations became more common and complex. Families were traditionally excluded from the resuscitation of a loved one (Man & Chair, 2006).

In 1982, Foote Hospital in Michigan had two instances in which family members demanded to be present. At that time the hospital had a policy that family was not allowed to be present during resuscitation but took this opportunity to examine the issue of family presence during resuscitation (Kingsnorth-Hinrichs, 2010). In 1985, Foote Hospital developed a program allowing family presence during resuscitation. Follow-up studies surveyed families of deceased patients to gain insight into their experiences and
to determine whether they felt the need or desire to be present during resuscitation (Doyle et al., 1987; Hanson & Strawser, 1992).

Additional researchers began to conduct studies on family presence during resuscitation (FPDR). Multiple studies indicated that FPDR was beneficial to the family in meeting emotional needs. These benefits included meeting the emotional and spiritual needs of the patient, increasing understanding of the patient's condition, decreasing guilt and anxiety for the family, and providing the ability to be with the dying person (Meyers, Eichhorn, & Guzetta, 1998). Families felt they were part of the process and had the ability to observe the efforts of the health care team. The families felt they were able to better gain closure after being present during an unsuccessful resuscitation, and the family did not report any psychological trauma (Doyle et al., 1987; Fitzgerald, 2008; Maxton, 2008). Despite the outcomes of these studies, controversy continued among health care professionals on the issue of FPDR.

**Perceptions of health care professionals**

A collection of research studies have documented research findings as well as personal experiences of health care professionals related to FPDR (Fell, 2009; Fitzgerald, 2008; McLaughlin & Gillespie, 2007; Man & Chair, 2006; Twedell, 2008; Twibell, Siela, Riwitis, Wheatley, Riegle, Bousman et al., 2008). Concerns voiced by health care professionals included the fear that family members might interfere with resuscitation efforts, be critical of staff efforts, observe behaviors that could be interpreted as uncaring or inappropriate, cause staff to lose concentration, and distract staff from the patient (Meyers et al., 1998). Other perceived disadvantages of FPDR were fear that the threat of increased litigation would inhibit the health care team and that the patient's privacy
would be violated (Fitzgerald, 2008). Ellison (2003) stated that health care professionals voiced concern that witnessing resuscitation of a loved one could cause psychological trauma to the family members. Additional concerns voiced by health care professionals were lack of space in the resuscitation room, loss of confidence in the physician if the resuscitation was unsuccessful, and that staff may have to care for family members rather than the patient (Demir, 2008).

Studies found nurses to be more supportive of FPDR than physicians (Helmer, Smith, Dort, Shapiro, & Katan, 2000; McClenathan, Torrington, & Uyehara, 2002; Mian, Warchal, Whitney, Fitzmaurice, & Tancredi, 2007). McClenathan et al. also found variations in opinions based on regional location with the strongest support in the Midwest compared to the remainder of the US. McClenathan et al. speculated that the efforts taken at Foote Hospital in Michigan to institute the practice of FPDR may have been influential to health care professionals from that region. The higher level of support of FPDR by nurses was reflected in the finding that hospital FPDR programs have often been started by nurses, usually beginning in the Emergency Department (MacLean, Guzetta, White, Fontaine, Eichhorn, Meyers, et al., 2003).

Several research studies have shown that concerns of health care professionals about the risks of FPDR have been largely unfounded. Fears of family interference, psychological trauma to the family, and increased litigation have not been borne out (Ellison, 2003; McClement, Fallis, & Pereira, 2009; McClenathan et al., 2002; Madden & Condon, 2007).

Past studies have shown that efforts to educate staff have resulted in increased acceptance of the practice of FPDR (Mian et al., 2007). Implementing policies and
guiding staff through education has been seen as a method for gaining acceptance for FPDR (Kingsnorth, O’Connell, Guzetta, Edens, Atabaki, Mecherikunnel, et al., 2010; Mian et al., 2007).

**Responses of professional organizations and acute care facilities**

Numerous professional organizations have issued position statements supporting FPDR. In 1993, the Emergency Nurses Association (ENA) developed a resolution supportive of allowing FPDR (Emergency Nurses Association, 1995). The American Heart Association (AHA) first addressed FPDR in 2000 and made revisions to their international guidelines that supported considering FPDR. These guidelines were developed over two years by the world’s top resuscitation experts from numerous countries (American Heart Association Guidelines, 2000). In 2002, the American Association of Critical-Care Nurses (AACN) recommended that health care organizations have a written policy for offering the option of FPDR (American Association of Critical-Care Nurses, 2004). In 1996, the Resuscitation Council in the United Kingdom recommended that relatives should be provided the opportunity to be present during resuscitation (Perry, 2009). The European Resuscitation Council also recommended families be offered the option to be present during resuscitation (Baskett, Steen, & Bossart, 2005). Additional organizations that have developed position statements supporting FPDR include the European Federation of Critical Care Nursing Associations, American College of Critical Care Medicine, American College of Emergency Physicians (pediatric FPDR), and the American Academy of Pediatrics.

Despite the positions taken by these organizations supporting FPDR, some institutions have been slow to institute policies supporting FPDR (Miller & Stiles, 2009;
Tamekia, 2008). Ongoing controversy among health care professionals reflects the absence of these policies (Fitzgerald, 2008). Presence of policies on FPDR gives structure to the practice and may ensure consistency in following guidelines. In institutions that have policies, health care professionals were made aware of their responsibilities in following the policies on FPDR and conflict between staff was decreased (Twedell, 2008).

According to Halm (2005), there have been radical changes in the methods of delivery of resuscitative care since the American Heart Association recommended offering families the option of being present during resuscitation in the 2000 guidelines. Families have become more informed consumers of health care and have demanded the right to be present during resuscitation.

Studies that have examined the perceptions of health care professionals related to FPDR have been limited by the absence of reliable, valid instruments. Use of such instruments would allow comparison across studies and exploration of the relationships between risks, benefits, and self-confidence in managing family presence during resuscitation. Another limitation of research on perceptions of health care professionals about FPDR is that the samples in past research on FPDR have focused on nurses employed in emergency departments. While there has been some inclusion of critical care nurses, few of the studies included nurses who worked in non-critical care units. Thirdly, past studies have not included samples with widely divergent demographic variables. Therefore, replication studies are needed to examine the relationships between respondents' demographics and perceptions of FPDR (Twibell et al., 2008). This study has addressed those gaps in knowledge through a partial replication of the study done by
Twibell et al.

**Statement of the Problem**

The practice of allowing family presence during resuscitation has caused continuing controversy among health care professionals for decades. Families have expressed that it is their right to be at the bedside when a loved one was dying. Research has shown that contrary to the beliefs of many health care professionals, this experience has not been psychologically traumatic to the families (Weslien, Nilstun, Lundqvist, & Fridlund, 2005). Despite support of FPDR by professional organizations, many health care professionals have continued to be resistant to the practice (American Association of Critical-Care Nurses, 2004; American Heart Association, 2000; Emergency Nurses Association, 1995). Research that utilizes reliable and valid instruments to measure nurses' perceptions of risks, benefits and self-confidence related to FPDR has been lacking (Twibell et al., 2008).

**Purpose**

The purpose of this study was to explore nurses’ perceptions of FPDR and the relationships of these perceptions to selected demographic variables. The study aimed to use instrumentation that had initial evidence of validity and reliability to measure perceptions of nurses’ self-confidence and the risks and benefits of FPDR.

**Research Question**

The research question used in this study was “What are the relationships between a nurses' perceptions related to FPDR and personal demographic variables?”

**Theoretical Framework**

No theoretical framework has been developed to ground the research on FPDR.
Most nursing theories focus on individuals as the recipient of nursing care. Bell and Wright (1990) noted that few nursing theories included any aspect of family. One theory that did address families as a focus of care was developed by Wright and Leahey (1990), but it has not been tested in research, and published reports of its application in practice are limited. Wright and Leahey's theory of family systems nursing was selected to guide the present study.

Wright and Leahey (1990) conceived the family systems nursing framework as different from the notion of family nursing. Family nursing focused either on the family in the context of the individual or the individual in the context of the family. Wright and Leahey stated that family systems nursing addressed the whole family as the unit of care. In this context, what affected any part of the family affected the family as an entity. The interaction of the family in a reciprocal manner was the specific focus of this theory. Family presence during resuscitation, as a research focus and a practice issue, could be grounded in a theory that describes and explains the interaction within families and between families and other entities during crisis.

Wright and Leahey (1990) believed that families as a whole owned health-related experiences and defined problems in their own terms. The nursing role was to offer alternatives and support the development of creative solutions to problems.

One reason that Wright and Leahey's (1990) work may not have attracted attention and testing in research and practice was that it was offered as a meta-cognitive theory, that is, a collection of theories. Wright and Leahey's theory offered a place to collect theories on communication, cybernetics, family therapy and systems and apply them to families functioning as a whole. Nurses would select specific theories as required, giving
attention to only combining theories with similar underlying assumptions. One published report of an application of family systems nursing theory suggested integrating Wright and Leahey's theory with Peplau's (1952) nursing theory on interpersonal relationships. Wright and Leahey acknowledged that advanced practice nurses would be best equipped to use a family systems nursing approach, given the required ability to evaluate theories before applying them.

This study focused on families being together as a whole unit during resuscitation of a member of the family. Wright and Leahey's (1990) framework allowed for the analysis and synthesis of multiple studies based on various theoretical frameworks and supported the discovery of new knowledge in the evaluative process. This approach addressed the needs of the patient and family and care was driven by their needs rather than controlled by health care professionals. These needs included maintaining a focus on their family member during a medical crisis and being present during the time of death. The families wanted to be kept informed of the patient's condition and if possible, be given time to anticipate loss in impending death (McGahey-Oakland et al., 2007).

Definitions of Terms

Family.

Conceptual Definition.

Human beings directly related to the patient and anyone with whom the patient has a close relationship, as defined by the patient (Fell, 2009).

Family presence during resuscitation.

Conceptual Definition.

The attendance of one or more family members in a location that affords
visual or physical contact with a patient during cardiopulmonary resuscitation (Eichhorn, Meyers & Guzetta, 2001).

**Perceived benefits and risks related to FPDR.**

*Conceptual Definition.*
Beliefs or opinions of the advantages and disadvantages of a situation or practice, such as FPDR (Twibell et al., 2008).

*Operational Definition.*
Beliefs or opinions of the advantages and disadvantages of FPDR as measured by the total score on the Family Presence Risk-Benefit Scale (FPR-BS) (Twibell et al, 2008).

**Self-confidence related to FPDR.**

*Conceptual Definition.*
Perception of ability to perform or manage in a given situation, specifically FPDR (Twibell et al., 2008).

*Operational Definition.*
Perception of ability to manage resuscitation in the presence of family as measured by the total score on the Family Presence Self-Confidence Scale (FPS-CS) (Twibell et al., 2008).

**Limitations**
Examination of limitations was important to promote improvement in future studies.

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 and could have contained 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 FPDR.

Summary

The controversy surrounding FPDR has been an ongoing issue for health care professionals. Families have expressed their wishes to be present at the bedside during the resuscitation of a loved one. Health care professions have exhibited ambivalence or resistance against FPDR which has raised debate on ethical, moral, legal and practical bases.

Perceptions of health care professionals regarding benefits, risks and self-confidence related to FPDR have been found to be widely divergent (Twibell et al., 2008). Health care professionals' perceived risks and fears have not been borne out in research. Support of FPDR by numerous professional organizations has created more impetus to embrace the practice, yet uncertainty remains. Continuing study of perceptions of health care professionals is needed to understand best approaches to support FPDR, promote self-confidence of health care professionals and institute FPDR as a consistent practice. The purpose of this study is to gain a better understanding of the underlying reasons for perceptions of health care professionals through the use of two new instruments with promising validity and reliability (Twibell et al.).
Chapter II

Literature Review

Introduction

The presence of family at the bedside during resuscitation of loved ones has been the subject of ongoing controversy among health care professionals around the world. Multiple stakeholders in the debate hold varying opinions and perspectives. Families overwhelmingly report the desire to be present at the bedside during resuscitation of a loved one. Research clearly indicates that families feel it is their right and that benefits of being present outweigh any risks (McGahey-Oakland et al, 2007). Numerous professional organizations have officially given support to family presence during resuscitation (FPDR) through position statements and guidelines. However, health care professionals sometimes resist family presence, citing more disadvantages than advantages (Doyle et al, 1987; Hanson & Strawser, 1992; Ellison, 2003; McClement et al, 2009). Thus, most hospitals exclude families from being present during a resuscitation despite that fact.

