THE EFFECT OF AN EDUCATIONAL INTERVENTION ON NURSES’ OPINIONS REGARDING FAMILY PRESENCE DURING RESUSCITATION

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ABSTRACT

RESEARCH PAPER: The Effect of an Educational Intervention on Nurses’ Opinions Regarding Family Presence during Resuscitation

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The American Heart Association (AHA) and the Emergency Nursing Association (ENA) encourage health care providers to give family members the option of being present during cardiopulmonary resuscitation of a loved one. There are differing opinions regarding this practice among nurses, which could inhibit consistency in operationalizing family presence during resuscitation (FPDR). The purpose of this descriptive study was to determine nurses’ opinions regarding FPDR before and after implementation of an educational program and to determine if nurses’ opinions differed after receiving education on the AHA and ENA guidelines. This study was a replication of Mian, Warchal, Whitney, Fitzmaurice, and Tancredi’s (2007) study. The sample included nurses (n = 200) who worked in the emergency, critical care, and cardiology units in one large teaching hospital in the midwestern United States. Nurses were educated regarding the guidelines for offering FPDR. Findings revealed the effect of education on nurses’ opinions regarding FPDR and provided information to guide educators and managers in coaching nurses to support FPDR.
Chapter I

Introduction

Health care institutions worldwide are debating the advantages and disadvantages of family presence during resuscitation of loved ones. Research has revealed that family members want to be present (Meyer et al., 2000; Duran, Oman, Abel, Koziel, & Szymanski, 2007; Doyle et al., 1987). Families who are present during resuscitation of their loved ones report experiencing reduced anxiety, increased bonding with healthcare professionals and families, a sense of closure, and a perception that everything possible was done for their loved ones (MacLean et al., 2003). Professional organizations, such as the American Heart Association (AHA) and the Emergency Nurses Association (ENA), have endorsed family presence during resuscitation (FPDR), and guidelines have been published that encourage this practice.

Despite the fact that research has revealed benefits to the family and professional organizations have supported this practice, controversy among healthcare professionals regarding FPDR still exists. Common concerns of healthcare professionals included the performance anxiety of the resuscitation team, family disruption of resuscitation efforts, increased litigation, and emotional trauma to the family (Twibell et al., 2008). Although research has not supported any of these deleterious outcomes, nurses remain ambivalent about FPDR.
Limited research suggests that nurses’ positive perceptions of FPDR can be enhanced through educational interventions; however, few studies have examined changes in nurses’ perceptions related to educational offerings in diverse settings. More research is needed to determine strategies that are effective in creating positive opinions of nurses toward FPDR.

**Background and Significance**

Before family presence during resuscitation was allowed, family members would wait in a designated room during resuscitation efforts, often distant from the resuscitation scene. A member of the healthcare team would periodically update families on how their loved one was doing. Families were excluded from the treatment room due to healthcare professionals’ concerns for the family and the resuscitation team.

The first reported practice of family presence occurred in 1982 at the Foote Memorial Hospital in Michigan when family members insisted on being present during their loved one’s resuscitation. Doyle et al. (1987) published the first report regarding this practice and reported that 72% of family members stated that they would want to be present during resuscitation. Subsequently, a family presence program was instituted at the Foote Memorial Hospital allowing specific family members the opportunity to be present. Three years later, a retrospective study was performed that revealed 81% of the healthcare team had experienced family presence, and 71% supported this practice (Walker, 2007).

Since the study by Doyle et al. (1987), the topic of family presence during resuscitation has been researched and debated. Due to widespread requests from families, professional organizations have issued specific guidelines to promote family
presence and encouraged hospitals to develop policies to support family presence. A resolution by the Emergency Nurses Association was adopted in 1993 to support family presence during cardiopulmonary resuscitation (CPR) and invasive procedures (Günes & Zaybak, 2009). An education program for institutions was developed by the ENA two years later. In 2000, the American Heart Association published guidelines that endorsed FPDR as well. Other professional organizations, such as the American Association of Critical Care Nurses and the Canadian Association of Critical Care Nurses, supported this practice and published statements to endorse FPDR.

