NURSES’ PERCEPTIONS RELATED TO FAMILY PRESENCE DURING RESUSCITATION:
A MULTI-SITE STUDY

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ABSTRACT

RESEARCH SUBJECT: Nurses’ Perceptions Related to Family Presence during Resuscitation: A Multi-site Study

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Families frequently request to be present during the resuscitation of loved ones. Nurses are often the staff members who make decisions regarding family presence during resuscitation. Since research has not yet clarified the perceptions of nurses from diverse geographic areas regarding family presence during resuscitation, this study proposed to expand what was known about nurses’ perceptions of risks, benefits, and confidence regarding families being present during resuscitation efforts. This project was a replication of Twibell et al.’s (2008) study, which was conducted in one Midwestern hospital. This study took place in three hospitals in a large southern state. The framework was based on Rogers’ (1995) theory of diffusion of innovation. The convenience sample for this correlational study was 250 registered nurses. The instruments were the Family Presence Risk-Benefit Scale (Twibell et al.) and Family Presence Self-confidence Scale (Twibell et al.). Results provide an enhanced description of nurses’ perceptions that may influence decisions regarding family presence during resuscitation. The information may give nurse educators and administrators guidance in developing policies and procedures for family presence during resuscitation.
Chapter I

Introduction

Family presence during resuscitation (FPR) is a controversial issue in health care settings around the world. Most families in recent studies have indicated that they would like to be present or offered the choice to be present when it comes to their family member being resuscitated (Holzhauser, Finucane, & Vries, 2006; Hung & Pang, 2011). According to McClenathan, Torrington, and Uyehara (2002), families tend to cope better when they are allowed in the room during resuscitation. “Ninety-four percent of families [who experienced FPR] said that they would participate again, and 76% thought that being present facilitated their adjustment to the patient’s death” (Mian, Warchal, Whitney, Fitzmaurice, & Tancredi, 2007, p. 52). McMahon-Parkes, Moule, Benger, and Albarran’s (2008) study suggested that patients wanted their families present for comfort.

Despite family members’ clear preferences, members of the health care team are ambivalent about FPR, seeing both risks and benefits. National associations, such as the American Heart Association and Emergency Nurses Association, have recommended that families be present during resuscitation and invasive procedures (Blair, 2004). However, many hospitals have yet to adapt or create new policies and guidelines for staff members. According to Oman and Duran (2010), only 5% of the hospitals in the United States currently have a policy regarding FPR. The lack of policies developed in the hospital
setting suggests that FPR remains a contentious issue for health care providers. Without a policy, the decision-making regarding FPR is left to nurses and physicians to make on a case-by-case basis (Mason, 2003). In most cases, it is the nurse’s perception of both positive and negative internal and external factors that affects the outcome of whether families are included in the resuscitation.

Opinions on this sensitive matter fluctuate significantly from one nurse to the next (Mian et al., 2007). Nurses with more experience tended to favor FPR compared to less experienced nurses, while nurses tended to favor FPR in general, more than physicians.

Ideally, all parties involved will find an evidence-based solution to meet the needs of the patients and their families, while generating a safe and healthy working environment for staff. Research is lacking “that describes actual programs or effective strategies for changing practices” (Mian et al., 2007, p. 52). The development and implementation of FPR programs must consider the perspectives of nurses (Twibell et al., 2008). While over two dozen studies have examined nurses’ opinions, consensus has not yet emerged. As a partial replication study of the study by Twibell and colleagues, the purpose of this research project is to gather information from practicing nurses regarding their thoughts on the topic of FPR and on their self-confidence level regarding resuscitation while family is in the room. By obtaining this critical information, perhaps hospital administrators, educators, and nurse leaders can construct clear policy and guidelines that are reflective of the perspectives of their staff, their patients, and their families.
Background and Significance

Statistics indicate that “cardiopulmonary arrest is a major health problem that claims 350,000 to 450,000 lives per year in the United States” (Whitcomb & Blackman, 2007, p. 2). Cardiopulmonary resuscitation (CPR) is the most common form of practice used in an attempt to restoring life to a person in cardiopulmonary arrest. CPR was first initiated on drowning victims in France in 1740, in which a person would start mouth to mouth. It was not until 1891 that the first documented case of chest compression took place by Dr. Friedrich Maass (American Heart Association, 2011). Today, research continues on the best way to deliver CPR and life saving measures to people around the world. Nurses often times play key roles in resuscitation efforts, administering CPR and other lifesaving medications to their patients in attempts to reviving their lives.

As the history of CPR and resuscitation efforts has evolved, so have the thoughts and attitudes of the healthcare providers, specifically nurses, on the concept of family presence during resuscitation. “The first reported practice of family-witnessed resuscitation took place at the Foote Hospital in Michigan in the United States of America in 1982” (Demir, 2008, p. 410). In the 1980s, Foote Hospital initiated a first of its kind study to uncover more information regarding FPR (Mason, 2003). In 1992, following the completion of the nine year study, they released their findings, which suggested a positive occurrence regarding family being present in the emergency room during resuscitation efforts. Following this study, Parkland Hospital in Dallas, Texas completed a study regarding FPR (Meyers et al., 2000). The results indicated that all families who were present during resuscitation would choose to be present again and felt
it was their right. This study also indicated that nurses and physicians were supportive of FPR. However, additional research sometimes showed nurses’ and physicians’ non-support of FPR. The battle regarding FPR continues, with attempts to understand physicians’ and nurses’ points of view, families’ points of view, and patient’s points of view.

Many studies reflected that nurses see both advantages and disadvantages to FPR. According to Twibell et al. (2008), nurses reported two advantages to FPR: families have an opportunity to understand the gravity of the situation and patient condition, and families can begin coping and finding closure as they visualize the work being done to save their loved one. Other advantages nurses identified in past research were that families were more appreciative on the work put forth by the resuscitation team; they were able to see that staff were treating their loved one as a person, and the nurse was able to give holistic care to both patient and family (Oman & Duran, 2010).

Families reported advantages to being present are numerous and diverse. Some advantages indicated were being able to stay emotionally connected and giving the patient emotional support while fulfilling their duties and staying by the patient’s side (Hung & Pang, 2011). Families also have argued that their presence helped to keep them informed on their loved one’s condition. The families were able to provide the staff with information about the patient and visualized that their loved one received the best care.

Although there are several perceived advantages for families to be present, both families and nurses also have acknowledged several disadvantages. Nurses have reported many risks factors with FPR. Some of those risks include: psychological and emotional
trauma to families, families interrupting care to the patient, performance anxiety on the part of the staff, poor communication between the resuscitation team participants, and families misunderstanding about the proceedings of the code (Oman & Duran, 2010). Still yet, nurses have reported the legal aspects of having the family in the room (McClenathan et al., 2002). Although most families indicated a strong need to be present during resuscitation, it was not without some hesitation, according to a study by Hung and Pang (2010). Families often times want to be present but do not want to be in the way of the resuscitation team. Families also perceived that it may inappropriate for them to be present.

In addition to the advantages and disadvantages, there is more to be learned about the perceptions and self-confidence nurses have when dealing with FPR (Twibell et al., 2008). Most hospitals have left the decision for FPR to nurses and physicians, despite recommendations for policies and guidelines from professional associations. “Guidelines serve to define healthcare providers’ roles and responsibilities during resuscitation efforts” (Oman & Duran, 2010, p. 532). To help create these policies and serve patients and their families effectively, it is important to gather more information from nurses. By understanding nurses’ perceptions, beliefs, and self-confidence, nurses may be able to create hospital policies for guidance on this sensitive subject.

**Problem Statement**

As families are becoming more involved and educated on medical issues, there are more families who are interested in being present during resuscitation efforts. Nurses and physicians continue to see risks as well as benefits. In most situations where no
policy exists, nurses are the staff members who make decisions regarding family presence during resuscitation. Research has not yet clarified nurses’ perspectives on FPR, especially their confidence in managing FPR. More research is needed to discover nurses’ perceptions of risk, benefit, and self-confidence in regards to having families present during resuscitation efforts.

**Purpose of the Study**

The purpose of this study was to expand what is known about nurses’ perceptions of risks, benefits, and confidence regarding families being present during resuscitation efforts. This is a partial replication study of Twibell et al.’s (2008) study.