The resolution of the matter is important, as health care systems strive to increase
patient and family satisfaction with policies and services while also creating healthy work conditions for professionals. To date, research on health care professionals' perceptions of FPDR has primarily consisted of descriptive opinion surveys (Demir, 2008; Madden & Condon, 2007; Miller & Stiles, 2009). More rigorous research is needed to clarify the perspectives of health care professionals and factors that influence their perceptions related to FPDR.

Purpose

The purpose of this study was to explore nurses' perceptions of FPDR and the relationships of these perceptions to selected demographic variables. The study aimed to use the instrumentation that had initial evidence of validity and reliability to measure perceptions of nurses' self-confidence and the risks and benefits of FPDR.

Research Question

The research question that guided the study was, “What are the relationships nurses' perceptions related to FPDR and personal demographic variables?” The primary perceptions included risk, benefit, and self-confidence.

Organization of Literature

The literature review provides the background for understanding the debate about FPDR. Thus, this review was divided into two sections designated as family perspectives and health care professionals' perspective. Health care professionals include only physicians and nurses in this review. While some of the studies primarily addressed either the family perspective or professional staff's perspective, many of the studies involved both. The studies were divided organizationally according to their main focus. This review does not address the perspectives of patients related to FPDR.
Theoretical Framework

While a specific, narrow-range theoretical framework for family presence during resuscitation has not been developed, several researchers have cited or inferred a broad theoretical basis for their studies. For example, Ellison (2003) referred to Ajzen and Fishbein's (1972) theory of reasoned action as a model for predicting behavioral choices in a broad range of settings. Ajzen and Fishbein stated that overt behavior resulted from behavioral intentions. The intention was the result of both the person's attitude toward a particular act and beliefs about what others expected the person to do in a particular situation. In turn, a person's attitude toward a specific action was a result of perceived risks and benefits. Ellison tied this theory to family presence during resuscitation (FPDR) in that attitudes were learned. Staff and family actions reflected the person's belief that a behavior was good or bad. These beliefs were a result of educational and experiential components that led to certain predictive adaptive behaviors.

Ellison (2003) also cited as a framework the adaptation model of Roy and Andrews' theory (1999), finding some results in her study to be explained by the tenets of the adaptation model. The adaptation model posited that persons interacted with their environment and adapted to stimuli. In this context, the staff with more education and experience were seen as the stimulus for a change in behavior, such as family presence as an adaptation of care. This theoretical position supported the findings in Ellison's study that nurses who were certified or worked in specialty units reported a more positive attitude toward FPDR.

In evaluating the effects of interventions to promote FPDR, Mian et al. (2007) seemed to infer the use of change theory. Rogers' (1962) and Lewin's (1947) change
theories most reflected the interventions instituted in the study by Mian and colleagues. Lewin posited three stages of change. First was the unfreezing stage, which occurred when disequilibrium surfaced and necessitated a need for change. Next was the moving stage in which information was gathered and used to influence change. Lastly was the refreezing stage in which the changes were integrated and equilibrium returned (Roussel & Swansburg, 2009).

Rogers (1962) expanded on Lewin's (1947) theory using five phases. These phases were awareness, interest, evaluation, trial and adoption. Mian et al. (2007) used these stages and phases in implementing and evaluating interventions to change staff attitudes and behaviors related to FPDR (Roussel & Swansburg, 2009).

Other theories that can be inferred from recent research studies on FPDR included, but were not limited to Ray's (1981) theory of bureaucratic caring, Peplau's (1952) theory of interpersonal relations, and Leininger's (1970) theory of cultural care diversity. Ray's theory of bureaucratic caring focused on nurses working in a complex organization such as a hospital. The hospital was viewed as a culture in which there were boundaries. Nurses were caring beings functioning within the culture or organization. As such, nurses valued the nurse-patient relationship and recognized the patient's right to make choices. According to the theory nurses were challenged to think outside their usual paradigms and transform the work world which included the interrelationships of all persons. In applying this theory to FPDR, the family was seen as part of the whole of the patient and the patient as part of the whole of the family (Tomey & Alligood, 2006).

Peplau's (1952) theory of interpersonal relations could also apply to FPDR. This theory presented a logical method for examining nursing situations. The nurse-patient
relationship developed in the phases of orientation, working, and termination. These phases led to adaptability in the relationship. As part of that relationship, Peplau emphasized including the family in the nurse-patient relationship. The nurse constantly did self-assessment focusing on thoughts and reactions to the patient that could be non-therapeutic (George, 2002).

By focusing on holistic and comprehensive care, Leininger's (1970) theory of culture care could be applied to FPDR. Leininger posited that the failure of nurses to recognize the cultural aspects of human needs resulted in less than beneficial nursing care. Culture was defined as the values that influenced a person's decisions and actions. It was the job of the nurse to discover these values and incorporate them into patient care. For example, during resuscitation the family might value being with the patient. The nurse needed to recognize that value and incorporate it into the care of the patient (Tomey & Alligood, 2006).

In addition to these theories, many others that focused on patient-centered care, family theory, and holistic care, could be used in guiding research on FPDR. Theories related to changing attitudes and values through experience and education were also possible frameworks.

Other than Peplau, most current grand and mid-range theories in the discipline of nursing focus on individuals as the recipient of nursing care. Bell and Wright (1990) noted that few nursing theories included any aspect of family. One theory that did address families as a focus of care was developed by Wright and Leahey (1990), but it has not been tested in research, and published reports of its application in practice are limited. Wright and Leahey's theory of family systems nursing was selected to guide the
Wright and Leahey (1990) conceived the family systems nursing framework as different from the notion of family nursing. Family nursing focused either on the family in the context of the individual or the individual in the context of the family. Wright and Leahey stated that family systems nursing addressed the whole family as the unit of care. In this context, what affected any part of the family affected the family as an entity. The interaction of the family in a reciprocal manner was the specific focus of this theory. Family presence during resuscitation, as a research focus and a practice issue, could be grounded in a theory that describes and explains the interaction within families and between families and other entities during crisis.

Wright and Leahey (1990) believed that families as a whole owned health-related experiences and defined problems in their own terms. The nursing role was to offer alternatives and support the development of creative solutions to problems.

One reason that Wright and Leahey's (1990) work may not have attracted attention and testing in research and practice was that it was offered as a meta-cognitive theory, that is, a collection of theories. Wright and Leahey's theory offered a place to gather together and possibly synthesize theories on communication, cybernetics, family therapy, and systems and apply them to families functioning as a whole. Nurses could select specific theories as required, giving attention to only combining theories with similar underlying assumptions. For example, one published report suggested integrating Wright and Leahey's theory with Peplau's (1952) nursing theory on interpersonal relationships. Wright and Leahey acknowledged that advanced practice nurses would be best equipped to use a family systems nursing approach, given the required ability to evaluate theories.
before applying them.

The present study focused on families being together as a whole unit during resuscitation of a member of the family. Wright and Leahey's (1990) framework allows for the analysis and synthesis of multiple studies based on various theoretical frameworks and supports the discovery of new knowledge in the evaluative process.

**Family Perspectives**

In 1982, Foote Hospital Emergency Department (ED) experienced several occasions when family members either demanded or requested to be present during the resuscitation of their loved ones. Staff at this hospital began to question the standard policy of family exclusion from the treatment room during resuscitation. They began on a limited basis allowing families at the bedside during resuscitation attempts. In 1985, Doyle et al. (1987) undertook a study of the families that had been present at resuscitation at Foote Hospital. The authors' focus was whether the program was helping meet the emotional needs of family members who had been present during resuscitation. At the time of the study there had been little follow-up with families that had been present for resuscitation.

At Foote Hospital, the family participation program had become more structured. Family members were met by either a chaplain or Emergency Department (ED) staff and asked if they wanted to be in the room during resuscitation. The family members were told what they might see in the room and a support person was present with the family. Staff attempted to allow family to be close enough to be able to touch the patient. If the resuscitation was unsuccessful, staff either asked the family to temporarily leave the room or the decision to terminate life supports was discussed with the family. Family
members were then given time with the loved one. A support person remained present during this time (Doyle et al., 1987).

Doyle et al. (1987) sent a survey to 70 family members who had been present during resuscitation. The purpose of the survey was to determine the feeling of the families about the experience and if the program was meeting the emotional needs of the families. Each person was contacted personally by the chaplain who had been present during their time with the patient. Twenty-one health care staff involved in the program also received a separate survey to assess their feelings about presence of family during resuscitation. No indication of reliability or validity of the survey was reported.

Seventy-three per cent of the family surveys were returned. Four returned surveys were not completed for various reasons. The majority (55%) reported that they had been asked if they wished to be present during resuscitation while the remainder did not remember if they were specifically asked. Seventy-two per cent stated they felt they had been given adequate information of what they would see in the resuscitation room. Questions on staff communication with family, support by a nurse or chaplain during their stay in the room, and being able to touch or talk to the patient all had positive reviews from the majority of the respondents. Every family member that responded to the survey indicated they felt the health care team had done all they could for their loved one. Most felt that they would want to be present if the situation arose again. Thirty-five per cent stated they felt they had the right to be present with a dying relative. The majority expressed that the experience helped them with the grieving process and that their presence was beneficial to the dying patient (Doyle et al., 1987).

All 21 staff members completed the survey. Respondents included 12 nurses, six
clerks, and three physicians. Six stated they felt anxiety about their performance when the family was present. Staff reported that the patient felt “more human” which increased their stress. Seventy-one per cent ultimately approved of the practice of FPDR (Doyle et al., 1987).

Doyle et al. (1987) concluded that the program appeared to have benefits for family members and had been successful at their hospital. The authors advised expanded use of this program with continuing study. They found no reason for policies to exclude family members being present during resuscitation.

As one of the earliest studies addressing FPDR, Doyle et al. (1987) set the stage for further research on this issue. Later research studies cited the foundational work of Doyle and colleagues (Demir, 2008; Ellison, 2003; Madden & Condon, 2007; Mian et al., 2007; Weslien et al., 2005).

Weslien et al. (2005) conducted a study to further explore family members’ perspectives of FPDR in different stages of the cardiac arrest event. The purpose of this study was to provide insight into family members’ experiences witnessing cardiac arrest.

The target population for the study was family members of cardiac arrest patients in two hospitals in Sweden. Contact was made one month after the event by a letter explaining the study. Of 41 family members contacted, 17 participated in the study. The design used descriptive interviews. Family members were interviewed either in their home (n = 13) or at one of the hospital’s nursing department (n = 4). These interviews occurred 5-34 months after the event. To test validity of the data collection method, two pilot interviews were conducted with women who had witnessed resuscitation of a family member (Weslien et al., 2005).
Participants narrated their experience and were allowed to pause if they had difficulty relating their story. Interviewers followed with open-ended questions and provided support to the family members. Interviews were transcribed. The authors read the data a number of times for content analysis. Each sentence was analyzed to detect and understand any underlying meaning. The co-authors discussed the analysis until agreement of interpretation was achieved (Weslien et al., 2005).

Stages of the cardiac arrest event were placed in categories. The first was the event that occurred to the patient, then the emergency medical service arrived and finally the staff took over at the hospital. As the event occurred, family members were found to have realized the need for assistance and sought help either by phoning the emergency call service (ECS) or contacting someone immediately available to help (Weslien et al., 2005).

Those who contacted ECS attempted to follow the instructions given to them. Some family members panicked when the patient stopped breathing while others started basic CPR. Family members stated these moments felt unreal and difficult to understand. Family members related feelings ranging from hopefulness to realizing there was no hope. Their behavior ranged from being calm to being very upset. The arrival of EMS gave the family members a feeling of hope and decreased stress. While some family members left the patient when EMS attempted resuscitation, those that stayed described it as not overly stressful. Some expressed the feeling that EMS was not respectful of the patient. Family members stated that they felt the most important person was the patient, forgetting their own needs. They attempted to help by giving health information to EMS (Weslien et al., 2005).
The final category occurred when the staff took over at the hospital. Family members understood the seriousness of the event and felt that news of death was not unexpected. Family members had confidence in the health care professionals and felt that everything possible had been done for the patient. Family members who were present in the resuscitation room were grateful that the staff allowed them to be present. Those who chose not to enter the room appreciated that they were not asked to be present at the bedside (Weslien et al., 2005).