While many professional organizations endorse this practice and encourage development of hospital policies on FPDR, opinions and attitudes of healthcare providers revealed in the literature show that not all professionals agree. Research has revealed that healthcare providers have concerns regarding this practice. One concern predominant in the literature was the possibility of emotional trauma to the family. Resuscitation is a stressful event, and the outcome, in many cases, is poor. Emotional trauma could lead to disruption due to family outbursts which may interfere with the team’s work. Another common concern listed by nurses was the possibility of not performing adequately in front of the family. Nurses have reported feeling anxious while family witnessed their loved one’s resuscitation. Performance anxiety and the fear of being sued can cause additional stress to the resuscitation team.

In addition, the perceived benefits of FPDR have been researched, and many studies reported that healthcare providers believed having the family present allowed families to observe that everything possible was being done for their loved one. Professionals also reported that FPDR provided the opportunity for the resuscitation team
to form a connection with the family, and the family seemed to appreciate the efforts of
the team. Research showed the resuscitation team believed FPDR helped the team to
remember the patient was a person and a member of the family. Family presence
reminded the team of the personhood of the patient and helped the team to behave in a
more professional manner.

Many research studies revealed nurses have a more favorable opinion of FPDR
than physicians. McClenathan, Torrington, and Uyehara (2002) suggested the possible
reason physicians had a less favorable opinion toward FPDR may be due to the fact that
physicians were ultimately responsible for the patient’s outcome. Mian et al. (2007) also
concluded that physicians had less favorable opinions toward FPDR. Possible factors
contributing to this result were that the physicians in the sample were less experienced
and younger than average and a low response rate.

In addition, families reported specific benefits when family members were
allowed to be present during their loved one’s resuscitation. Families reported that being
present allowed them to be supportive of their loved one and gave them the opportunity
to provide comfort for their loved one. While observing their loved one’s resuscitation
was stressful for the family, families perceived more stress when they were not allowed
to be present. Being present allowed families to be informed about their loved one’s
condition and provided closure when the outcome was the end of life. In some
retrospective studies, families reported that even in cases when the resuscitation was
unsuccessful, families still perceived benefits to being present with their loved one
(Redley, Botti, & Duke, 2004).
There is a high mortality rate associated with CPR, and those rates are similar between family witnessed resuscitation and non-witnessed resuscitation (Redley, Botti & Duke, 2004). However, patients reported feeling safer, comforted, and less afraid when families were present. Research showed patients also felt the connection between the patient and the family was strengthened when family presence was allowed. Patients believed families had the right to be present and being present helped the patient feel supported. Family members were seen as patient advocates, and their presence helped ensure quality of care.

Some studies researched specific variables that influenced healthcare professionals’ opinions regarding FPDR. Twibell et al. (2008) discovered nurses who were certified, members of professional organizations, or worked in the Emergency Department were more likely to invite family presence and perceived more benefits and fewer risks regarding FPDR. Some studies showed family presence was invited more often when nurses had more experience with family presence and when hospital staff had higher levels of training and education.

Although research is limited, the effect of educational strategies on healthcare professionals’ opinions toward FPDR has been investigated. Research showed educational interventions improved nurses’ attitudes toward family presence. Nurses who had previously opposed family presence were more supportive toward family presence after receiving education about it. Mian et al. (2007) showed the impact of an educational intervention on healthcare professionals’ opinions. Their study revealed that nurses reported more positive attitudes toward family presence after implementation of the family presence program. While many patients and families want FPDR, many
nurses are still ambivalent. More research on the effects of educational interventions could help guide the development of strategies to promote nursing support of FPDR.

**Statement of the Problem**

Family presence during resuscitation remains a controversial subject among health professionals. Guidelines have been established by several professional organizations that encourage family presence. However, many healthcare providers still remain reluctant to invite FPDR. Studies have been done to evaluate opinions, attitudes, and beliefs of healthcare providers regarding this topic. Only limited research has been done to evaluate the effectiveness of educational strategies to improve nurses’ attitudes on family presence during resuscitation.