**Research Questions**

1. What are nurses’ perceptions of risks and benefits regarding family presence during resuscitation?

2. What are nurses’ perceptions of self-confidence related to managing family presence during resuscitation?

**Conceptual Framework**

The theory chosen as the conceptual framework for this study was Rogers’ (1995) theory of diffusion of innovations. This theory described how a new concept or idea could be distributed through a social system. There were five stages of diffusion in which an idea or concept was implemented into a person’s daily practice. Those five stages included knowledge, persuasion, decision, implementation, and confirmation. There were five characteristics of innovations, which included relative advantage, complexity, compatibility, trialability, and observability. Combining both the diffusion
aspect with the attributes on innovations and the concept of family presence during resuscitation allowed an exploration of how nursing could incorporate new ideas and concepts into practice. This framework was appropriate for this study as it acted as a guide to understanding how new concepts affect nurses and how they could perceive risks and benefits of new ideas.

**Definitions of Terms**

**Family presence.**

*Conceptual Definition.* Family presence can be described as the existence of family in the area or room where patient care is taking place, in which the family can see or touch the patient during resuscitation efforts (Capehart, Jackson, Cosper, & Bardakjy, 2009).

**Resuscitation.**

*Conceptual Definition.* The emergent action to restore life through chest massage, emergency medication administration, and airway management.

**Nurses’ perceptions of benefits and risks of FPR.**

*Conceptual Definition.* Nurses’ views and opinions on the advantages and disadvantages of FPR (Twibell et al., 2008).

*Operational Definition.* A total mean score and mean subscale scores on the Family Presence Risk-Benefit Scale (FPR-BS) (Twibell et al., 2008).

**Self-Confidence of nurses regarding FPR.**

*Conceptual Definition.* Nurses’ opinions and thoughts of their capability to manage or perform duties during FPR (Twibell et al., 2008).
Operational Definition. Total mean score on the Family Presence Self-confidence Scale (FPS-CS) (Twibell et al., 2008).

Limitations

By reviewing the information gathered, it is important to acknowledge limitations, in which adjustments may be made in future studies. The collection of data from a single geographic area may have limited the generalizability of findings to all populations of nurses. A second limitation was the early development of the instrumentation, which required further testing for reliability and validity.

Assumptions

Assumptions of this study included:

1. All nurses responded with integrity to the questionnaire.
2. Nurses who responded have knowledge, understanding, and experience regarding FPR.
3. The idea of a new concept such as FPR was initiated through the socialization of the concept and the members of that social structure.

Summary

FPR remains controversial as nurses and physicians strive to care for the patient and their families in the best ways possible while maintaining professionalism. Families and patients indicate that is important for them to be at the bedside. Professional organizations have presented hospitals and their staff will suggested policies to implement for guidance on this sensitive topic. However, hospitals and institutions struggle with initiating policies and guidelines of their own. Resuscitation team member
continue to struggle with the advantages and disadvantages to FPR as well as their own confidence within themselves. The purpose of this study was to expand knowledge about nurses’ perceptions of risks, benefits, and confidence regarding families being present during resuscitation efforts. The framework for this study was Rogers’ (1995) theory of diffusion of innovations with a focus on the concept of FPR. The framework provided a viewpoint on how new information was passed through a social network such as nursing in a hospital. It is important to uncover the beliefs, attitudes, and perceptions of nurses and their confidence levels to incorporate these attributes into policies and guidelines that help guide healthcare staff in making the correct decisions about FPR.
Chapter II

Literature Review

Nurses’ perceptions and decisions are the key determinants in whether families are present during resuscitation efforts on behalf of their loved one. The decision to allow family to be present or not is multifaceted and complex. This project was a replication of Twibell et al.’s (2008) study. The purpose of this study was to determine nurses’ attitudes regarding family presence during resuscitation efforts, and the benefits and risks of family presence during resuscitation. Understanding and knowing the opinions of nurses and other healthcare providers as well as attributes of family and patient wishes gives nurse educators and administrators clarity in developing policy and guidelines for handling this critical but sensitive issue.

Organization of Literature

A review of literature was completed on recent studies on the topic of FPR both in adults and children from the perspectives of nurses, other health care providers, families, and patients who survived resuscitation. Both quantitative and qualitative studies were reviewed. The literature review was divided into four sections.

1. Theoretical framework
2. Nurses’ perceptions of FPR
3. Nurses’ and families’ perceptions of FPR during pediatric resuscitation
4. Families’ and patients’ perceptions of FPR

Theoretical Framework

Rogers’ (1995) Theory of Diffusion of Innovations and the concept of family presence during resuscitation formed the framework for this study. Rogers’ theory was used in this study to describe how an idea or trend can be spread throughout a social organization, such as a health care facility. Nursing was described as a social profession, in which both good and bad changes in practice occurred routinely. Risks and benefits of an idea were evaluated, decisions to change were made, implementation of the change happened, and both positive and negative outcomes transpired. Rogers’ theory of diffusion of innovations had two key foci that related to this study: diffusion and innovation. Utilizing Rogers’ theory and the concept of family presence during resuscitation can define how nursing could change and adapt to new ideas and concepts.

Diffusion.

Rogers (1995) defined diffusion as “the process by which an innovation is communicated through certain channels over time among the members of a social system” (p. 5). Rogers determined that there were five stages in which an idea or concept changed the practices of that system.

1. Stage one - Knowledge: This stage was defined as a person becoming aware of an innovation or idea and having some thoughts on how it functioned.
2. Stage two - Persuasion: A person developed either a positive or negative view toward the idea or concept.
3. Stage three - Decision: A person participated in education that concluded with
either using the idea or concept or rejecting it.

4. Stage four - Implementation: A person utilized the idea in practice.

5. Stage five - Confirmation: A person looked at the outcomes and confirmed practice or rejected practices and made changes accordingly.

**Innovations.**

According to Rogers’ (1995) theory, there are five attributes to innovations: “(a) relative advantage, (b) compatibility, (c) complexity, (d) trialability, and (e) observability” (p. 208). Nurses need to be able to see how a concept, such as FPR, has more advantages and benefits than risks to be able to integrate the concept. Nurses need to identify the value of the concept and evaluate past experiences to adapt to a new idea.

“An innovation can be compatible or incompatible with sociocultural values and beliefs, with previously introduced ideas, or with clients needs for the innovation” (p. 224).

Rogers (1995) asserted that an idea or concept that was too difficult to grasp and utilize would have a harder time being implemented by nurses. An idea or concept such as FPR, may be trialed on a smaller scale, in an intensive care unit or emergency department to determine success of the idea. Lastly, nurses should be observed actively using the idea or concept in their daily practice for successful innovation. Rogers’ theory provided a framework for change on a sensitive topic for nurses, other healthcare providers, families, and patients on the concept of family presence during resuscitation.

Literature has shown that family presence during resuscitation remains a controversial topic among nurses and other healthcare providers. There continues to be a need to determine nurses’ attitudes about the risks and benefits to implementing policies
on FPR. By utilizing Rogers’ (1995) theory as a framework, research can determine factors that influence the diffusion of FPR as an innovative practice. This research study utilized Rogers’ theory as a framework to explore nurses’ thoughts regarding FPR, which in turn could provide knowledge useful in implementing FPR effectively.

Nurses’ Perceptions of FPR

As more research supports the practice of FPR, more hospitals are attempting to implement the guidelines for FPR by the Emergency Nurses Association (ENA) (2009). In Colorado, one university hospital has used these guidelines to develop policies for their nurses, physicians and resuscitation team. The purpose of this study was twofold: (a) to see how often families were actually present during resuscitation and (b) to determine what kind of experiences healthcare workers had when family members were present (Oman & Duran, 2010). The conceptual framework utilized for this study was a holistic approach to FPR based on patient-centered and family-centered care.

This descriptive and narrative study was completed in a 407-bed teaching hospital, complete with resuscitation team. Nurses, physicians, and respiratory therapists, who encompassed the resuscitation team, were emailed a survey within three weeks of a resuscitation event regarding FPR. Of the 134 possible participants who were sent emails, 65 responded with the majority being nurses (65%) (Oman & Duran, 2010). No demographic data were collected for this study.