Negative feelings of the family members toward hospital staff included feeling abandoned. Some physicians appeared to have difficulty dealing with the family, and this response was perceived as unprofessional behavior by the family. Some felt they were not given any information about the treatment and were not prepared for the appearance of the patient following death. They wanted to be informed about the option to be present during resuscitation. Follow-up with a social worker several days later was something the family members emphasized as necessary (Weslien et al., 2005).

Weslien et al. (2005) stated that using unstructured interviews gave rich data for insight into the family members’ experiences. Getting a large sample proved difficult. The detailed information of events given by participants was not atypical as they had sharpened awareness during the event (Dyregrov, 2001). They stated that they would recall the caring they had received for many years. They were also able to accept and understand information given by health care professionals and found this information important.

Results of this study demonstrated that experiences of family members of a patient in cardiac arrest varied widely. The actions of the health care staff had a large impact in
helping the family members regain equilibrium following the event. The focus of staff should be what was best for the family. This included whether the family wished to be present at resuscitation. Weslien et al. (2005) expressed the hope that the findings of their study would affect the practice of staff in dealing with family members effectively.

McGahey-Oakland et al., (2007) further developed the evidence base for FPDR by conducting a study in a pediatric population. The purpose of McGahey-Oakland et al.'s study was three-fold. The first purpose was to explore and describe the experiences of family members of children that had undergone resuscitation. The second goal was to identify important information about family experiences to improve the experience in the future. Assessing the mental and health status of the family members was the third purpose.

This descriptive, retrospective study took place in a large tertiary children's hospital in Texas. This hospital did not have a policy regarding FPDR. It also did not routinely have support staff available to families during resuscitation. The sample consisted of family members whose children had undergone resuscitation that was initiated prior to arrival at the hospital. Due to the population, both English and Spanish speaking families were included. A total of 25 patients met the criteria set by the investigators. Of these, 10 family members were interviewed. Seven of these family members had been present during resuscitation. All 10 of the patients died after the resuscitation attempt (McGahey-Oakland et al., 2007).

Data were collected using both qualitative and quantitative instruments. The Parkland Family Presence during Resuscitation/Invasive Procedures Unabridged Family Survey (FS) consisted of 15 items to assess families' attitudes, problems and benefits of
FPDR. Some modification of the questions were done for families that had not been present. For family members not present during resuscitation, a parallel tool (FPAS-FM) was developed to reflect lack of presence. The FPAS-FM tool was reviewed by a panel of family members and health care providers to establish content validity. The Brief Symptom Inventory (BSI-18) (Meyers, Eichhorn, & Guzetta, 2000), the Short Form Health Survey version 2 (SF-12v2) (Derogotis, 2001), and the Post Traumatic Stress Disorder (PTSD) instrument (Ware, Kosinski, Turner-Bowker, & Gandek, 2002) were used to measure the psychological and mental health status of the families. Five investigator-developed questions and the FS were used to obtain data on the family member experiences. The FS included demographic and open-ended questions regarding FPDR (McGahey-Oakland et al., 2007).

Following one hour audio-taped interviews and compilation of results of the instruments, McGahey-Oakland et al. (2007) analyzed the data. Transcripts of each interview were reviewed and compared to each other to establish thematic categories.

Quantitative analysis of results of the FPAS-FM tool indicated that all of the families felt the importance of having the option to be present during resuscitation. The mean score for this tool was 24.1 (SD = 4.9) with a possible score range of 15-60. Low scores on this tool indicated support for FPDR. Results of the Global Severity Index showed a higher stress level in the sample compared to normed population scores. Comparison of results from the Physical Component Summary and the Mental Component Summary from the SF-12v2 tool showed results comparable to the general population. The mean score of 2.8 (less than the cutoff score of 4) on the PTSD indicated an absence of traumatic stress (McGahey-Oakland et al., 2007).
McGahey-Oakland et al. (2007) found that qualitative analysis demonstrated five themes in the interviews. The families felt the right to be present. They stated that their presence was critical. The families that had been present said they would recommend being present to other families. At the same time, the families expressed that if their presence was detrimental to the care given the patient it would be appropriate for them to be asked to leave. The families expressed the opinion that the connection and comfort made a difference. The families felt their presence was supportive of their child and that the child wanted them there. Part of this need to be present was the ability to give the child permission to die. Family members stated that being present helped in their healing after the death.

Seeing the efforts made on the behalf of the patient assured the family members that everything possible had been done. This notion was expressed as “seeing is believing.” Family members that had not been present questioned whether the outcome could have been different. As a result of seeing the attempted resuscitation, family members felt closure and the beginnings of acceptance. Being present did not equate with being in another room and receiving updates. Being separated from their child caused anxiety in the families (McGahey-Oakland et al., 2007).

The method of getting in during resuscitation differed. Those that were not present either were not at the hospital or were asked to leave the room. Others were in the room at the time of the arrest and were not asked to leave while others were invited into the resuscitation room. None of the family members were ready to face the fact that their child would require resuscitation. This was true even for families with chronically ill children. During the resuscitation, the child rather than the resuscitation effort was the
focus of the family. The timing of the information given to the family during the resuscitation was very important. Again the focus was the child, and the family members expressed that they did not want someone else talking to them during this time. If they had questions they wanted the information later. At the same time, some family members expressed that it would have been helpful to have a facilitator there to explain things (McGahey-Oakland et al., 2007).

McGahey-Oakland et al. (2007) recognized that the small size of the sample limited generalizing the results. The results did confirm findings of previous studies (Doyle et al., 1987; Hanson & Strawser, 1992; Jarvis, 1998; Mangurten, Scott, Guzetta, Sperry, Vinson, Hicks et al., 2005; Mangurten, Scott, Guzetta, Clark, Vinson, Sperry et al., 2006; Meyers, Eichhorn, & Guzetta, 1998, 2000). Perceived disadvantages of having families present were not shown to be factual in the results. These perceived disadvantages included fear of disruption of the resuscitation, unknown emotional effects on the family, and families not understanding the resuscitation event.

Conclusions of the study were that families were increasingly becoming a part of resuscitation events. In order to achieve a consistent approach to FPDR, a written policy was essential. The families needed support from a health care provider or facilitator during the resuscitation event. The authors expressed the need for continuing research into FPDR to gain insight into the beliefs and values of both family members and health care workers (McGahey-Oakland et al., 2007).

In another study of parents' perspectives regarding FPDR of a child, Maxton (2008) proposed a study to provide in-depth understanding of the meaning for parents who were present or absent during attempted resuscitation of their child in the Pediatric Intensive
Care Unit (PICU). Maxton based the study on the belief that separating families from critically ill pediatric patients could produce stress and uncertainty for both the parents and the child. Separation could have long-term negative effects on the family dynamics (Board & Ryan-Wenger, 2002). Maxton noted that while open visitation in a PICU was often allowed, parents may have been prevented from staying with their child during critical situations (MacLean et al., 2003; Meyers et al, 2000). This study had the objective of exploring the parent's experience in being present during the resuscitation of a child in a PICU. As in adults, family presence during resuscitation of children was an area of controversy. Maxton stated that while there were studies of staff opinions on FPDR and family members experiences on failed pediatric resuscitation, little research had been done to investigate the effects of family presence or absence of parents during successful and unsuccessful resuscitation in a PICU.

This study took place in a PICU in Australia. Patients in the unit ranged from newborn to 16 years of age. The unit had a policy in place that offered the parents the choice to be present during resuscitation. This policy was not always followed. Maxton (2008) used purposive sampling. Participants were parents of children that required resuscitation. Eight sets of parents participated. There was a mixture of successful and unsuccessful resuscitation and presence and absence of the parents during the resuscitation attempts.

Data collection was performed by doing eight in-depth, unstructured interviews. Six sets of parents and two single parents were interviewed. Along with the interview, structured debriefing allowed the participants to discuss concerns about either the interview or feelings. Names of support groups/agencies were shared with the parents.
whose child had died (Maxton, 2008).

Maxton (2008) used a qualitative descriptive design and van Manen's (1990) framework to analyze the data. Thematic analysis was done from review of the interviews. From this analysis, Maxton derived four themes of the parents' experiences: “being only for a child; making sense of a living nightmare; maintaining hope in the face of reality; living in a relationship with staff” (Maxton, p. 3170). Parents expressed the need to be with their child and provide comfort and support. This need outweighed any trauma experienced in witnessing resuscitation. By focusing on the child, parents' needs and trauma were lessened. Not being with their child caused the parents to feel like they had failed the child.

In order to make sense of the nightmare, parents needed to understand what was happening to their child. Despite this need, parents found it painful to recall the event, and many remembered little detail of the situation. Parents stated they remembered being with their child and saying goodbye, not the resuscitation itself. If the attempt to resuscitate was unsuccessful, parents appreciated being able to say goodbye to their child. When the resuscitation was successful, parents better understood how critically ill their child was if they witnessed the event. They wanted explanations that were easily understood. The use of medical terms made it harder for some parents to understand the event (Maxton, 2008).

Even in understanding the seriousness of the resuscitation event, parents continued to maintain hope. Crying while present met a need but was interpreted by staff as an inability to cope. Coping was enhanced by the ability to leave and return at intervals. Some parents stated they feared staff would perceive their leaving as inability to cope so
stayed when they felt the need to take a break. Parents primarily sought support from each other and other family members. The parents also sought support from staff but to a lesser degree. Parents found interventions from social workers as not being helpful. They felt the social workers did not really understand what was going on when they could not answer technical questions. An experienced nurse was perceived as the best to serve in the support role during the resuscitation. Parents did not need constant information. Having the support person near was often enough. Their primary focus was on the child (Maxton, 2008).

Maxton (2008) recognized that the small number of parents in the study served as a limitation and saw this study as contribution to increase understanding of the parents' experiences. The fact that no parents that were absent at the time their child died were included in the study was seen as another limitation.

**Health Care Professionals Perspectives**

While exploration of families' perspective of FPDR found a positive need for FPDR, controversy among health care professionals continued. Controversy centered on perceived risks and benefits of FPDR as seen by the health care professionals.

Using a sample of health care professionals attending an international medical conference, McClenathan et al. (2002) assessed the opinions regarding FPDR. At the time of the study, several organizations had recommended FPDR. Of interest in this study is the fact that the majority of respondents, who were nurses, physicians, and allied-health providers, had primarily critical care background with frequent experience in resuscitation.

McClenathan et al. (2002) stated that advocates for FPDR concluded that families
were better able to deal with their grief if they witnessed the attempted resuscitation (Doyle et al., 1987). According to Meyers et al. (2000), family presence led to increased professional behavior by the resuscitation team. Brown (1989) stated that FPDR increased the bond between staff and family. Arguments against FPDR included fear of distraction for health care professionals, violation of patient confidentiality and privacy, and fear of increased litigation (Helmer et al., 2000).

Following an incident of the presence of an unsolicited family during resuscitation at their hospital, McClenathan et al. (2002) developed a survey to evaluate staff opinions regarding FPDR and the reasons for their opinions. The design was descriptive. The survey included six questions asking about resuscitation experience, demographics, and opinions on FPDR. No reliability testing of the survey was reported. This survey was distributed at an international medical conference in San Francisco in 2000. Respondents included 494 physicians, 28 nurses, and 21 other allied health care personnel.

No significant differences of opinion on FPDR were found to be based on age, medical specialty, years of experience, or size or type of hospital of practice. Seventy-eight per cent of all respondents surveyed disapproved of FPDR for adults. Eighty-five per cent disapproved of FPDR for pediatrics. Eighty per cent of physicians opposed FPDR compared to 61% of nurses and allied health care workers combined (p = 0.0037) or nurses alone (p = 0.0066) (McClenathan et al., 2002).

McClenathan et al. (2002) found that geographical region of practice did show significant differences in opinion. Compared to the rest of the nation, Midwest health care workers were more likely to allow FPDR for adult situations. For pediatric patients, the results were not statistically significant. Those from the northeastern US
were the least in favor of FPDR for either adult or pediatric situations (12% and 5%).
Reasons for regional differences were not explored in this study. McClenathan et al. did
speculate that the higher rate of acceptance of FPDR in the Midwest may be a result of
this practice being initiated at Foote Hospital in Michigan. There were no differences in
opinions between international and US participants.