**Purpose**

The purpose of this study was to determine nurses’ opinions regarding FPDR before and after implementation of an educational program that included the AHA and ENA guidelines.

**Research Question**

The research question for this study was:

1. What were the differences in nurses’ opinions toward FPDR before and after an educational intervention that featured the ENA and AHA guidelines for FPDR?

**Theoretical Framework**

Peplau’s (1997) theory of interpersonal relations was used as the theoretical framework for this study. Establishing a therapeutic relationship between the nurse and the patient was the focus of Peplau’s theory of interpersonal relations. Incorporating family within that relationship is essential for the patient’s well-being.
Peplau’s (1997) theory of interpersonal relations consisted of three specific phases. Each phase described the development of the relationship between the nurse and the patient. Peplau asserted that as each phase evolved, the nurse must use specific strategies and skilled communication while assuming specific roles in each phase. According to Peplau, the ability to interact with the patient was essential for development of each phase. However, when the patient was unconscious or unresponsive, Peplau’s theory of interpersonal relations could still be used while the nurse developed a relationship with the family of the patient. When specific roles, such as teacher, counselor, and leader, have been assumed by the nurse during the patient’s resuscitation, a therapeutic relationship likely will be developed with the family, which in turn may reduce the family’s anxiety and promote bonding between the team and the family.

Definitions of Terms

Families.

*Conceptual Definition:* Relatives or significant others with whom a patient shares an established relationship (Emergency Nurses Association, 1995b).

Cardiopulmonary Resuscitation.

*Conceptual Definition:* An emergency medical procedure that is employed after respiratory or cardiac arrest (Badir & Sepit, 2007).

Family Presence during Resuscitation.

*Conceptual Definition:* Having a family member present in visual or physical contact with the patient during resuscitation (Meyers, Eichhorn, Guzzetta, Clark, Klein, & Taliaferro, 2000).
Educational Intervention.

*Conceptual Definition*: Provision of information by teacher/expert to learners.

Nurses’ Opinions.

*Conceptual Definition*: Beliefs or perspective held by nurses as likely to be true.

*Operational Definition*: Perceptions of nurses regarding FPDR as measured by a three-part survey (Mian et al., 2007).

Limitations

Several limitations were noted in this study.

1. Family members’ perceptions were not evaluated.
2. Individual changes in attitudes were not measured due to the anonymous responses of the participants.
3. Only nurses’ opinions were evaluated. No other medical staff’s opinions were included.
4. Only one hospital was included in this study.

Assumptions

Three assumptions guided this study.

1. Participants in the study responded to all survey questions honestly.
2. The sample was a representation of the population being studied.
3. Participants had awareness and knowledge of FPDR.

Summary

Research has shown that healthcare providers perceive risks and benefits toward family presence during resuscitation. While health professionals continue to debate this topic, families are still requesting to be present with their loved one. Including the family
in the resuscitation room is one way to fully operationalize family-centered care.

Attitudes, opinions, and beliefs of nurses and physicians have been researched, and most studies have revealed that nurses remain ambivalent about FPDR. Further evaluation of the opinions of nurses regarding FPDR is necessary in order to determine how to improve their support of families. Many studies have suggested the implementation of educational programs (Perry, 2009; Günes & Zaybak, 2009; Köberich, Kaltwasser, Rothaug, & Albarren, 2010). However, there is limited research on the effectiveness of educational programs in influencing nurses’ opinions of FPDR. This study aimed to determine nurses’ opinions regarding family presence before and after implementation of an educational program.
Chapter II

Literature Review

Introduction

Healthcare professionals worldwide have debated the topic of family presence during resuscitation (FPDR) for over a decade. Professionals’ perceptions of the risks and benefits of this practice have been researched, and literature shows that health care providers still have differing opinions regarding family presence. While this topic remains a controversial one among healthcare providers, families and patients are requesting family presence during a loved one’s resuscitation. In addition, numerous professional organizations endorse FPDR and have provided specific guidelines to encourage family presence.