Researchers for this study used a Likert scale to create an electronic survey that included open-ended questions as well as 7 questions that participants could report their answers from strongly disagree to strongly agree (Oman & Duran, 2010). Open-ended
questions were used for participants to fill in opinions regarding FPR. Reliability was measured by Cronbach alpha which was 0.81 for the Likert scale section of the survey and “members of the hospital resuscitation committee reviewed the survey for content validity” (p. 525).

During the time of the study, there were 106 resuscitation events at this hospital; families were present in 31 cases, while 24 cases did not have complete data (Oman & Duran, 2010). Most patients survived the resuscitation (71%), while 29% of the patients did not. Most participants declared that families were relatively emotionally stable during resuscitations efforts and they did not attempt to interfere with resuscitation teams efforts. Most subjects agreed that family presence was beneficial to family members, while it was undecided whether the patient benefitted from family being present or not. Almost all participants indicated that a family facilitator was present at the resuscitation event. Participants who answered the open-ended questions suggested three main themes: (a) family presence was beneficial to family members, (b) family presence was emotional for family, and (c) a family facilitator was necessary for optimal family support.

Results from this study indicated, despite family presence, there were no negative changes to the way the patient was cared for. Half of the staff believed family presence was a benefit to the family, and most of the staff believed a family facilitator was helpful. The authors recommended that the focus of the FPR debate move from the values and perceptions of the healthcare professionals to concentrate on the perspective and outcomes of the patient and their families regarding FPR. The authors believed more research was needed at facilities that had policies and procedures regarding FPR and
those facilities that did not have written policies carefully evaluate their outcomes (Oman & Duran, 2010). Lastly, the authors suggested more studies be completed on the role of family facilitators during resuscitation and how the facilitator eased the stress of incorporating FPR at the bedside for both staff and families.

A second study on the perspectives of health care providers regarding families in the room during resuscitation of their loved ones, was a descriptive study to determine the opinions of nurses and doctors on the topic of FPR (Demir, 2008). The setting of this study took place at a large Turkish university hospital involving two different intensive care units and the emergency department. Of the 181 staff members that were currently working at the time, 62 doctors participated, as well as 81 nurses, the majority of whom worked in the intensive care units. Most participants were less than 30 years of age, female, and bachelor-prepared staff nurses with less than 3 years experience. Of the physicians who participated, most held a medical degree and held a primary position of research assistant. Besides the specific units involved, there were no other specified criteria for inclusion in this study.

Using literature as a foundation, a survey questionnaire was prepared to include four open-end questions and 17 multiple choice questions for participants to answer. The four open-end questions allowed staff to answer in their own words their opinions on topics like, who should make the decision to allow FPR, what kinds of experiences they had when family was in the room, what was the family’s reaction, if it was necessary to have the family in the room or not, and any additional thoughts they might want to record about FPR (Demir, 2008). The reliability and validity of the study instrumentation were
Most participants were in agreement that FPR was not appropriate (82.6%) for multiple reasons. Most doctors and nurses indicated numerous reasons families should not be allowed in the resuscitation room, such as families would be a distraction to resuscitation efforts; it would be traumatic to families; performance of the team could suffer; families would misunderstand CPR efforts; not traditionally or culturally acceptable in Turkey; liability reasons; no guidelines to indicate FPR; resuscitation times would be longer; and lastly, families of healthcare providers should be given authorization to be present (Demir, 2008). Of the very small number (.09%) of those who thought FPR was acceptable, there were a variety of reasons indicated. Those small number of doctors and nurses believed that families could see that healthcare providers were aggressively attempting to help; families would be able to cope better; it was the family’s right to be there; and confidence levels in health care providers would improve.

Most participants (91.6%) that answered the questionnaire indicated they had never allowed FPR (Demir, 2008). The small number of healthcare providers that allowed FPR, determined that most of the families fainted, exhibited signs and symptoms of fear and anxiety, and possibly felt guilty over the traumatic event that occurred to their loved ones. About half of the participants felt that the decision of FPR was a team decision, not an individual one. There were few participants that freely wrote comments; most kept any other opinions to themselves.

Using a government based healthcare system, such as Turkey’s system, made comparing it to studies from other countries that had insurance-based systems difficult.
In addition, the Turkish sample had cultural dissimilarities compared to other studies. Most nurses and doctors at these Turkish hospitals agreed that FPR was not appropriate.

In a third study of nurses’ perceptions related to FPR, Twibell et al. (2008) explored nurses’ perceptions through the development of two new instruments that measured self-confidence, risks and benefits related to FPR. The precise purpose of the study was to test two new instruments, analyze nurses’ opinions of FPR, and evaluate the nurses’ perceptions of self-confidence related to FPR, as well as explore relationships among study variables and the nurses’ demographic variables. The authors of this study chose to use Rogers’ (1995) theory of diffusion of innovation, which suggested people adapt to new ideas and theories if they know the benefits. Bandura’s (1986) theory of self-efficacy was also a chosen concept for this study, which insinuated the more confidence a person had in themselves and their skills, the more likely they would adopt new behaviors.

In this descriptive and instrument testing study, researchers utilized a convenience sample (n = 375) of individuals who were either registered nurses or licensed practical nurses from a small Midwestern town working in an acute care setting. Participants were required to be 18 years or older, have the ability to read English, and were currently licensed in the state (Twibell et al., 2008). Nurses from many clinical areas of the hospital completed pen-and-paper surveys. There were two instruments created for this specific study, the Family Presence Risk-Benefit Scale (FPR-BS) and the Family Presence Self-Confidence Scale (FPS-CS). FPR-BS instrument was utilized in this study to quantify “nurses’ perceptions of the risks and benefits of family presence to the family,
patient, and resuscitation team” (p. 103). FPS-CS instrument served to determine “nurses’ self-confidence related to managing resuscitation with patients’ families present” (p. 103). The response format was a 5-point Likert scale in which 1 was to strongly disagree and 5 was to strongly agree. A pilot study was conducted to determine if adjustments were needed on both instruments.

The validity of the two new instruments was supported through the maximum likelihood exploratory factor analysis with varimax rotation (Twibell et al., 2008). A single factor solution for the FPR-BS explained 53% variance in the perceptions of nurses related to the risks and benefits of family being present during resuscitation. The Cronbach alpha reliability was .96 on the 22-item scale. Factor loadings ranged from 0.498 to 0.890. A single factor accounted for 52% of the variance on the FPS-CS, which measured the self-confidence nurses have while family were present during resuscitation. Factor loadings ranged from 0.553 to 0.825. The Cronbach alpha statistical test was .95, showing that the internal consistency reliability of the two instruments used in this study was acceptable.

Researchers found that most responses ranged from strongly agree to strongly disagree on all items, indicating that family presence remained a contentious issue between nurses. Although most family wanted to be present and several professional organizations have promoted FPR, nurses continue to debate the risks and benefits. Most nurses in this study indicated they had moderate to high-self confidence when taking care of patients with family in the room. It was not determined that higher self-confidence levels directed more invitations for family to be in the room or whether more invitations
of family gave the nurse’s more self-confidence. The results of this study did not clarify why nurses make the choices they make about family presence but that the nurses who have invited family into the room during resuscitation recognized more benefits than risks in this practice. These same nurses also demonstrated more self-confidence than nurses who did not invite family members to be present (Twibell et al., 2008).

The demographics in this study showed that nurses who were active in professional organizations, certified, or working in the emergency department, were more likely to ask family to be present during resuscitation (P < .001). Nurses who worked in critical care areas, with the exception of the emergency department, did not differ from nurses who worked in non-critical areas in response to perceptions, risks, and benefits of having the family present. Nurses who were employed in the outpatient setting did see more risks and less benefits possibly because they had less experience and resuscitation did not occur often in this area (F = 6.9, P < .001). There was no significant association between nurses’ age, years of experience, and perceptions regarding family presence. Nurses did not agree amongst themselves in regards to families having a “right” to be in the room during resuscitation efforts. The nurses in this study were divided equally on whether the family had the right to be in the room during resuscitation efforts. The two instruments created for this research study were found to have internal consistency and construct validity (Twibell et al., 2008).

Further development of the two instruments, FBR-BS and FPS-CS, is needed to extend validity and reliability to other samples (Twibell et al., 2008). Validity could be tested by giving the FPR-BS to other sample groups with more variety from various
locations and more ethnic assortment. Since there was high Cronbach alpha score, some items could be unnecessary and could be taken off the instrument. Both instruments need to be revised and expanded to test specific concepts. A larger study could be conducted to look at the past experiences of the nurses in the sample in regards to resuscitation and family presence.