Twenty-two per cent of those with resuscitation experience stated they would allow
family presence during adult resuscitation of an adult patient compared to 42% who did
not have experience ($p = 0.043$). Fifty-nine per cent of the participants had been in
situations of FPDR. Of these, only 40% would allow family presence at future
resuscitation attempts. Those opposed to FPDR listed reasons for disapproval. Fear of
psychological trauma to the family was the most common reason (79%). Resuscitation
team anxiety and medico-legal issues were other concerns. Another common reason
listed was that family presence could be a distraction of the resuscitation team resulting
in delay of treatment (McClenathan et al., 2002).

Of the 61% of physicians surveyed that had previous experience with FPDR, only
39% would allow family presence in future resuscitations. The physicians viewed FPDR
as a negative experience. Forty-seven per cent of the nurses characterized FPDR as a
negative experience. Lack of support for FPDR found in this study was significant, as
the respondents were primarily critical care professionals that often dealt with
resuscitation situations (McClenathan et al., 2002).

McClenathan et al. (2002) cited the Hanson and Strawser (1992) study of the Foote
Hospital experience with FPDR in advocating that families only be brought in the
resuscitation room after placement of invasive lines. McClenathan et al. stated they
believed health care professionals would be more accepting of family presence once these procedures were completed.

While surveys of family members in other studies showed that the majority of families wished to be present at resuscitation, health care workers continued to debate the issue. McClenathan et al. (2002) stated the belief that education of staff about the guidelines on FPDR, implementation of FPDR policies, and training staff to support families could result in better acceptance of families in the resuscitation room. They also recommended that more vigorous studies should be done before widespread implementation of FPDR.

Limitations of this study included the method of survey distribution at an international conference which did not allow for the calculation of a response rate. Possibly only those with strong beliefs completed the survey. As only 20 of the physicians were pediatricians, the results may not have been representative of the support of FPDR for the pediatric population (McClenathan et al., 2002).

In another study of nurses regarding family presence during resuscitation, Ellison (2003) set out to explore the relationships between nurses' demographics and nurses' attitudes of FPDR. Ellison stated that attitudes were learned and influenced the person's judgment of behaviors. Ellison based this study on Ajzen and Fishbein's (1980) theory of reasoned action, which proposed a model for predicting behavioral choices. Culture was viewed as a significant factor in the development of attitudes and resultant behavior (van der Woning, 1997).

At the time of Ellison's (2003) study, FPDR was a relatively new concept. Health care providers held varying views regarding this concept. While families preferred being
present at the resuscitation, previous studies showed that health care professionals continued to not allow the families at the bedside (Doyle et al., 1987; Eichhorn, Meyers, Mitchell, & Guzetta, 1996; Robinson et al., 1998).

Ellison (2003) used a descriptive, correlational design that had a qualitative component. Two hundred and fifty surveys were sent to a target population comprised of New Jersey Emergency Nurses' Association (ENA) members and hospital nurses. The hospital was an acute care teaching hospital. The sample was randomly selected and consisted of 99% RNs (n = 193) and 1% LPNs (n = 15). Age range of subjects was 41 to 55 years old with mostly white females who worked in the emergency department. Both staff and managerial nurses took part.

The survey instrument used was the Family Presence Support Staff Assessment Tool (ENA, 2001). This tool measured the attitudes of health care professions toward FPDR and/or invasive procedures. Using a Likert scale from strongly agree (1) to strongly disagree (5), the survey had 13 statements to assess the nurses' ability to provide psychosocial and/or emotional support to families during resuscitation. Six open-ended questions assisted in evaluating attitudes, concerns, and beliefs, and current practices. Reliability analysis of the tool was conducted, resulting in a Cronbach's reliability coefficient of 0.470 for the first 6 questions and 0.675 for the remainder (Ellison, 2003).

Analysis demonstrated a significant positive relationship between educational level and attitude toward FPDR ($r = .216$, $p < .01$). Certified emergency nurses (CEN) also demonstrated a more positive attitude toward FPDR. Education, role as an RN or LPN, and the unit worked were statistically significant predictors of attitude on this issue. Area of specialty (Emergency Department) correlated with positive attitudes ($r = 0.234$, p
RNs had less favorable attitudes than LPNs (r = 0.199, p < 0.01). Answers to the open-ended questions were analyzed and showed patterns that emerged. Fifty-eight per cent answered that family presence interfered with their job performance. When asked if they would want to be present if their family member was ill or injured, 80% responded positively to be present for invasive procedures and 56% for resuscitation. Forty-three per cent wanted the option to be present during invasive procedures and 31% for resuscitation. Eighty-seven per cent wanted their family present if they were the patient. They voiced that their family members would serve as support, would advocate for them, and would give them an opportunity to say goodbye if the situation was fatal.

Nurses identified barriers that would prevent them from participating in the practice of FPDR. These included problems dealing with death, lack of comfort having the family observing them, and litigation (Ellison, 2003).

The findings that showed an influence from experience, education, and certification on the attitudes and behaviors of nurses was consistent with Roy and Andrews (1999) theory. This association was shown in the more positive attitude of CENs working in the emergency department than nurses working in other units (Ellison, 2003).

Changing the attitude of nurses about FPDR is a continuing process. The author proposed the use of education to raise the consciousness of staff on this issue. The acceptance of FPDR throughout the organization would be aided by the formation of a multidisciplinary committee and a commitment from the organization. Ellison (2003) stated that allowing the family to be with their loved one had an ongoing effect on the family and the way they viewed how they were treated by health care staff. A family needed to be allowed to say goodbye and should not be denied this opportunity.
Madden and Condon (2007) conducted a study to further explore why exclusion during resuscitation was common practice despite research evidence that it was positive for families. The authors noted that the outcomes of cardiopulmonary arrest are poor with a survival rate of 10% to 15%. Most arrests in a hospital occur in the emergency department and are unanticipated. Madden and Condon stated that the philosophy of nursing was to include the family in the care of the patient, and excluding families from resuscitation events was not consistent with family-centered philosophy.

According to Madden and Condon (2007), family presence during resuscitation (FPDR) had been supported by many organizations but was still controversial among nursing staff. Exploration of nurses' practices and understanding of FPDR may point to necessary interventions to promote FPDR. The purpose of this study was to examine emergency department nurses' practice and understanding of FPDR. Objectives of the study included identification of demographic characteristics of emergency nurses, ascertaining nurse's knowledge of policies related to FPDR, determination of preferences and practices of the nurses regarding FPDR, and identification of barriers and facilitators on this issue. This study used quantitative methods in a descriptive design.

Madden and Condon (2007) used a quantitative questionnaire to explore the emergency nurses' practices and understanding of FPDR. Content of this questionnaire was previously established by the ENA with a panel of experts. A pilot study of the tool was conducted prior to the study for reliability and validation. The questionnaire was distributed to nurses working in a level I trauma emergency department in Cork University Hospital in Ireland. A hundred questionnaires were distributed to
convenience sample of nurses with greater than six months experience in the Emergency Department. Ninety were completed.

The survey consisted of four sections of close-ended questions. The first section comprised demographic data of the nurses. Years of experience, sex, age, work hours and position held were included in this section. The second section explored nurses' knowledge of existing policies and practices related to FPDR. The third section asked nurses' preferences for policy development on FPDR. The last section listed barriers and facilitators on FPDR (Madden & Condon, 2007).

Sixty-five per cent of the nurses in the sample answered correctly that no unit policy existed on FPDR. Seventy-four per cent voiced a preference for a written policy allowing the option of FPDR at the discretion of the emergency team. Only 2.2% preferred that families be prohibited from being present during resuscitation (Madden & Condon, 2007).

Identified barriers included the belief that FPDR could cause conflicts for the emergency team. The participants expressed concern of a conflict with the medical profession. Another perceived barrier was increased stress levels for the emergency team when families were present. Other barriers expressed by the sample were fear of legal issues and interference with the resuscitation efforts by the family. Facilitators included enhanced understanding by staff of the benefits to families and patients with the practice of allowing family presence. Eighty-eight per cent of the nurses stated that the presence of a written policy would be a facilitator (Madden & Condon, 2007).

Results were reported in frequencies and percentages for each answer with mean and standard deviations. Number of times the nurse had taken family members to the bedside
during resuscitation was reported. No correlation analysis was done. Madden and Condon's (2007) discussion of the findings identified a positive attitude among the nurses in this sample regarding FPDR. This finding reflected those in a study done by Meyers et al. (2000). Lack of clear protocols and/or policies was a concern as it put nurses in a difficult position when confronted with a family requesting presence during resuscitation. This same concern was expressed by Hallgrimsdotter (2000) in a study that resulted in 71% of emergency nurses stating the need for a clear written policy on the issue. Fear of conflict with the resuscitation team was significant.

Madden and Condon (2007) expressed the benefits of this study as heightening emergency nurses' awareness and knowledge regarding FPDR. As a result of the study, a written policy was developed in support of FPDR for the trauma center.

Studies on health care staff attitudes regarding FPDR often utilized retrospective surveys. Mian et al. (2007) expressed an interest in evaluating staff attitudes before and after implementation of a family presence program. The authors also wanted to find if there was a difference in attitudes between physicians and nurses. Their review of the literature indicated support of FPDR by organizations including the Emergency Nurses Association, the American Association of Critical-Care Nurses, and American Heart Association. Despite these endorsements, studies reported clinicians' reluctance to embrace this practice.

Mian et al. (2007) indicated a dual purpose for their study. The first was to implement a program for family presence in the emergency department. The second purpose was to evaluate the attitudes and behaviors of the health care staff in the emergency department both before and following the implementation of the program.
Although not stated, the study implied the use of change theory (Lewin, 1947) as a framework.

Using a quasi-experimental design, the study was conducted in a level I trauma center emergency department in the northeast US. The hospital was affiliated with an emergency medicine residency program. All nurses and physicians working in the emergency department were included in the sample if they agreed to participate. Mian et al. (2007) used a pre and post-test design to meet the purposes of the study. Eighty-one per cent of the nurses and 50% of the physicians responded to the initial survey. The follow-up survey was completed by 80% of the nurses and 23% of the physicians.

Implementation of the family presence program was advocated by a team of emergency department staff including three nurses and one physician. The team followed the Emergency Nurses Association recommendations to establish practice guidelines for the program. The team also created the survey used in the study. This survey evaluated nurses' and physicians' attitudes and behaviors both before and after the program was implemented (Mian et al., 2007).

The survey design measured factors felt to influence the staff's acceptance of the change in practice allowing FPDR. A 30-item Likert scale measured attitudes, values, and behaviors. Twelve questions evaluated staff's personal experience with FPDR. Demographics included age, sex, education, years of practice, and emergency room experience. The survey was distributed to the sample members prior to the start of the implementation of the FPDR program and one year after implementation. Survey content was validated by expert review and a pilot study (Mian et al., 2007).

Implementation of the program included education by the clinical nurse specialist
and the physician over a three-month period. The education included current research and a video of a family telling of their experience of witnessing resuscitation. Dialogue with the staff was part of the education. With initiation of the program, the team provided support and feedback both for staff and family. Before entering the room, family was presented with an agreement tool that guided their behavior at the bedside. With positive experiences, the staff became more open to allowing family presence in the resuscitation room. Reluctant physicians were encouraged by nursing staff who were able to share the benefits of the program (Mian et al., 2007).

Comparisons of nurses’ and physicians’ attitudes in the pre-survey indicated more support of family presence by nurses (71%) than physicians (51%). This comparison result was similar on the follow-up survey. Mian et al. (2007) found their results to be consistent with previous studies including Helmer et al. (2000), McClenathan et al. (2002), Mitchell and Lynch (1997), and Williams (2002). A low response rate by physicians on the follow-up study limited these findings. The authors attributed the physicians’ low response rate to the age and experience of the physicians in the study, as physicians in residencies were sampled.

The implementation team deemed the program successful, and it became standard practice at their hospital emergency department. Factors cited as key in the success were administrative support and availability of the team to staff and families during the implementation. The authors stated their belief that the FPDR practice is nurse-driven. Providing nurses with skills with constant reinforcement by the team was integral to success of the program (Mian et al., 2007).

Demir (2008) viewed allowing family to be present during resuscitation as an ethical
issue. Families kept from the resuscitation area became anxious and questioned whether everything was done to save the patient. The families experienced guilt and sadness that they were not with the patient at the time of death. The purpose of Demir's study was to evaluate the opinions of nurses and physicians working in emergency departments and critical care units about FPDR. The implied framework was family systems theory.