According to Madden and Condon (2007), “when death occurs in the emergency department, it is most frequently as a result of unforeseen or unanticipated event that can have a profound effect of the family” (p. 434). The authors pointed out that, as FPR becomes more widely accepted, policies and procedures were lacking for staff members regarding this sensitive issue. The purposes of this descriptive study were to (a) discover demographic data of emergency room nurses, (b) examine nurses’ awareness of policies and guideline on FPR, (c) discover emergency room nurses’ typical procedure regarding FPR, and (d) uncover obstruction to FPR. The conceptual framework for this study was from the Emergency Nurses Association (ENA) (2002) guidelines on FPR. The study sample included 90 emergency room nurses. Most participants were female (83.3%), 30 to 40 years old, and currently working as staff nurses (80%). Half of the sample (50%) had 4-10 years of nursing experience. To be included in this study, nurses must have worked in the emergency department, had six months or more of experience, and worked currently in a level one trauma center. “All participants were involved in working in the resuscitation room and dealing with resuscitation efforts” (p. 436).

A closed-ended questionnaire, which included 15 questions in four sections, was given to participants. The first section requested information related to demographic
traits. The second section used “yes,” “no,” and “don’t know” questions to determine nurses’ understanding of current policies and guidelines used in FPR. In this section, the researcher also determined how many times the participant was involved in FPR in the past year. The third section uncovered the nurses’ opinions related to policy improvement by having the participants circle one written statement (Madden & Condon, 2007).

Lastly, the fourth section requested participants to respond to a list of possible obstructions to FPR with “yes,” “no,” and “don’t know” answers. Validity of the instrument was supported by the Emergency Nurses Association “using a panel of experts consisting of 3 critical care nurses, 3 emergency nurses, and 1 physician, who rated the relevance and clarity of the questionnaire” (Madden & Condon, 2007, p. 435). The panel of experts determined that the questionnaire was 100% relevant to measuring FPR. The survey tool was piloted on 10 emergency room nurses not associated with the level one trauma center. The tool was modified as needed from the pilot study, and the pilot study results were not incorporated in the main study.

The response rate for this study was 90%. Ninety nurses out of 100 completed the instrumentation. Most demographic traits were described earlier; however, it was found that of the staff nurses who had “the most contact with patients, 16.7% were clinical nurse managers, and 3.3% reported other positions such as clinical facilitators or advanced nurse practitioners” (Madden & Condon, 2007, p. 436). The participants also indicated a high level of professional credentials, in which 41.6% held a degree higher than a diploma in nursing. In other findings, 65% indicated that there was no policy for FPR at their facilities; 35% did not know if a policy of FPR even existed.
In further results, 58.9% of the sample allowed FPR despite having no policy or written guidelines in their facility. Almost three-fourths of the sample expressed a desire for a written policy to be in place. Only 20% of the participants specified that they were not in favor of a written policy being put into place, but still would like to have the option of taking family to the bedside during resuscitation. Finally, only 2.2% of emergency room nurses would rather family not be present during resuscitation (Madden & Condon, 2007).

Lastly, results regarding obstacles to FPR were reported. Controversy between emergency health care professionals was a concern of 58% of emergency room nurses. By having families present, 50% of nurse participants believed the stress level would increase among personnel in regards to the fears and concerns of making a mistake in front of them. Interference from family (27%) and legal prosecution (39%) were indicated as reasons not to bring family members to the bedside during CPR. Finally, most nurses (96.6%) identified that they would like more knowledge about the advantages of FPR, as well as a general agreement regarding FPR (94%) from all emergency health care providers (Madden & Condon, 2007).

The authors of this study concluded that more understanding and guidelines needed to be created regarding FPR. Maddon and Condon (2007) suggested “that every hospital should have a policy on family witnessed resuscitation” (p. 439) to reduce conflict and to make certain effective and safe practice occurs. The authors reported that more research was needed to further the development of such policies. Madden and Condon suggested that a qualitative study could uncover a deeper understanding and
insight into the perception of emergency room nurses toward FPR.

In a fifth study of nurses’ perceptions of FPR, McClement, Faillis, and Pereira (2009) proposed to determine the benefits and risks that critical care nurses described about FPR. The underlying concepts for this particular study were risks and benefits of FPR.

In this descriptive qualitative study, a convenience sample of nurses was sent an online survey. All participants were members of the Canadian Association of Critical Care Nurse (CACCN) who had given the CACCN an email address. Data were collected through an outside agency, which received 450 responses to the survey, for a response rate of 48% (McClement et al., 2009). According to the responses, most of the participants were female, between the ages of 40-49 years of age, working full time, employed at a teaching hospital, working mostly with adult patients, and who had experience in the critical care area for 15 years or more. A survey was created from the foundational work of Maclean and colleagues (2003) and modified to meet the standards of CACCN and their position on FPR. The survey incorporated 18 descriptive questions as well as a dialogue area in which participants could write free text and comments on their position, thoughts, and opinions of FPR. The validity and reliability of the survey were not discussed.

Free text comments were analyzed through content analysis and constant comparative techniques (McClement et al., 2009). Four major categories arose from this analysis: perceived benefits for family members, perceived risks for family members, perceived benefits for the health care team, and potential risks for the health care team.
Each group had several sub-categories. Benefits for family members included allowing time to say good-bye to loved ones, seeing resuscitation efforts firsthand, and providing a comforting presence for their loved during a critical time. Risks that nurses indicated for FPR included bodily harm and psychological harm for the family.

Nurses indicated that two benefits to having FPR were (a) being able to see that their patient had people and families were supportive of the patient and (b) that they were more than just an illness or an emergent incident. Nurses believed that family who were present were more adapt to understanding resuscitation efforts and everything was done for their loved one (McClement et al., 2009). Finally, nurses unveiled multiple risks for FPR. Nurses determined that having FPR could cause some legal issues, making nurses feel incompetent in their job performance and unable to use effective coping strategies. Nurses indicated that families may divert attention away from resuscitation efforts through various antics, such as their physical presence taking up inadequate space in the room, yelling at staff members and becoming emotionally distraught, and heaving themselves across their loved one, blocking healthcare providers from the patient.

The authors recommended that nurse administrators, educators, and practicing clinicians be aware of the thought processes that critical care nurses use when deciding to bring family into a room where resuscitation efforts were taking place. Understanding nurses’ perceptions could contribute to policies and procedure changes as well as proper education to further strengthen self-confidence, skills, and abilities. The researchers suggested that a multicultural study would provide new knowledge on this topic, as this research study did not include cultural considerations (McClement et al., 2009). “Future
research efforts also need to capture the perspectives of family facilitators, those members of the healthcare team who provide support for family members through their ordeal of watching the resuscitation of a loved one” (p. 238). McClement et al. also argued that more research was also needed on the subject of healthcare providers meeting the needs and being supportive to family members during resuscitation efforts.

In another study that included not only nurses but other health care professionals, McClenathan et al. (2002) aimed to clarify the debate between healthcare workers who opposed and supported FPR. The purpose of the study was to determine whether critical care professionals supported or did not support new guidelines on FPR, to assess the rationale behind health care workers opposition to FPR, and to determine if demographics influenced a healthcare provider’s opinion. McClenathan et al. chose the concept of family-centered care as a framework for this descriptive study.

Surveys were distributed to a population that included physicians (n = 494), nurses (n = 28), and allied healthcare professionals (n = 21) who were attending the international meeting of the American College of Chest Physicians in October 2000 (McClenathan et al., 2002). Surveys returned totaled 554. Sixteen participants did not include their qualifications, and 28 verified that they had never been involved in a resuscitation attempt; their responses were not included in the analysis. Most of the participants were male physicians (n = 394), white (n = 293), and most with specialties in pulmonary (n = 388) or critical care areas (n = 283). The average age of the participant completing the questionnaire was 43.6 years, with most having experience in healthcare for the past 11 years.
The questionnaire was designed to be completed in 2 minutes or less and included six questions. Items tapped the subjects’ resuscitation experience, views of FPR, and demographic data. Validity and reliability were not reported in this study (McClenathan et al., 2002).

“Regardless of the occupation, the majority (78%) of all health-care professionals surveyed opposed [family presence during resuscitation] for adults” (McClenathan et al., 2002, p. 2206). Collectively, physicians more than nurses or other healthcare workers were against FPR. Healthcare professionals (85%) also pointed out they would rather not have FPR when dealing with a pediatric patient. Researchers attempted to define what areas of the country supported FPR more than the others. They found that the northeastern parts of the United States were far less likely to include family during resuscitation of pediatric (5%) or adult (12%) patients than any other area in the country. The Midwestern areas of the United States were the most likely to include family during resuscitation (37%).

Out of the participants surveyed, most health care providers had had experience with FPR (59%), and fewer of those participants (40%) would have FPR again (McClenathan et al., 2002). Researchers also found that 75% of physicians who had participated in FPR had some type of negative experience, while fewer nurses (47%) indicated similar values. There were a variety of reasons healthcare workers pointed out to researchers for why they prefer not to have FPR. The most commonly reported reason (79%) was the concern for psychological trauma that could have occurred to the family from witnessing such an event. Other less popular reasons were legality issues (24%),
clinical inadequacy (27%), and other (9%) various reasons, such as distraction from family.

Despite new guidelines from American Heart Association suggesting families should be present during resuscitation, findings suggested that the majority of healthcare workers, specifically physicians, nurses, and other personnel, did not prefer FPR (McClenathan et al., 2002). Although resuscitation was a team effort, physicians were accountable for the decisions and outcomes of the resuscitation attempt. The researchers suggested that further research needed to be completed prior to the implementation of the new suggested guidelines of the American Heart Association due to the conflicts and preferences indicated by current healthcare providers.

While research to date has demonstrated the variety of opinions of nurses and other health care professionals related to FPR, few programs have been designed and implemented to support FPR. Guidelines for FPR were scarce (Mian et al., 2007). The purpose of the study by Mian and colleagues was to: (a) create and put into practice a family presence program in an emergency department, and (b) assess “attitudes and behaviors of nurses and physicians towards family presence before and after implementation of the program” (p. 53).

This descriptive study was conducted in a metropolitan hospital in the northeastern United States. This hospital was a level one trauma emergency department that handled both adult and pediatric emergent events. The sample used in this study was a convenience sample of all the nurses and physicians who were actively employed at the hospital’s emergency department and contracted to complete surveys from January 2002
to May 2003. To the first survey, 86 nurses and 35 physicians responded. In the second survey, 89 nurses and 14 physicians participated. The demographic data were collected with the initial survey. Most participants were in the age range of 30-49 years of age; most nurses were female (86%); most physicians were male (66%); most nurses (65%) were bachelor’s prepared; and most physicians (74%) were residents. The experience indicated by both nurses (39%) and physicians (54%) were mostly 1-5 years (Mian et al., 2007).

The researchers in this study developed their family presence program using the guidelines of the Emergency Nurses Association (1995). A three-part survey questionnaire was developed using prior research and information from staff experiences. The first part of the instrument used a 5-point Likert scale to rate professional attitudes, values, and behaviors. The second instrument consisted of twelve questions that asked for the participants’ personal and professional experience. Mian et al. (2007) also noted that there were four questions in addition to those twelve when the second survey was given out, which dealt with the family presence program and educational sessions that the facility implemented.

Lastly, demographics were requested, including sex, age, educational level, years of experience, and experience in the emergency room. The content validity of this survey was assessed through a pilot study conducted on twelve former emergency room nurses and small changes were made to the survey. The researchers used Cronbach alpha to test the reliability of this study, which was found to be adequate (Mian et al., 2007).

The results of the survey, which was given prior to practice and educational
sessions, indicated that nurses demonstrated stronger support for family rights and their right to be present during resuscitation efforts than did physicians. However, nurses were less supportive of families being present during emergent procedures and did not believe that FPR helped families. “Physicians were divided about the patient’s right to having family members present during a medical resuscitation (51%)” (Mian et al., 2007, p. 56). Both nurses and physicians raised several concerns, such as family members being distressed and distracting, about the teaching experience for residents, higher levels of anxiety, legality, and confidentiality.

After training sessions were completed and several months went by, a second survey was taken to examine how education and guidelines changed the attitudes and behaviors of the nurses and physicians. The follow up survey showed that nurses had greater support for FPR, family presence during emergent procedures, and during trauma resuscitations. The attitudes about the benefits of FPR remained low and unchanged from the first survey. Nurses seemed to indicate less anxiety and showed they were less anxious about the learning experiences the residents would get if the families were present. Upon completing the four extra questions on the survey, only “39% of nurses reported having a more positive attitude toward family presence after an educational program, and 36% of nurses felt more positive about family presence after the program was implemented” (Mian et al., 2007, p. 58).

Finally, due to the small number of physicians responding to the follow up survey results should not be examined without due consideration. Physicians’ responses showed less receptiveness to FPR and indicated that they were more troubled with practice issues
than in the prior survey. Physician attendance to the educational and practice sessions was very low, with 92% saying there was no change in beliefs or attitudes on FPR after the program was started. Physicians did indicate, however, they had more support for “the statement suggesting that family presence is beneficial to the patients’ families” (Mian et al., 2007, p. 58).

Although there were multiple concerns with FPR, the authors reported that the educational program initiated into the emergency department was considered a success and continued as a standard of practice. Authors conveyed that continuing education was a key strategy to support FPR. The more education and practice that nurses received on FPR, the more confident they may be and the stronger advocates they may become for their patients and their family during resuscitation efforts. Because the researchers did a more general group survey, the author suggested doing a more individual survey that might indicate how the educational material changed the attitudes of the nurses (Mian et al., 2007). Educating physicians also served as a challenge as they generally did not attend educational sessions. Perhaps, a separate study with education tailored to the physicians could be completed to get a better understanding on the attitudes and beliefs of this specific group.

**Family’s Perception of FPR during Pediatric Resuscitation**

Research on FPR with adult patients leaves a lack of clarity regarding nurses’ perceptions. A collection of research studies have been conducted on FPR with pediatric patients and may add new knowledge about the perceptions of family members, which may help nurses make decisions and support families during FPR.
In a study that examined family perceptions of pediatric resuscitation, McGahey-Oakland, Lieder, Young, and Jefferson (2007) conducted an in-depth examination of families who witnessed the resuscitation of their pediatric loved one. The purpose of this descriptive, retrospective study was to (a) define family experience during FPR of children in an emergency room in two different hospitals, (b) discover where improvements could be made from family who witnessed FPR, and (c) evaluate mental and health stability of the family member who participated in this study.

A large urban children’s hospital in Houston, Texas served as the setting for this study. At the time of the study, there was not a policy in place regarding FPR, and there were no identified family facilitators used for FPR. Families included in this study were reviewed by the Cardio-Pulmonary Resuscitation committee to see if they met criteria (McGahey-Oakland et al., 2007). There were 25 families that met the criteria of speaking English or Spanish, adult family members of a child who had resuscitation, an event that occurred between March 2002 and April 2003.

After attempting to contact the 25 family members, 9 families declined to participate related to emotional distress and 6 family members could not be located. Of the 10 family members who did participate, 7 were mothers, 2 were fathers, and 1 was a great-grandmother. Seven out of ten participants were present in the resuscitation room. Six of the ten family members were Hispanic, 2 White, and 2 Black. The mean range of ages was 35.9 years, with varied education levels, from 4.4 years to post graduate. The children’s age ranges who were resuscitated were 3 months to 10 years, in which all 10 children did not survive. Three children had chronic illness that resulted in resuscitation,
while 7 children had an acute life threatening event occur (McGahey-Oakland et al., 2007).

There were two tools used to in this study: a quantitative instrument known as the Family Presence Attitude Scale (FPAS-FM) and a qualitative instrument which contained open-ended interview questions for the family. The FPAS-FM utilized a 4-point Likert scale to assess issues, attitudes, and benefits of FPR. The scale was used to assess both family members who were at their child’s beside during resuscitation and those who were not. This qualitative survey was based on the Parkland hospital instrument, Family Presence during Resuscitation/Invasive Procedures Unabridged Family Survey (Meyers et al., 2000). The qualitative part of the study included 10 demographic questions and 22 open-end questions for further investigation of FPR, taking in to consideration those family members who were present for their child during resuscitation and those who were not (McGahey-Oakland et al., 2007). A panel consisting of healthcare providers and family members reviewed the questions for clarity and relevance purposes. Seventy percent or more of the panel approved of the questions used for this interview.