The study took place in a large university-affiliated hospital in Turkey. Demir (2008) included the emergency department, cardiology and anesthesia intensive care units in the study. Working in these units as a nurse or physician constituted inclusion criteria. A response rate of 79% resulted from a total staff of 181 nurses and physicians.

Demir (2008) used a descriptive survey design. The survey consisted of four open-ended questions that asked why the staff felt it was or was not necessary for family to be present during resuscitation and who should make the decision to allow the family at the bedside. Seventeen multiple choice questions contained more items about staff opinion, knowledge about research and guidelines regarding FPDR, and past experience with FPDR. There was no indication of reliability testing of the instrument used for this survey.

Only 13 of the 144 participants felt it was appropriate for the family to be present during resuscitation. Reasons given included that families would see how much was done to save the patient, and the family would be more accepting of the situation. This group also expressed that it was the family's right to be present (Demir, 2008).

Almost 83% of the sample were not in favor of patient's family being present during resuscitation. This group stated a fear that the family would interfere with the resuscitation efforts, and it would be traumatic for the family. They also expressed
concern that the team would feel stressed by the family presence, resulting in less than their best performance. Forty-seven per cent stated it should be the team's decision about whether the family should be allowed at the bedside during resuscitation. Twenty-six per cent thought the physician should make the decision. Additional comments made in the surveys reiterated much that was said in the open-ended questions, with 2.1% stating only family members that were in health care should be allowed to be present during resuscitation. The chi-square test was used for analysis of the fixed-choice questions and showed no statistically significant differences in the opinion of appropriateness of family presence based on profession \( (x^2 = 5.660, d.f. = 2, p = 0.060) \), education \( (x^2 = 1.844, d.f. = 4, p = 0.764) \), or number of years of working experience in the profession \( (x^2 = 9.977, d.f. = 10, p = 0.433) \) (Demir, 2008).

The Turkish cultural background was viewed as inappropriate for observing the procedure of resuscitation. It was common for some members of this culture to express grief loudly and physically, wailing, beating their chests, fainting and even attacking medical staff. Attitudes about this behavior may have influenced staff willingness to have families present at the bedside at the stressful time of attempted resuscitation (Demir, 2008).

Almost all of the respondents stated that the hospital did not have a policy in place on this issue and therefore family members were not allowed to be present during resuscitation. Five of the respondents stated there was a written policy forbidding families from being present during CPR. In fact, no such policy existed (Demir, 2008).

One result in this study that differed from findings found in the literature was that the respondents that had permitted family to be present during resuscitation reported a
negative experience. Demir (2008) stated that possible causes for this negative experience were lack of preparation, lack of support from staff, and cultural differences. Ninety-three percent of the respondents stated that they had not had any education about FPDR and were unaware of the guidelines of professional organizations. Demir expressed the belief that this lack of knowledge influenced the attitudes of the respondents and that along with education, a written policy could possibly eliminate staff concerns about FPDR.

In further defining what is known about health care professionals and FPDR, Twibell et al. (2008) tested two new instruments to measure nursing staff perceptions of FPDR. Twibell et al. Examined how perceptions of risk and benefit related to demographic variables and self-confidence levels of nurses.

Twibell et al. (2008) cited several gaps in knowledge about nurses’ perceptions of FPDR. Due to the use of opinion surveys designed by individual researchers, data collection methods were difficult to replicate across studies. In addition, earlier studies used samples consisting of mostly emergency department and critical care nurses. No studies included nurses working in other areas. Furthermore, past sample sizes have been small and response rates have been historically poor. Using a broad sample from different hospital care units, Twibell et al. compared demographic variables, perceptions of self-confidence, and perceptions of risks and benefits of FPDR. The purpose of this study was to close gaps found in previous studies and test instruments used to measure nurses' perceptions of FPDR related to risks, benefits, and self-confidence in this situation. The research questions for this study were:

1. What are the psychometric properties of 2 new instruments used to measure
nurses' perceptions related to family presence?

2. What are the relationships between nurses' perceptions of risks, benefits, and self-confidence related to family presence during resuscitation?

3. What are the relationships among demographic variables and nurses' perceptions of family presence during resuscitation?

4. What are the differences in perceptions of nurses who have and have not invited patients' families to be present during resuscitation?

The design of the study was descriptive and correlational. The population in the study by Twibell et al. (2008) consisted of registered nurses (RNs) and licensed practical nurses (LPNs) working in a regional medical center that lacked a policy on FPDR. A total of 375 nurses participated in the sample, which was a response rate of 64%. The majority of the sample consisted of women who were white and had more than 6 years of nursing experience.

Twibell et al. (2008) developed two instruments to measure perceptual variables. The first instrument was the Family Presence Risk-Benefit Scale (FPR-BS). This instrument measured nurses' perceptions of risks and benefits of FPDR to the family, patient, and the resuscitation team. The Family Presence Self-Confidence (FPS-CS) instrument measured the self-confidence of nurses in resuscitation of a patient with the family present. A 5-point Likert scale was used on both instruments with choices varying from strongly agree (1) to strongly disagree (5). A pilot study was done resulting in modification of the original instruments.

Analysis by Twibell et al. (2008) of participant responses showed a mean total score of 3.15 on the FPR-BS and 3.65 on the FPS-CS, with a range of 1-5. High scores
indicated perceptions of more benefits and less risks. Lower scores indicated a perception of higher risks and less benefits of FPDR. There was wide variation in participant responses. Correlation between nurses' perception of risks and benefits of FPDR and their self-confidence in this situation was significant ($r = 0.56, p < .001$). This finding showed that nurses who saw the benefits as greater than the risks for FPDR were more self-confident about their management of family presence.

Twibell et al. (2008) reported a significant difference in scores of nurses based on membership in professional nursing organizations on both the FPR-BS ($t = 5.3, p < .001$) and FPS-CS ($t = 5.1, p < .001$) instruments. Nurses who were certified or members of a professional organization saw more benefits and fewer risks and felt more self-confidence than those who were not certified and were not members of a professional organization. No difference of perceptions was found related to education levels of RNs. LPNs reported less self-confidence and saw fewer benefits and more risks ($p = .04$). Years of experience and age were not related to perceptions. Emergency nurses perceived significantly more benefits and fewer risks as compared to both critical care nurses and non-critical care nurses ($p < .001$). There was no significant difference in the perceptions of the critical care nurses compared to non-critical care nurses. Results indicated that the more times a nurse invited the family to the bedside, the more benefits were perceived ($p < .001$).

Twibell et al. (2008) stated that the variability of scores reflected the ongoing controversy surrounding FPDR. The mean score on the FPR-BS was slightly positive (3.15) signifying that nurses do see both benefits and risks in the practice of FPDR. The nurses in the sample scored themselves as moderately high in self-confidence in being
able to care for the patient with the family present. Data gathered in this study indicated a disagreement about the “right” of the family to be present at the bedside during resuscitation. While families reported this as a right, nurses in the study were divided in their opinions.

Twibell et al. (2008) discussed methods that might be used to increase nursing acceptance of FPDR. Education, role playing, simulations, and mentoring were some of these methods. Further use and development of the scales used in this study could contribute to increased knowledge about nurses’ perceptions of FPDR. The scales could be used before and after interventions to promote FPDR to test the outcomes of the interventions.

Citing the literature documenting changes in the increasing practice of allowing family presence during resuscitation, Miller and Stiles (2009) sought to explore the experiences of nurses who had participated in this practice. They addressed family presence during resuscitation (FPDR) and during invasive procedures (IP) and how family presence affected the nurse, an attempt to gain the meaning of the experiences of these nurses. The authors used phenomenology as the methodology. According to Patton (2002), this approach is used to focus on learning how humans make sense of an experience, transform experience into consciousness, and give meaning to experience.

A sample of 17 nurses participated in this study. All of these nurses had participated in family presence at resuscitation or during invasive procedures and were recruited from personal and professional networks. Purposive sampling was accomplished through fliers posted at professional organization meetings and educational offerings. Participants represented both urban and suburban hospitals and both adult and pediatric
caregivers. The first 13 volunteers were female, and these participants were requested to recruit male participants in order to provide diversity. The age range of participants was 38 to 57 years. Fifteen of the participants worked in emergency departments, critical care areas, or on transport services. The respondents listed how many times they had participated in family presence during resuscitation and invasive procedures. The range was 4 to more than 100 times (Miller & Stiles, 2009).

Each participant was interviewed using a semi-structured format. First, each participant was asked to relate an experience in family presence during resuscitation or an IP. They then were asked to share feelings and thoughts about the experience. Transcripts from the interviews were read a minimum of six times following a consistent method of analysis to isolate thematic statements. Themes were categorized with supportive examples. As a result, Miller and Stiles (2009) identified four themes. Nine major and nine minor clusters emerged.

The first theme to emerge was permitting the family to be present during resuscitation and IPs allowed the nurse to forge a connection with the family. Within this theme the major clusters were “connecting with the family”, “promoting the needs of the family”, and “promoting the needs of the patient” (Miller & Stiles, 2009, p. 1434). Under these major clusters, the minor clusters were making a difference, feeling appreciated, seeing and knowing, realistic understanding, promoting closure, receiving important information from the family, providing the opportunity for the family to comfort the patient, and allowing the family to stop excessive resuscitation.

Miller and Stiles (2009) found engaging with the family as the second theme. The major cluster associated with this was active participation by the family.
The third theme was transition to acceptance, with the major clusters including “overcoming stereotypes”, “adapting to change”, and “committing to change” (Miller & Stiles, 2009, p. 1434). The final theme was a cautious approach with clusters covering ambivalence and nonacceptance.

Supportive statements made by the participants addressed forming a deep relationship with the family, making positive contributions in the face of a bad experience for the family, and appreciation from the family. The nurses stated that the families saw what actually occurred giving them a realistic view of resuscitation. The nurses also stated how the situation could be negative and in the situation of a non-accidental trauma law enforcement would not allow family presence until it was determined what had actually happened to the patient. One nurse voiced a strong opinion against family presence citing fear of litigation and distraction (Miller & Stiles, 2009).

Miller and Stiles (2009) issued a summary description of the phenomenon that expressed that the participation in FPDR and IP could be a positive experience for the nurse by forging a connection with the family. This experience could promote acceptance of the practice resulting in a commitment to change. This experience would allow families input on decision making during resuscitation and invasive procedures. Forging a connection was seen by the participants as beneficial to the family, the patient, and the nurses. The nurses voiced that it was important for the family to see how hard the resuscitation team worked to save the patient. They stated family participation in making the decision to stop further efforts was integral to care of the patient.

Some of the nurses expressed ambivalence about having the family present, while others stated it was not in the best interest of the patient or family. These opinions reflect
results of earlier studies (Helmer et al., 2000; McClenathan et al., 2003). Miller and Stiles (2009) stated that the decision to allow family presence at the bedside was usually made by the nurse. As a result of their findings, they recommended that nurses be encouraged to engage in the practice of FPDR and IP. They also voiced that nurses can be advocates in changing practice to allow FPDR.

Cultural backgrounds influenced nurses’ perceptions regarding family presence during resuscitation (FPDR). Despite European guidelines supporting FPDR, not all countries in Europe embraced the practice. Nurses practicing in Ireland and the United Kingdom were found to be more supportive of FPDR than nurses on the European mainland (Moons & Norekval, 2008). Studies of nurses’ attitudes and practices on FPDR have been conducted in many countries. McClement et al. (2009) conducted a study in an effort to explore these attitudes in Canada. The practice of excluding families from the resuscitation room appeared to be changing. Families were demanding the right to be present. At the same time, nurses were placing increased emphasis on family-centered care (Davidson, Powers, Hedayat, Tieszen, Kon, Shepard, et al., 2007).

McClement et al. (2009) used a descriptive, qualitative design. An online survey was sent to a convenience sample that consisted of 944 members of the Canadian Association of Critical Care Nurses (CACCN). Eighty-eight per cent of the nurses that received the survey responded (n = 450). Respondents represented the majority of the Canadian provinces and territories. Most of the respondents were female between the ages of 40 and 49 years old, worked full-time in a hospital, and had at least 15 years of critical care experience. Other than being a member of CACCN, no other inclusion criteria were given.
The qualitative survey was constructed to determine the attitudes and practices of these nurses related to FPDR. The survey was modified with permission from the study done by MacLean et al. (2003). Eighteen questions collected information on demographics, attitudes and practices regarding FPDR, and knowledge of organizational and professional polices on FPDR. There was also an area that allowed the respondents to describe their experiences with FPDR (McClement et al., 2009).