The FPAS-FM determined that family, regardless of if they were present or not during resuscitation, wanted the option to be at the bedside of their child during an emergent event. This instrument also determined that, although there was more stress in these families’ lives than the average population, there was no evidence of traumatic stress (McGahey-Oakland et al., 2007). The qualitative analysis determined five major themes from the responses of the 10 participants. “These included (a) ‘It is their right to be there’, (b) connection and comfort makes a difference, (c) seeing is believing, (d)
getting in, and (e) information giving” (p. 220).

The 10 family participants all determined that it was their right to be in the resuscitation room for various reasons, such as a responsibility to be there, the natural thing to do, and the obvious right of the parent. Families indicated they believed that their children wanted them near during this time of crisis for comfort, support and strength. Participants also wanted to know that every measure was taken for their child in efforts to revive them. By being present, families were assured this was the case. Families had different opinions about getting in to the resuscitation room. Several families were asked to be present, some were asked to wait outside, some were traveling to the hospital, and still others just were present without being asked to leave or stay. Lastly, families indicated that it was not the timing of the information given that was important. They were more anxious about the outcome than what was actually going on during the resuscitation. Most indicated they would have preferred a family facilitator be present to help them understand things as the resuscitation process moved along (McGahey-Oakland et al., 2007).

The researchers of this study concluded that support of the family was necessary to the success of initiating a policy regarding FPR (McGahey-Oakland et al., 2007). By creating a policy on FPR, healthcare providers could provide options to families as well as consistent care to all who were involved. Continued research on this topic was critical to examine the beliefs and attitudes of the patient and families involved during an emergent event. A thorough understanding from families, patients, and healthcare staff could assist those in creating policy that met the needs of each party involved in the
In a second study on FPR for pediatric patients, a different but related qualitative approach to data collection was selected. The purpose of the phenomenological study was to give a comprehensive description of the meaning parents assign to being present or absent during resuscitation efforts of a child in a pediatric intensive care unit (PICU). The theoretical framework used for this study was the “hermeneutic phenomenological approach guided by van Manen as a way of uncovering the meaning of human experience” (Maxton, 2008, p. 3169).

This study took place in a specialized, urban, 20-bed PICU in Australia, in which child’s age ranged from newborn to sixteen years of age. Purposive sampling was used to select participants whose child required resuscitation efforts (Maxton, 2008). Eight couples were included, in which an assortment of experiences was sought, including parents of children who had survived CPR and parents of children who had died despite resuscitation efforts. Of those included in this study, four parents had a child die and four parents had a child who survived.

Data were gathered through 90-minute interviews, in which interviewers used unstructured discussion to gain information. “Interviews were audio-taped and transcribed verbatim” (Maxton, 2008, p. 3170). The thematic analysis was determined by listening and reading transcripts, and the hermeneutic phenomenological interpretation provided a description of what it was like to be a parent in this situation.

After utilizing a thematic analysis to examine findings, the results revealed four predominantly linked themes described by parents: “(1) being only for a child; (2)
making sense of a living nightmare; (3) maintaining hope in the face of reality; (4) living in a relationship with staff” (Maxton, 2008, p. 3170). The idea of being present for the support and comfort of their child during resuscitation efforts was identified as one of the most important reasons; most indicated that it would be unimaginable for them not to be there for their child. Despite all the fear and suffering that parents might have had during resuscitation efforts, they acknowledged that being present allowed them to know every effort was made by healthcare staff to save their child. Parents indicated most recollections of the event were a blur and it was important they be there for their child rather than actually witness the resuscitation efforts.

Parents believed regardless of the outcome, maintaining hope and keeping a positive attitude were crucial during FPR. Lastly, parents acknowledged it might have been difficult for the healthcare providers to have parents present during stressful event. They indicated that support staff, such as social workers or chaplain, were not much help since they could not explain what was happening during resuscitation efforts. Parents instead found it more helpful when an experienced staff member, usually a nurse not involved in the resuscitation efforts, was available to answer questions and provide comfort to the family (Maxton, 2008).

Parents from this study indicated that being present during resuscitation of their child was extremely important to them and the process of coping. If possible, staff should nominate an experienced clinician to answer question and give emotional support to parents and families during resuscitation efforts. The researchers did indicate, due to the small size and singular setting, this study may not be generalized to all PICU patients and
their families (Maxton, 2008). This study also failed to interview parents who were not able to be present during resuscitation efforts. Larger studies with various parental experiences may lead to more generalized results and aid in the development of policies and procedures that would guide staff in the best way of handling parents whose child is being resuscitated (Maxton, 2008).

**Family and Patient Perceptions of FPR**

Completed research results from prior studies have tended to focus on nurses’ and other staff members’ perceptions of risks and benefits to FPR. The research on this subject is expanding to include family’s perceptions. The purpose of such a study by Hung and Pang (2011) was to understand family members’ attitudes and opinions on being present while they witness the resuscitation of their loved one who survived as well as to understand factors that play a role in their preferences.

This phenomenological study took place in a large Hong Kong hospital in the accident and emergency department. Criteria for inclusion in the study were “family members aged 18 years or more of patients who had survived a critical or emergency situation after receiving life-sustaining interventions in the resuscitation room” (Hung & Pang, 2011, p. 58). Thirty-two family members were asked to participate in this study; however, only 18 agreed to do so. There were a variety of age ranges from 20 years to 89 years old, with equally 9 men and 9 women participating. Of those participating, 14 had secondary education or beyond, most were working or retired, and all patients had some type of critical or emergent issues except for one who had a surgical crisis.

An open-ended interview was given to participants within 24 hours of the
emergent event. Each researcher collecting data “remained aware of her own personal experiences and preunderstandings” (Hung & Pang, 2011, p. 58) while gathering information from the participants. Researchers conducting the interview indicated that interviews lasted from 15 minutes to 1 hour. Interviews were recorded, and the researchers wrote notes to describe physical expressions, gestures, and demographic distinctiveness. Interviews were then transcribed for review, in which the researchers looked for common themes and differences between participants. From the interviews conducted, researchers were able to determine 10 themes and subthemes. Hung and Pang indicated three major themes: emotional connectedness, knowing the patient, and perceived appropriateness. These three themes contained multiple subthemes. Under the theme of emotional connectedness, three subthemes arose. Families indicated that their presence during an emergent event gave the patient emotional support. They were able to stay emotionally attached with the patient. Finally, families were able to continue an excellent or reasonable association with the patient and other family members.

The second major theme that was prevalent in this study was knowing the patient, which had four subthemes. Families identified that they felt more helpful to the patient by being in the resuscitation room because they could give vital information to the resuscitation team about the patient. Families indicated that they wanted to be included and involved with resuscitation efforts, and being present during resuscitation allowed this to occur. Lastly, families wanted to be updated about what was occurring, whether it was good or bad news (Hung & Pang, 2011).

The final major theme from this study, perceived appropriateness, had three
subthemes. Families indicated that they were fearful of getting in the way of the resuscitation team. Families indicated that they thought there were rules set by the hospital or staff to prohibit them from being present during resuscitation. Families also indicated that it would be easier to be present in the resuscitation room, if they knew what procedures were going on (Hung & Pang, 2011).

Hung and Pang (2011) indicated that hospitals should provide trained support personnel to accompany the family at the bedside. The researchers suggested that healthcare providers further uncover the individual needs of the family members regarding FPR. The authors recommended that hospitals set up trauma rooms with space for FPR, while newly constructed hospitals should build trauma rooms with FPR in mind. For successful support of FPR, policies and guidelines should be in place to give staff clarity on this sensitive subject. The researcher indicated that this study was conducted only with families of patient who survived and recommended that a study be conducted to include families of patients who did not survive. Further studies should also be completed from the patient’s perspective, to gain understanding of their preferences during emergent situations.