Fifty per cent of the respondents were aware that the CACCN had a position paper supporting FPDR. Eight per cent stated their hospital had a written policy on the issue. Sixty-six per cent (n = 252) of the respondents included written descriptions of their experiences with FPDR. Comments made by these nurses resulted both from their own experiences and experiences of friends. Very few nurses cited literature as influencing their attitude and practice. Comments were independently analyzed by two of the authors using content analysis and constant comparative techniques. The researchers then met and discussed the findings to reach consensus. The data showed a major theme of “risk-benefit calculations” by the respondents. These calculations influenced their decisions on having the family members present in the resuscitation area (McClement et al., 2009).

These nurses perceived that the family benefited from witnessing the efforts made to resuscitate their loved one. They also believed that the ability to touch, support and talk to the dying patient resulted in emotional benefits for the family. Allowing the families the opportunity to say goodbye was seen as a major benefit of the practice. Risks of having the family present included psychological trauma of viewing the measures and invasive procedures. Having a support person with the family was seen as decreasing
this trauma. Another risk expressed was a fear of physical harm to family members during defibrillation attempts (McClement et al., 2009).

Benefits to the health care team included viewing the patient as a person, someone that “belongs to somebody”. Respondents also expressed that family presence often led to acceptance and understanding of the decision to stop resuscitation efforts. A lack of confidence in clinical skills led some nurses to be resistant to FPDR. Resuscitation itself was stressful. Having the family present increased this stress for some nurses especially those lacking experience (McClement et al., 2009).

Another risk seen by the respondents was the increased risk of legal liability resulting from the family watching everything the team did. The nurses stated that in resuscitation attempts many interventions were often tried unsuccessfully, which would affect the family's confidence in the health care team. Members of resuscitation teams used coping mechanisms including humor to handle the stress of the situation. Having family members present would keep the team from resorting to these measures. An additional concern expressed was fear of distraction or disruption of resuscitation efforts by the family (McClement et al., 2009).

McClement et al. (2009) acknowledged the complexity of the decision to include the family at the bedside during resuscitation. They stated that both the cultural background of the family and the health care team influenced the impact of having the family present. The authors expressed the importance of continuing research in diverse populations. The opinions of those that have had first-hand experience in FPDR were needed. Follow-up or longitudinal studies of the long term effects on the families were also warranted. The authors also stated that future studies of the members of the health care team that served
as family support is needed. Understanding of the perspective of these facilitators would assist in describing behaviors that best support the families in these circumstances.

**Summary of Findings**

While the practice of FPDR has received support from many professional organizations and families strongly argue for the option to be present, controversy and reluctance remain among health care professionals. This study intended to clarify selected FPDR-related perceptions of nurses. In providing a background for this study, this chapter has reviewed twelve studies on family presence during resuscitation from the perspectives of both the families and health care professionals.

The studies that focused on family perceptions all supported FPDR. Themes that emerged were the families' belief that it was their right to have the option to be present at the bedside of a dying family member and that their presence supported the person receiving resuscitative measures. Families felt that seeing the attempted resuscitation and even death hastened closure to the grieving process. The information the families received and gave during that time was seen to be an important part of the experience. Studies of families did not indicate traumatic stress as a result of witnessing resuscitation efforts (Doyle et al., 1987; McGahey-Oakland et al., 2007; Maxton, 2008; Weslien et al., 2005).

The majority, but not all, of the studies based on the opinions and beliefs of health care professionals showed some support for FPDR. The studies were published between 2002 and 2009, more than twenty years since Foote Hospital began allowing family presence during resuscitation (Doyle, 1987; McGahey-Oakland et al., 2007). Tools used to gather data on FPDR opinions ranged from short, unvalidated questionnaires
(McClenathan et al., 2002) to surveys that had been tested for reliability and validity
(Ellison, 2003; Madden & Condon, 2007; Twibell et al., 2008). More testing is needed
of the instruments in the study of Twibell et al., and replication of the study is needed to
clarify the relationships among perceptions of risk, benefit and self-confidence. Reliable
and valid instruments can serve as pre and post tests in intervention studies, which are the
next step in knowledge development about FPDR.

Risk, benefit, and self-confidence were seen as underlying concepts in the literature
regarding health care professionals' perspectives (McClement, 2009; Twibell et al.,
2008). Health care professionals saw possible psychological trauma to the families as a
risk. There was also a fear of increased stress for staff, increased litigation, and possible
interference by the family with resuscitation efforts. Perceived benefits included forging
a connection with the family, supporting the family, and providing the opportunity for
closure for the family. Not many intervention studies have been conducted on the issue
of FPDR. Mian et al. (2007) evaluated health care professionals' opinions of FPDR
before and after implementation of a program to provide education on the issue in the
emergency department. Mian et al. found that, following implementation of the program
there were positive changes in staff attitude regarding FPDR.

Various demographic data of health care professionals were evaluated through
studies and correlated with opinions of FPDR. Demographics that influenced results
included membership in a professional nursing organization, clinical specialty
certification, RN versus LPN role, and area of clinical specialty (Twibell et al, 2008).
Specifically, Ellison (2003) found that certified nurses demonstrated a more positive
attitude toward FPDR than non-certified nurses. Emergency Department nurses had a
more positive attitude regarding FPDR than nurses in other specialty areas. Overall, nurses were more supportive of FPDR than physicians (McClenathan et al., 2002).

Many health care institutions did not have a policy regarding FPDR (Demir, 2008). Most health care professionals preferred a policy supporting FPDR (Madden & Condon, 2007). Professional organizations such as the Emergency Nurses Association and the American Association of Critical Care Nurses recommended that health care institutions have a policy supporting FPDR (McClement et al., 2009).

While most of the studies were based in the United States, other countries represented by studies included Canada (McClement et al., 2009), Sweden (Weslien et al., 2005), and Turkey (Demir, 2008). Cultural influence was most clearly seen as an influential factor related to FPDR in the study done in Turkey. There was little support of FPDR by health care professionals in this study. The loud and physical expressions of grief in the Turkish culture were seen as rendering FPDR inappropriate.

One factor that complicated the clarity of the literature review was that some studies explored family presence during invasive procedures as well as family presence during resuscitation (Ellison 2003; Miller & Stiles, 2009). Perceptions seemed to vary regarding family presence during resuscitation and during IP, so findings related to these two focal events cannot be combined.

Further research in this area would be beneficial to find a proper program to use for institution of FPDR. An education program for staff members would help them to know how to deal with their own perceptions and how to deal with family members feelings (Mian et al., 2007). Administrative support and written policies/guidelines also have a positive impact (McGahey-Oakland et al., 2007; Miller & Stiles, 2009). Further study on
the perceived risks and benefits and the effects on nurses would be helpful in determining
the support needed. As FPDR policies become more widely developed, research on
which ones provide the best guidelines for use and how to best implement these would be
extremely beneficial. Use of consistent reliable and valid instruments across studies
would allow for comparisons in larger populations thus guiding future interventions and
programs to promote the support of FPDR in health care professionals.
Chapter III
Methodology and Procedures

Introduction

Cardiopulmonary resuscitation, by its very nature, is stress-producing for medical personnel. Knowledge, skills, and the ability for health care professionals to function under pressure are tested in this situation. Perceptions of nurses related to family presence during resuscitation (FPDR) vary widely, from positive to negative. FPDR is supported by several nursing organizations including the Emergency Nursing Association and the American Association of Critical Care Nurses. Understanding and correlating the nurses' perceptions with other factors may assist in designing education to allow nurses to be accepting and supportive of FPDR.

This study is a replication in part of a research study by Twibell et al. (2008). Twibell et al. found gaps in earlier research on nurses' perceptions of FPDR. The purpose of this study was to explore nurses' perceptions of FPDR and the relationships of these perceptions to selected demographic variables. The study aimed to use two instruments, for which there was early evidence of reliability and validity (Twibell et al.).
Research Question

The research question that guided this study was “What are the relationships between a nurses' perceptions related to FPDR and personal demographic variables?”

Population, Sample, and Setting

Nurses from two hospitals in Southern Indiana participated in this study. The population consisted of approximately 300 registered nurses (RNs) and licensed practical nurses (LPNs) employed full or part-time as staff nurses at these hospitals in the emergency department, critical care units and the medical-surgical units. In addition, the participating nurses were at least 18 years of age. Each of these hospitals had a policy in support of FPDR. The emergency department and critical care unit of one of the hospitals routinely used FPDR while the remainder of the units did not.

The convenience sample consisted of approximately 150 nurses. A power analysis was done to determine minimal acceptable sample size. In addition to the criteria above, all participants could read English and were over 18 years of age.

Protection of Human Subjects

Documents used for the study were submitted to each hospital's Institutional Review Board (IRB) for approval prior to initiation of the study. Following approval by the IRB, information was given to the Chief Nursing Officers of each hospital and to the directors/managers of each participating unit. Packets of information about the study were made available on all nursing units for nurses who were interested to take. Notices about the study and the information packets were posted on each unit and circulated through email and other system-wide announcements.

The packet included the survey, as well as an invitation and cover letter that stated
the purpose of the study, participant rights, and the expected return date. Return of the
surveys was considered consent to participate, as indicated in a cover letter.

Participation was voluntary, and the participants were informed that they could
withdraw from the study at any time. All data were confidential and seen only by the
researcher and data entry personnel. Nurses were instructed to not write their names on
the survey. The only possible risk to participants was the risk of being identified by the
demographics reported. The demographic variables included gender, ethnicity, level of
education as an RN or LPN, current professional certifications, type of patients on their
unit, type of unit, and number of years experience as a nurse. In the pool from which the
sample was drawn, there were nurses of a wide range of ages. Ethnicity was also
diverse. However, there were few male nurses. The participants were informed that they
could skip any demographic question if they did not wish to disclose demographic
information. The instrumentation was not coded in any way. There was no punishment
for not participating in the study.

There were no benefits to the participants other than to contribute to professional
knowledge for the discipline. The importance of the study was cited in the cover letter
and included gaining knowledge about nurses' perceptions of FPDR. No one can provide
these perceptual data except staff nurses. The risk:benefit ratio was considered
acceptable.

Participants placed the completed instrument in a sealed envelope and placed it in a
data collection box located centrally within the nursing units. Completed surveys were
kept secured by the primary researcher in a locked file. Data were destroyed at the
study's completion.
Procedures

The researcher made information packets available on each nursing unit containing a copy of the instruments along with a cover letter explaining what each participant was to do in completing and returning the surveys. An envelope in which to place and seal the completed surveys was included in the packet. The surveys were returned to a designated, sealed drop box that was centrally located and were collected every 48 hours by a member of the research team. There was no direct interaction between the researcher and the participants regarding the study. Use of previously tested instruments ensured potentially acceptable reliability and validity of the data. In this study there was no manipulation of variables by the researcher. In order to examine the relationship among the multiple variables in the study and provide insight into FPDR, the design chosen for the study was descriptive and correlational.

Instruments and Methods of Measurement

Based on Twibell et al.'s (2008) study, two instruments were used to measure nurses' perceived risks and benefits, nurses' self-confidence as it related to family presence during resuscitation, and selected demographics. The Family Presence Risk-Benefit Scale (FPR-BS) developed by Twibell et al. was used to measure nurses' perceptions of risks and benefits of FPDR. This instrument consisted of 26 items using a 5-point Likert scale with 1 equaling strongly disagree and 5 equaling strongly agree. The second instrument was the 17-question Family Presence Self-Confidence Scale (FPS-CS). This instrument measured the nurses' self-confidence in participating in resuscitation of a patient with the family present. This instrument used the same Likert scale as FPR-BS. Both the FPR-BS and FPS-CS instruments were designed and tested by a team of clinical
experts in FPDR, academicians, and statistical experts. A pilot study was conducted using 20 nurses resulting in modifications of both instruments prior to use in the Twibell et al. study. Reliability and validity were supported in a test of the two tools in a sample (n = 375) of nurses from a variety of clinical settings in a hospital in the Midwest. Thus, it was anticipated that the tools would be valid and reliable in the present study.

An additional tool measuring demographic variables was used. These variables included age, gender, ethnicity, level of education as an RN or LPN, current professional certifications, type of patients on their unit, type of unit, and number of years experience as a nurse. An additional item asked the number of times the participant had invited a family to be present during a resuscitation attempt. Response for this last question was never, fewer than five times, or 5 times or more.

**Data Analysis**

Data were entered into an SPSS program. Negatively worded items were reverse scored. Analysis of the construct validity of the FPR-BS and FPS-CS instruments was accomplished by using a factor analysis with varimax rotation to determine the factor structure of the two scales. The factor structure was compared to that of the sample in Twibell et al.’s (2008) study. Once the underlying structure of the scales was confirmed, Cronbach's alpha coefficient value was used to assess reliability of items consistently measuring the same underlying ideas, or internal consistency. Descriptive analysis was used to describe demographic variables. Pearson r correlations were used to assess relationships between scores on perceptual scales and the demographic variables measured at interval level. For data not measured at the interval level, other correlations were selected and t-tests or analyses of variance were computed to check for
relationships and differences among groups. For example, a chi square of association was computed to examine the association of nurses' professional certification with scores on the study instrumentation. Significance was set at $p < .05$ (Burns & Grove, 2009).

**Summary**

As a replication of the study conducted by Twibell et al. (2008) this study aimed to explore nurses' perceptions of FPDR and the relationships of these perceptions to selected demographic variables. The study used two instruments, for which there was early evidence of reliability and validity (Twibell et al.). Data collection occurred through a written questionnaire completed by 150 nurses. Data analysis included psychometric testing of the instruments, followed by correlations of study variables to address the research question. Some differences among groups were assessed. Results of the study will enhance the use of evidence-based practice in identifying and measuring these variables in future studies. Results may indicate learning strategies to promote nurses' self-confidence in participating in FPDR.
References


Brown, J. R. (1989). Letting the family in during a code: legally, it makes good sense.

*Nursing 1989, 19(46), .


Eggenberger, S.K. & Nelms, T.P. Being family: the family experience when an adult member is hospitalized with a critical illness. *Journal of Clinical Nursing, 16*, 1618-


Hallgrimsdotter, E., (2000). Accident and emergency nurses' perceptions and experiences


McGahey, P. R. (2002). Family presence during resuscitation: a focus on staff. *Critical Care Nurse, 22*(6), 20-34.