Another study of family perceptions of FPR used quantitative methods in a randomized control trial. The purpose of this study was to discover how FPR affected families in an emergency room and to discover the families’ attitudes were towards the concept of FPR (Holzhauser, Finucane, & Vries, 2006). The researchers reported an interest in conducting research on FPR in Australia to fill a gap in knowledge about the Australian culture and this family-centered practice. This study appears to be on families
and could go in the prior section as well. The quasi-experimental study used a randomized controlled trial method to place participants into either a control group or experimental group. There were rigorous criteria to be included in this study. Patients had to meet resuscitation criteria to be included, such as triage level of a 1 or 2, with or without change in level of consciousness, low blood pressure, respiratory distress, or the need for CPR. Family members must also have met a certain criteria such as: must be 18 years old or older, immediate family or significant other, the obtaining of written consent, the presence of a trained support person and the relative must not be disruptive to the treatment.

The setting of this study was an emergency room of an Australian hospital. There were 99 participants, in which 39 were placed in the control group and 60 were placed into the experimental group. The control group was placed in the quiet room while the experimental group was able to be in the resuscitation room with their loved one. Demographically, for both groups, most of the participants were spouses or partners of the patient over the age of 50 (Holzhauser et al., 2006).

The instrument used in this research study was a questionnaire developed by researchers, which included open-ended questions, demographic questions, and yes/no answer questions. Questions were based on clinical staff experiences after reviewing research literature. Data were collected via a phone interview approximately one month later after resuscitation (Holzhauser et al., 2006).

Both the control group and the experimental group reported a variety of data on the phone survey. One hundred percent of the experimental group were glad they were
able to be in the resuscitation room during their loved ones resuscitation. They indicated that staff was very supportive and able to clarify procedures and processes of the resuscitation. Almost the entire experimental group (96%) indicated that their presence during resuscitation helped them come to the reality of their loved ones’ outcome.

Within the experimental group, a group in which their loved survived (85%) determined that their presence was helpful to the situation and recovery of the patient (Holzhauser et al., 2006). The experimental group also made positive comments which described them being able to see how staff cared for their loved in a difficult time attempting to everything that they were able to do.

After the follow up phone survey, the control group indicated, if they were asked to be in the emergency room during resuscitation, 67% of them would have said yes. The control group indicated they felt staff informed them well of their loved one’s condition prior to resuscitation and after, as well as provided them with support during a difficult time. The control group (71%) also pointed out, if they were able to be present during their loved ones resuscitation, then they would have been able to cope more effectively (Holzhauser et al., 2006).

The researchers suggested that their findings were similar to those found in other areas of the world, in which families do signify the value of being included in the resuscitation process of their loved one. The researchers called for more research to determine the psychological and emotional consequences may occur to family members being present during resuscitation of their loved ones. However, the researchers indicated that this study showed better coping for families who were present with no unfavorable
outcomes mentioned by those who participated (Holzhauser et al., 2006).

Although there are studies completed regarding FPR and the views of various healthcare providers, there are few studies completed on the patient’s viewpoint regarding FPR. The purpose of this phenomenological study was to determine the experiences and partiality of resuscitation survivors regarding family members being present during their resuscitation, as well as survivors of emergency situations that did not require CPR efforts (McMahon-Parkes et al., 2009).

Participants for this study were recruited from two significant cities in southwestern England, which incorporated four university hospitals. A sample of 61 participants were included in the study, of which there were resuscitated survivors (N = 21) and emergent cases not requiring CPR (N = 40). Data were collect over an 11-month period. Participants were required to be: “18 years of age or older, able to speak and understand English, and judged to be clinically and psychologically stable by ward staff” (McMahon-Parkes et al., 2009, p. 222). Demographically, 38 out of 61 participants were male, with varied ages from 38-83 years old and fell into either of two groups.

Research subjects that met criteria were classified into two groups, resuscitated survivors and emergent cases not requiring CPR. Resuscitated survivors described different types of resuscitation efforts such as “basic life support, defibrillation, cardioversion, tracheal intubation and/or aggressive fluid replacement” (McMahon-Parkes et al., 2009, p. 222). Emergent cases not requiring CPR or other life saving measures, but requiring emergency interventions which varied from “suspected cardiovascular, respiratory, gastro-intestinal or neurological conditions” (p. 222) were
included in other studied group.

Data were collected through a detailed interview process. Research subjects were asked structured, open-ended questions, in which their responses were recorded verbatim during a 30 minute interview. Both groups were asked comparable questions with the exception of one group having received CPR; the emergency intervention group was more hypothetically based. Data were reviewed by reading and re-reading statements from subjects, identifying similar words, statements and concepts. Each research team member participated in this process, and a common analysis was agreed upon.

The results of the data analysis indicated three core themes and seven sub-themes. The three core themes were: “being there, welfare of others, and professional’s management of the resuscitation” (McMahon-Parkes et al., 2009, p. 223). The seven sub themes that arose were: “emotional help and support, advocacy, knowing and understanding, presence at the end, getting on with the job, decisions of the healthcare staff, and maintaining fidelity with the patient” (p. 223). The majority of participants indicated that would prefer family presence during resuscitation efforts or other emergent interventions for support and encouragement, to be advocates, to receive clarity that the healthcare providers had done their best, and lastly, that family would be present at the end for closure and understanding of the event witnessed.

Research subjects indicated that they had some concerns regarding the wellbeing of their family member once they had witnessed resuscitation, as it might be traumatic for them. Some participants suggested it would be better if they could choose the family member who would be most suitable to handle such a situation. More importantly,
participants wanted the desires of their family members to be appreciated in regards to FPR (McMahon-Parkes et al., 2009). Lastly, most participants wanted the best the care that healthcare providers could provide, giving full attention to them during this critical time. Although participants desire for their families to be present, they want to be sure their best interest is at hand despite the trauma the family may see. Researchers suggested that the families should determine whether they stay during that time or to leave. Finally, participants indicated they had confidence that healthcare providers would attempt to “maintain patient confidentiality and dignity” (p. 226). Most participants determined that healthcare providers should be sensitive with their personal information and what might need to be said in front of families should be said regardless of violating confidentiality if it would help the resuscitation efforts.

The authors of this study concluded from the findings that most patients have preferences to whether their family is present or not during resuscitation efforts. They suggested more research was needed to uncover a better understanding of patient preference. Perhaps, assessments should be made of patient’s preference to FPR if possible prior to the event. Limitations to the study resulted from a small sample size which did not assess the ethnic minority groups (McMahon-Parkes et al., 2009). The study also did not examine how faith and religion affected the decision of the patient, which may or may not have affected the outcome of the study.

Summary of Literature Review

The controversy surrounding FPR is multifaceted. A literature review has explored the perceptions of nurses, other health care providers, families, and patients
related to FPR. Nurses are typically the key to whether family members are allowed into the room during the resuscitation process. There are a variety of reasons nurses allow or do not allow family to be present. The result of this literature review indicated that nurses appear to weigh the benefits and risks that can occur while family is present when determining their position of FPR. Oman and Duran (2010), Demir (2008), Twibell et al. (2008), and McClement et al. (2009) indicated that nurses identified benefits and risks related to FPR. Some of the benefits nurses identified were: a chance for the family to say goodbye, the opportunity for the family to know that everything was done for their loved one, providing that patient with the family’s comforting presence, and helping to initiate the grieving process. Some of the risks that nurses associated with family presence were: psychological trauma to the family, legal liability, a lack of self-confidence in their skills, and increased levels of stress on the staff performing resuscitation.

In studies completed by McGahey-Oakland et al. (2007) and Maxton (2008), the focus was on parental and family member presence during resuscitation. Both studies determined that families, specifically parents, wanted to be present during resuscitation of their child regardless of staff preference or trauma they may have seen. Various themes arose for these studies, supporting the need for families to be present during resuscitation.

Three studies were completed to determine reasons the families wanted to be present during resuscitation, as well as patient preference (Hung & Pang, 2011; Holzhauser et al., 2006; McMahon-Parkes et al. 2008). Studies of these families revealed various themes that indicated reasons for both being present and to not be present. Families wanted to be able to support their loved ones, start the grieving process, and
know that everything was done for their family member. In contrast to this, families also did not want to be in the way of healthcare providers nor did they want to be a disturbance. Patients indicated that although they liked the support of their families, they did not want them to be traumatized nor in the way of healthcare providers caring for them (McMahon-Parkes et al., 2008). More research is needed on this topic to create clarity on the side of the family for policy and guidelines to guide staff.

Madden and Condon (2007) and Mian et al. (2007) described the importance of creating and implementing policy and guidelines regarding FPR. There needs to be thoughtful and effective strategies to incorporating policy into practice with all staff members regarding the topic of FPR. This perspective reflected Rogers’ theory diffusion of innovation, in which there were specific and strategic ways to make changes in a social area such as nursing. McClenanthan et al. (2002) completed a study that suggested, despite recommended guidelines from professional organizations, most healthcare workers did not include family members in the resuscitation room and suggested that national standards be developed to help in creating policy and guidelines to FPR.

It can be concluded from this literature review that there is a significant need for more research to be conducted to gain better understanding of nurse’s perceptions of risks and benefits of family being present during resuscitation both for adult and pediatric patient populations. There needs to be more evidence to suggest a positive verses a negative outcome for all parties involved, nurse, patient, and family. It is not obvious from these studies whether nurses should or should not have family present during resuscitation. Even patients do not give healthcare providers clear determination or
indication of whether they want their family present or not. Although professional organizations suggest family presence, healthcare providers do not agree with those suggestions and do not follow them. With more research, knowledge, and clarity, perhaps hospital policies and national guidelines can be created to give nurses and other healthcare provider’s better direction and confidence when dealing with family presence during resuscitation.
Chapter III

Methods and Procedures

Nurses are oftentimes placed in the situation of being the gatekeeper, making the decision of whether families are present during resuscitation efforts of loved ones or not. Although literature reflects a diverse response from a variety of healthcare providers, clarity is needed on perceptions of nurses regarding FPR. This study was a partial replication of the study by Twibell et al. (2008). The purpose of this study was to expand what is known about nurses’ perceptions of risks, benefits, and confidence regarding families being present during resuscitation efforts. The theoretical framework for this study was the concept of family presence during resuscitation and Rogers’ (1995) theory of diffusion of innovations. This chapter identifies the research questions, population, sample size, setting, protection of human subjects, procedures, methods of measurement, design of the study, and data analysis.

Research Questions

1. What are nurses’ perceptions of risk and benefit regarding family presence during resuscitation?

2. What are nurses’ perceptions of self-confidence related to managing family presence during resuscitation?
Population, Sample, and Setting

This study took place in three hospitals in the Metroplex area of Dallas, Texas. There were approximately 800 registered nurses that were employed at these three hospitals. The convenience sample size for this study, determined by power analysis, was 250 registered nurses who meet the inclusion criteria. Inclusion criteria for this study was an individual who held a current registered nurse license in the state of Texas, was 18 years or older, had a minimum of 6 months experience, could read English, and was employed full or part time at one of the three target hospitals in Texas. Demographic data collected were the number of years of nursing experience, age, cultural background, types of patients on the unit where they are employed and type of unit, level of nursing education, gender, and number of times that registered nurse had invited family to be present during resuscitation efforts.

Research Design

A descriptive correlation design was used in this study. This was an appropriate design for this study because the object is to “examine the relationships that exist in a situation” (Burns & Grove, 2009, p. 246). A correlation study has no intervention, information is collected from one single group, and data analysis examines relationships among variables. This study focused on registered nurses and their relationship between the variables of benefits, risks, and perceptions about FPR. There was no control group, and no intervention completed, rather an examination of information gathered from participants.
Protection of Human Subjects

After approval of the study by Ball State University’s Institutional Review Board, permission to the conduct the study was sought from the chief nursing officers of the three hospitals. In addition, IRB review from the three hospitals was sought as required. Participation was voluntary and anonymous. Participation in the study was not a condition of employment nor required in any way.

A letter of introduction about the study and a hard copy of the instrumentation was mailed to all RNs in the hospital through intra-hospital mail, along with a return envelope. The letter of introduction explained that the participants would be anonymous and the data would be kept confidential. The letter also provided contact information for the researcher, should the participants have any questions. Participants were able to withdraw from the study at any time by not returning the survey. Participants were able to skip any question they wished. Participants were not required to provide demographic data. Questionnaires were not coded in any way.

Completed surveys were returned to a designated, sealed drop box on each unit which would be later collected by the researcher for data analysis. There was no direct interaction between the researcher and the participants regarding the study. Return of the surveys was considered consent to participate as indicated in a cover letter. No danger or risk to human subjects was seen. No attempt was made by the researcher to determine who participated in the study.

Returned surveys were kept in a locked drawer in the locked office of the researcher. No one had access to the data but the researcher and a data entry person. No
names were recorded on the surveys.

All RNs received the study materials and the criteria to participate. RNs who had not met the study criteria likely did not respond. As a check, participants responded to demographic items to verify the fact that they met the study criteria. Data from RNs who responded but did not meet the sample criteria were kept in a locked drawer in the locked office of the researcher. No one had access to the data but the researcher and a data entry person. All survey data were destroyed when dissemination of the study results were completed.

**Procedure**

The researcher mailed each nurse working on the designated units, copies of the surveys/instruments along with a cover letter explaining the study. Participants were instructed to not write their name or any identifying information on any forms. The completed surveys were returned to a designated, sealed drop box on each unit, which was later collected by the researcher for data analysis. Participants had three weeks to complete the instrumentation. Signs were posted on all nursing units to remind nurses that they were invited to participate. There was no direct interaction between the researcher and the participants regarding the study.

**Instruments and Methods of Measurement**

As a partial replication of Twibell et al.’s (2008) study, two instruments were used to measure perceived risks and benefits, each nurse's perceived self-confidence as it related to family presence during resuscitation, and related 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) (Twibell et al.). 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.

An additional tool measuring demographic variables will be used. These variables will include gender, age, level of education, types of clinical unit and patients, and years of experience (Twibell et al., 2008). An additional item will ask the number of times the participant has invited a family to be present during a resuscitation attempt. Response for this last question will be never, fewer than 5 times, or 5 times or more.

**Data Analysis**

As the first step in data analysis, the psychometrics of the two instruments were evaluated in three ways (Burns & Groves, 2009). Psychometric testing was needed because the FPS-C and FPR-B were new instruments and need to be tested in diverse samples. First, initial analysis of the FPR-BS and FPS-CS instruments was accomplished by using a factor analysis with varimax rotation to determine the construct validity of the scales. Factor analysis “examines interrelationships among large numbers of variables and disentangles those relationships to identify clusters of variables that are most closely
linked together” (p. 700). Secondly, Cronbach’s alpha coefficient value was used to assess reliability of items consistently measuring the same underlying ideas, or internal consistency. Thirdly, concurrent validity was assessed by examining Pearson’s $r$ correlations among perceived benefits or risks and self-confidence. Correlations in prior studies have been moderate in size. Pearson $r$ correlation covers the relationships between the variables measured at the interval level.

Descriptive analysis was used to report and analyze the relationships among demographic variables. Pearson $r$ correlations, $t$ tests, and analysis of variance assessed the differences and relationships among perceptual and demographic variables. A t-test examined the differences between variables measured at the interval level, including age, years of nursing experience, risks, benefits, and self-confidence (Twibell et al., 2008). Analysis of variance tested interactions and differences among variables that were not measured at the interval level, such as number of times FPR was invited, gender, and type of unit worked (Burns & Grove, 2009).

The first research question was addressed by inspection of mean scores on items that reflected risk and benefit of FPR, which included all the items on the FPR-BS instrument. Risks and benefits were rank ordered by frequencies. The second research question was addressed by inspection of mean scores on items that reflect self-confidence related to FPR, which included all the items on the FPS-CS instrument. Aspects related to self-confidence were rank ordered by item frequencies. Significance was set at $P < .05$. Negatively worded items were reverse scored.
Summary

The purpose of this study was to reinforce and expound upon what is known about nurses’ perceptions of risks, benefits, and confidence regarding families being present during resuscitation efforts. A descriptive correlational design was used. A sample size of 250 was recruited. Instruments to collect data used in this study were the Family Presence Risk-Benefit Scale (FPR-BS) and the Family Presence Self-confidence Scale (FPR-CS) (Twibell et al., 2008). Demographic data were collected. The rights of human subjects were protected, and data were anonymous and confidentiality. Data were collected by mailed survey. Descriptive statistics, factor analysis, analysis of variance, Pearson r correlations and t-tests were used to analyze data and address the research questions. This project was a replication of Twibell et al.’s (2008) study. The long-term aim of this study was to contribute to what is known about nurses’ perceived risks, benefits and self-confidence regarding FPR, in efforts to provide guidance, understanding and clarity to nurse educators and administrators on creating policies regarding this sensitive subject.
References