<table>
<thead>
<tr>
<th>Article 1 Source</th>
<th>Problem</th>
<th>Purpose Research Questions</th>
<th>Framework or Concept</th>
<th>Sample</th>
<th>Design</th>
<th>Instrument</th>
<th>Results</th>
<th>Implications</th>
</tr>
</thead>
<tbody>
<tr>
<td>Demir (2008)</td>
<td>Family presence during resuscitation (FPDR) evokes differing opinions from health care professional despite guidelines supporting this practice. Research has not yet clarified the perspectives of health care professionals regarding FPD</td>
<td>To determine opinions of nurses and physicians working in an emergency department and intensive care unit regarding FPDR.</td>
<td>FPDR, CPR, opinions of nurses, and physicians</td>
<td>Convenience sample of 82 nurses &amp; 62 physicians working in a Turkish university-affiliated hospital's emergency department, cardiology and anesthesia intensive care units. Response rate was 79</td>
<td>Descriptive</td>
<td>Survey/questionnaire developed by the researcher with 4 open-ended and 17 multiple choice questions. Survey was based on literature. No reliability/validity testing reported.</td>
<td>Eighty-three percent were not in favor of FPDR. Reasons given were fear of family interference, trauma for the family, and increased stress for the team. Forty-seven percent said team should make decision of FPDR. Per chi-square test, there was no statistical difference of opinion of FPDR based on profession, education, or work experience.</td>
<td>Possible cultural differences from other studies need further investigation. In Turkey expressions of grief may be very vocally violent. No policy is present to guide staff on FPDR, which can produce misunderstanding and differences in practice.</td>
</tr>
<tr>
<td>Article 2 Source</td>
<td>Problem</td>
<td>Purpose Research Questions</td>
<td>Framework or Concept</td>
<td>Sample</td>
<td>Design</td>
<td>Instrument</td>
<td>Results</td>
<td>Implications</td>
</tr>
<tr>
<td>-----------------</td>
<td>---------</td>
<td>---------------------------</td>
<td>----------------------</td>
<td>--------</td>
<td>--------</td>
<td>------------</td>
<td>---------</td>
<td>--------------</td>
</tr>
<tr>
<td>Doyle, Post, Burney, Maina, Keefe, &amp; Rhee (1987)</td>
<td>It is standard practice in emergency departments to exclude families from the resuscitation room of victims of cardiac arrest. Some family members have asked to be present. Foote hospital began allowing this practice on a limited basis. There had been little follow-up with the families.</td>
<td>To determine how families that had been present during resuscitation felt about the experience and whether this was helping meet the emotional needs of the families of persons dying unexpectedly</td>
<td>FPDR, family perceptions</td>
<td>Seventy family members who had been present during resuscitation in the first 6 months of 1985 at Foote Hospital were asked to participate. Two declined. Only family members who had had contact with a hospital chaplain were included. Families were excluded if less than 4 months had elapsed since the event. Twenty-one nurses, physicians, and ward clerks were used in a separate sample.</td>
<td>Survey</td>
<td>Family survey questions were not listed but addressed areas of whether family was asked if wanted to be present, if family was adequately informed about what they would see, did staff communicate adequately with family, was support given by a chaplain or a nurse, did they touch or talk to the patient. Staff survey covered areas of feeling hampered by family presence, anxiety about performance, and concerns for emotional/ or disruptive family</td>
<td>Fifty-five per cent of families stated they were asked if wanted to be present, remainder did not remember. Seventy-two percent felt they were adequately informed of what they would see in the room. Eighty-three percent stated they were supported by a nurse of chaplain. Most remembered touching and/or talking to the patient. Staff survey: 30% felt hampered by family presence due to anxiety and concern for trauma to the</td>
<td>Doyle et al. Felt that FPDR program was beneficial to families and such programs need wider application and study.</td>
</tr>
</tbody>
</table>
behavior. No reliability or validity was reported. family. Seventy-one percent endorsed the practice of FPDR.
<table>
<thead>
<tr>
<th>Article 3 Source</th>
<th>Problem</th>
<th>Purpose Research Questions</th>
<th>Framework or Concept</th>
<th>Sample</th>
<th>Design</th>
<th>Instrument</th>
<th>Results</th>
<th>Implications</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ellison (2003)</td>
<td>Although FPDR has been found to be an important clinical issue, many health-care workers continue to deny family access. Research has not shown what variables influence health care staff attitudes and beliefs about family presence during resuscitation (FPDR) or invasive procedures.</td>
<td>FPDR was newer concept but not accepted by many staff. To identify the relationship between demographic variables and nurses attitudes and beliefs regarding FPDR or invasive procedures.</td>
<td>FPDR, attitudes, beliefs, invasive procedures, CPR, and staff demographic variables of educational preparation, specialty certification, experience, completion of family presence educational offering, age, sex, and ethnicity.</td>
<td>Target population: New Jersey ENA members and hospital nurses from an acute care teaching hospital. Random sample selected from all the nursing units and ENA members. 250 surveys distributed to each group. 208 surveys were completed by both RNs &amp; LPNs Sample was 99% RNs (N=193) and 1% LPNs (n=15) with response rate of 42%.</td>
<td>Descriptive/correlational</td>
<td>Family Presence Support Staff Assessment tool was used to identify attitudes with a total of 13 questions and collection of demographic data. Reliability analysis was conducted with a Cronbach α reliability coefficient of 0.470 for the first 6 questions and 0.675 for the next 8.</td>
<td>Educational preparation and attitude toward accepting FPDR and family presence during invasive procedures were significantly related (p&lt;.01). Positive correlation between specialty certification &amp; attitudes accepting of family presence (p&lt;.01). Certified emergency nurses had more positive attitudes toward FPDR. Specially area also correlated with positive attitudes (p&lt;.01). RNs had less favorable attitudes than LPNs (p&lt;.01). The specialty areas were Use of education could raise staff awareness of FPDR. Acceptance of FPDR would be aided by multidisciplinary committee and organization commitment. FPDR affects family of treatment by staff.</td>
<td></td>
</tr>
</tbody>
</table>
statistically significant predictors of attitudes (p< .001). Respondents identified (58%) that FPDR interfered with job performance. Respondents (39%) perceived FPDR as an opportunity to promote open communication between staff & family. Cultural differences identified as potential barriers to family presence. Traditional professional mindset views FPDR as a foreign concept, but it will continue to be an issue in health care. Education that raises the consciousness of the staff and addresses staff concerns is a necessity.
<table>
<thead>
<tr>
<th>Article 4 Source</th>
<th>Problem</th>
<th>Purpose Research Questions</th>
<th>Framework or Concept</th>
<th>Sample</th>
<th>Design</th>
<th>Instrument</th>
<th>Results</th>
<th>Implications</th>
</tr>
</thead>
<tbody>
<tr>
<td>McClement, Fallis, &amp; Pereira (2009)</td>
<td>Nurses' attitudes and perceptions of FPDR are influenced by culture. Practices of excluding families during resuscitation are changing but are not embraced by all countries despite support by many professional organizations.</td>
<td>To explore the practices and preferences of critical care nurses in Canada regarding FPDR for adult patients.</td>
<td>FPDR, nurses' practices and beliefs</td>
<td>Convenience sample of 944 nurses who were members of Canadian Association of Critical Care Nurses with 48% response. Membership in CACCN was the only inclusion criteria.</td>
<td>Descriptive, qualitative methods</td>
<td>Online survey with 18 questions on demographics, attitudes, practices, knowledge of organization and professional policies regarding FPDR. There was also an area for respondents to describe their experiences with FPDR. The survey was adapted from one used by MacLean (2003). No reliability or validity were reported.</td>
<td>Half of respondents were aware of professional position statement supporting FPDR, and 8% knew of hospital policy re FPDR. Sixty-six percent wrote comments regarding perceptions of risk/benefits of FPDR.</td>
<td>Continued research in diverse cultures is important using those that have had first-hand experience in FPDR.</td>
</tr>
<tr>
<td>Article 5 Source</td>
<td>Problem</td>
<td>Purpose Research Questions</td>
<td>Framework or Concept</td>
<td>Sample</td>
<td>Design</td>
<td>Instrument</td>
<td>Results</td>
<td>Implications</td>
</tr>
<tr>
<td>-----------------</td>
<td>---------</td>
<td>-----------------------------</td>
<td>----------------------</td>
<td>--------</td>
<td>--------</td>
<td>------------</td>
<td>---------</td>
<td>--------------</td>
</tr>
<tr>
<td>McClenathan, Torrington, &amp; Uyehara (2002)</td>
<td>Advocates state that FPDR helps families deal with grief and promotes professional behavior by staff. The practice remains controversial and is opposed by many health-care professionals.</td>
<td>To assess if critical care professionals support international emergency cardiovascular and cardiopulmonary resuscitation guidelines that recommend FPDR.</td>
<td>FPDR, critical care professionals' opinions, practice guidelines</td>
<td>A random sample of health-care professionals attending an international professional conference in California. Respondents included 494 physicians, 28 nurses, and 21 allied health care professionals.</td>
<td>Descriptive, Survey</td>
<td>Survey consisted of six questions covering CPR experience, opinions on family member presence, and demographic data. No reliability or validity were reported.</td>
<td>No specific differences of opinion found based on age, specialty, experience, size or type of hospital practice. Seventy-eight per cent disapproved of FPDR in adults and 85% disapproved of FPDR in pediatrics. Eighty percent of physicians and 61% of nurses/allied health care disapproved of FPDR. Geographical region did influence opinion with highest approval rate in the Midwest. Fear of</td>
<td>Authors believed that negative attitude toward FPDR could not be dismissed. Rigorous study of FPDR was encouraged prior to widespread implementation.</td>
</tr>
</tbody>
</table>
psychological trauma to the family was the most common reason given for opposition to FPDR
<table>
<thead>
<tr>
<th>Article 6 Source</th>
<th>Problem</th>
<th>Purpose Research Questions</th>
<th>Framework or Concept</th>
<th>Sample</th>
<th>Design</th>
<th>Instrument</th>
<th>Results</th>
<th>Implications</th>
</tr>
</thead>
<tbody>
<tr>
<td>McGahey-Oakland, Lieder, Young, &amp; Jefferson (2007)</td>
<td>FPDR is a controversial issue. It is supported by professional organizations and continues to grow despite inconsistent acceptance.</td>
<td>To describe experiences of family members whose children had CPR in a children's hospital ED, to identify critical information about family experiences, to assess mental and health status of these families.</td>
<td>FPDR, Family experiences, resuscitation of children</td>
<td>Purposive sample of family members of children who had undergone CPR identified from medical record review in a Texas children's hospital ED. Included 7 mothers, 2 fathers, and 1 great-grandmother. Six participants were Hispanic, 2 were White, and 2 were Black</td>
<td>Descriptive, retrospective</td>
<td>Parkland Family Presence During Resuscitation/Invasive Procedures Unabridged Family Survey, that had been previously validated, included both quantitative and qualitative components. The Brief Symptoms Inventory measured 3 psychological dimensions. Semi-structured interviews were conducted.</td>
<td>All families felt it was important to be given the option to be present during resuscitation. Traumatic stress was not indicated by results. Interviews resulted in 5 themes: the right to be present, connection and comfort make a difference, seeing is believing, getting in, and information giving.</td>
<td>To ensure a consistent approach to FPDR, a written policy is essential. Continued research is needed to gain insight into family experiences and staff beliefs.</td>
</tr>
<tr>
<td>Article 7 Source</td>
<td>Problem</td>
<td>Purpose Research Questions</td>
<td>Framework or Concept</td>
<td>Sample</td>
<td>Design</td>
<td>Instrument</td>
<td>Results</td>
<td>Implications</td>
</tr>
<tr>
<td>------------------</td>
<td>---------</td>
<td>-----------------------------</td>
<td>----------------------</td>
<td>--------</td>
<td>--------</td>
<td>------------</td>
<td>---------</td>
<td>--------------</td>
</tr>
<tr>
<td>Madden &amp; Condon (2007)</td>
<td>Family members sometimes request to be present during resuscitation of a loved one. This practice has been met with resistance from some nursing staff. Review of these nurses’ practice and reasons for resistance may lead to necessary interventions to allay this resistance.</td>
<td>This study was done to examine emergency room (ED) nurses’ practice and understanding of family presence during resuscitation (FPDR).</td>
<td>Family presence, CPR, Nurses’ practice, Nurses’ understanding</td>
<td>A convenience sample of 90 emergency room nurses with more than 6 months experience in the ED of university-affiliated hospital in Ireland</td>
<td>Descriptive</td>
<td>Survey questionnaire developed by Emergency Nurses’ Association; consisted of 15 close ended questions. Content validity previously established by ENA panel of experts.</td>
<td>Preferences and Practices - 74% would prefer a written policy on FPDR. Almost half (58.9%) had taken families to the bedside during CPR. Main facilitator identified was to increase understanding of benefits of FPDR-need for education.</td>
<td>Shows need for ongoing education and policy development on FPDR.</td>
</tr>
<tr>
<td>Article 8 Source</td>
<td>Problem</td>
<td>Purpose Research Questions</td>
<td>Framework or Concept</td>
<td>Sample</td>
<td>Design</td>
<td>Instrument</td>
<td>Results</td>
<td>Implications</td>
</tr>
<tr>
<td>------------------</td>
<td>---------</td>
<td>----------------------------</td>
<td>----------------------</td>
<td>--------</td>
<td>--------</td>
<td>------------</td>
<td>---------</td>
<td>--------------</td>
</tr>
<tr>
<td>Maxton (2008)</td>
<td>Separating families from critically ill pediatric patients can have long term negative effects, yet parents are often prevented from being with their child during crisis situations. More information is needed about how parents respond to family presence during resuscitation (FPDR).</td>
<td>To explore the parents' experience in being present or absent during a resuscitation attempt on their child.</td>
<td>FPDR, family experience, parental perspectives</td>
<td>Purposive sampling from parents with children in an Australian metropolitan hospital pediatric intensive care unit that required CPR. Eight parent couples chosen.</td>
<td>Descriptive design with qualitative/phenomenological methods.</td>
<td>In-depth unstructured interviews with structured debriefing.</td>
<td>Four themes emerged: being only for a child, making sense of a living nightmare, maintaining hope in the face of reality, and living in a relationship with staff.</td>
<td>Confirms parents' compelling need to be with their child. Support is integral for parental coping.</td>
</tr>
<tr>
<td>Article 9 Source</td>
<td>Problem</td>
<td>Purpose Research Questions</td>
<td>Framework or Concept</td>
<td>Sample</td>
<td>Design</td>
<td>Instrument</td>
<td>Results</td>
<td>Implications</td>
</tr>
<tr>
<td>------------------</td>
<td>---------</td>
<td>----------------------------</td>
<td>----------------------</td>
<td>--------</td>
<td>--------</td>
<td>------------</td>
<td>---------</td>
<td>--------------</td>
</tr>
<tr>
<td>Mian, Warchel, Whitney, Firzmaurice, &amp; Tancredi (2007)</td>
<td>Past studies examined staff opinion re: family presence during resuscitation (FPDR) and invasive procedures. There is a need to study difference of opinion before and after FPDR program was instituted</td>
<td>To design and implement a FPDR program in an emergency department and evaluate attitudes/behaviors of nurses/physicians pre- &amp; post-implementation</td>
<td>FPDR, Staff opinions/change, Program implementation</td>
<td>Convenience sample: Pre-implementation: 86 nurses and 35 physicians from an emergency department in Massachusetts. Post-implementation: 89 nurses and 14 physicians. Similar demographics in both pre- and post-groups.</td>
<td>Quasi-experimental</td>
<td>Survey/questionnaire: 3 parts- Professional attitudes, values, behaviors-30 item Likert scale, personal and professional experience with FPDR-12 questions, 4 additional questions about practice and educational sessions post-implementation. Demo-graphics. Demographics. content validated by expert review and pilot study</td>
<td>Pre-implementation: Nurses (71%) showed more support for FPDR and physicians (51%). Post-implementation: Increased nursing support (80%), physicians (45%). Values, attitudes, behaviors put in 9 sub scales/3domains. Changes were analyzed by t test (benchmark p&lt;0.05). Significant group mean scores included personal values, staff beliefs, patients’ rights, families’ rights, residents’ education, families’ benefits, and staff</td>
<td>Success of implementation of FPDR requires administrative support and availability of support staff during FPDR. Providing nurses with skills and reinforcement important to implementing FPDR program</td>
</tr>
</tbody>
</table>
distress. Few physicians responded to post test and mean scores were heavily influenced by nurses' scores.
<table>
<thead>
<tr>
<th>Article 10 Source</th>
<th>Problem</th>
<th>Purpose Research Questions</th>
<th>Framework or Concept</th>
<th>Sample</th>
<th>Design</th>
<th>Instrument</th>
<th>Results</th>
<th>Implications</th>
</tr>
</thead>
<tbody>
<tr>
<td>Miller &amp; Stiles (2009)</td>
<td>In spite of studies showing benefits for families and staff when the family is present during critical procedures, health care workers continue to have mixed attitudes and opinions.</td>
<td>To explore nurses' experiences of family presence during resuscitation (FPDR)</td>
<td>FPDR, nurses’ experience</td>
<td>Seventeen nurses that had participated in FPDR were recruited from personal and professional networks including ENA and AACN via flyers. Sample was voluntary. The nurses ranged in age from 38 to 57 years of age, 15 were female, 2 males. All were White. Fifteen worked in the emergency department, critical care units, or on transport teams. Nursing experience ranged from 1.5 to &gt;37 years. Experience with FPDR ranged</td>
<td>Descriptive design with Phenomenologic al methods.</td>
<td>Interviews: face-to-face or by telephone.</td>
<td>Four themes identified: 1. forging a connection - FPDR seen as a positive experience by nurse. Nurses felt they promoted needs of the family and patient, were appreciated, seeing and knowing, realistic understanding, promoting closure, providing information to family, allowing family to comfort patient and stop excessive resuscitation efforts. 2. engaging with the family with active</td>
<td>Exploring the experience of FPDR may result in acceptance of the practice and commitment to change.</td>
</tr>
<tr>
<td>participation by the family.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>-----------------------------</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. transition to acceptance-</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>overcoming stereotypes,</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>adapting to change, and</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>committing to..</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. cautious approach -</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ambivalence and non-acceptance.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Article 11 Source</td>
<td>Problem</td>
<td>Purpose Research Questions</td>
<td>Framework or Concept</td>
<td>Sample</td>
<td>Design</td>
<td>Instrument</td>
<td>Results</td>
<td>Implications</td>
</tr>
<tr>
<td>------------------</td>
<td>---------</td>
<td>-----------------------------</td>
<td>----------------------</td>
<td>--------</td>
<td>--------</td>
<td>------------</td>
<td>---------</td>
<td>--------------</td>
</tr>
<tr>
<td>Twibell, Siela, Riwitis, Wheatley, Riegle, Bousman, et al. (2008)</td>
<td>Knowledge development about family presence during resuscitation (FPDR) is constrained by the lack of reliable and valid instruments to measure key variables. Lack of research that has examined risks, benefits, and self-confidence of nurses related to FPDR. Research has not yet clarified the effect of demographic variables on nurses' perceptions of FPDR.</td>
<td>To test instruments used to measure perceptions of family presence, explore demographic variables and perceptions of self-confidence, relating these to experience with FPDR. To test instruments used to measure perceptions of family presence, explore demographic variables and perceptions of self-confidence, relating these to experience with FPDR.</td>
<td>Convenience sample: RNs and LPNs (n=375) from multiple clinical settings in one hospital in the Midwestern USA. Predominantly female and Caucasian.</td>
<td>Descriptive/correlational</td>
<td>Family Presence Risk-Benefit Scale (FPR-BS) 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 (FPS-CS) used to measure nurses' self-confidence related to managing resuscitation with patients' families present. Scales were shown to be reliable, FPS-CS with .95 and FPS-BS with .96.</td>
<td>The relationships among nurses' perceptions of risk and benefits and self-confidence was significant (r=0.56, p&lt;.001). Perceptions were significantly related to perception of fewer risk and more benefits (r=0.72, p=.008). High scores on the FPS-CS (r=.40, p=.04). LPNs perceived fewer benefits and more risks (p&lt;.001) and LPNs reported less self-confidence than RNs (p=.04). Scores on FPR-BS differed significantly between nurses who did or did not belong to a</td>
<td>Methods to increase nurses' acceptance of FPDR include education, role-playing, simulations, and mentoring. Continued use of study scales may produce increased knowledge of nurses' perceptions of FPDR</td>
<td></td>
</tr>
</tbody>
</table>
professional nursing organization (p<.001) and those who were and were not certified in a clinical specialty (p<.001). Certified nurses and members of professional organization perceived greater self-confidence than non-certified nurses and nonmembers. The more times nurses invited family presence, the more benefits they perceived.
<table>
<thead>
<tr>
<th>Article 12 Source</th>
<th>Problem</th>
<th>Purpose Research Questions</th>
<th>Framework or Concept</th>
<th>Sample</th>
<th>Design</th>
<th>Instrument</th>
<th>Results</th>
<th>Implications</th>
</tr>
</thead>
<tbody>
<tr>
<td>Weslien, Nilstun, Lundqvist, &amp; Fridlund (2005)</td>
<td>Family presence during resuscitation (FPDR) raises the need to examine family reactions. There are no relevant studies on this issue. Earlier studies have not yet clarified the perspectives of family members regarding FPDR.</td>
<td>To provide insight into family members experiences witnessing cardiac arrest.</td>
<td>Families experiences with FPDR.</td>
<td>Convenience sample of 41 family members invited to participate and 19 accepted. Population from families of cardiac arrest patients from two hospitals in Sweden.</td>
<td>Descriptive.</td>
<td>Interviews involving demographic questions and narration of the experience by participants. Method validated by 2 pilot interviews.</td>
<td>Themes emerging from the data included: 1. True interaction 2. Overactive family members 3. Inactive family members 4. Reserved passivity. Nursing care needs to include comfort and compassion for families. Needs and reactions of families varied.</td>
<td>By focusing on family, actions of health care professionals can have impact on families’ ability to regain equilibrium.</td>
</tr>
</tbody>
</table>