The role of nurses during resuscitation often includes being the “gatekeeper” to the resuscitation room and extending an invitation to family to be present. Therefore, it is necessary to know nurses’ beliefs and opinions regarding FPDR and the extent to which an educational intervention influences opinions about FPDR.

Organization of Literature

The literature review regarding family presence during resuscitation provided insight into reasons why there are differing opinions among healthcare professionals.
regarding this topic, with a focus on nurses’ opinions. The organization of the literature is divided into three sections.

1. Healthcare providers’ perspectives toward family presence during adult resuscitation
2. Healthcare providers’ perspectives toward family presence during pediatric resuscitations
3. Nursing interventions and practices related to FPDR, including educational interventions

**Theoretical Framework**

Peplau’s (1997) theory of interpersonal relations in nursing focused on the relationship between the nurse, patient, and family. According to Peplau, nursing is a process that involves an interpersonal and therapeutic relationship between the nurse and the patient. Peplau’s theory consisted of three specific phases. The three phases were labeled orientation, working, and termination phases. During these phases, the nurse can take on several different roles. These roles include teacher, resource, counselor, leader, technical expert, and surrogate (George, 2011).

The orientation phase begins with the introduction of the nurse, patient, and family. It is critical during this phase for the nurse to be aware of any personal reaction toward the patient. The relationship between the nurse and patient begins because of the needs of the patient. Peplau (1997) emphasized the importance of the nurse working together with the patient and family to identify and understand the patient’s problem during this phase. Rapport is established, and decisions are made by the nurse, patient, and family in order to meet the patient’s needs. A trusting relationship begins to be
developed, and collaboration between the nurse, patient, and family augments patient care during this phase (George, 2011).

The working phase correlates with the planning and implementation phase of the nursing process. However, according to Peplau’s (1997) theory, it is the patient who initiates the working phase. Goal setting and definition of outcomes are the priorities of the working phase, and a therapeutic relationship is established between the nurse and patient. During this phase, the patient begins to have a feeling of belonging and becomes responsive when personal needs are met. The patient begins to see the benefits of the nurse’s knowledge and expertise and may feel empowered to deal with the illness and its symptoms (George, 2011).

During the termination phase, the needs of the patient have been met or the patient and family are equipped to manage the needs. Thus, the therapeutic relationship between the nurse and the patient and family is terminated. Occasionally the patient or family may become dependent upon the nurse, which can make the therapeutic relationship difficult to end. Once the patient’s physiological needs have been met or mitigated, it is important for the nurse and the patient and family to dissolve the psychological link between them (George, 2011).

The focus of Peplau’s (1997) theory of interpersonal relations is the relationship between the nurse, patient, and family. Collaboration between all involved is essential for the well-being of the patient. Applying Peplau’s theory to FPDR can help nurses determine how to form a working relationship and communicate well with the patient and family. Healthcare professionals have many concerns regarding FPDR, but utilizing Peplau’s theory can help professionals recognize what is best for the patient and family.
In situations where resuscitations are unexpected, the nurse may need to meet the family for the first time and move quickly through the orientation phase to the working phase. In such cases, the termination phase may also come quickly. Nurses can develop astute communication skills that foster speedy development of an effective nurse-family relationship. There are other scenarios where the nurse may have a working relationship with the patient and family before the resuscitation occurs. The nurse functions in the working phase to support family presence during resuscitation. Staying with the family, explaining what is occurring, encouraging the family to speak to the patient, and debriefing the family after the resuscitation event are ways the nurse supports the family during this phase. The nurse may also need to escort the family out of the room if the situation becomes too intense. If the resuscitation is unsuccessful, the nurse negotiates the termination phase, which can be difficult for the family and nurse.

The roles that the nurse assumes most often when supporting FPDR are the resource person role, as the nurse negotiates the family’s presence and guides the family in and around the resuscitation area; the teacher role, as the nurse provides information and interprets the resuscitation activities; and the counselor role, as the nurse emotionally supports the family during and after the resuscitation activities. All of these roles are essential to ensure the development of a relationship between the nurse, the patient, and the family during the resuscitation event.

**Healthcare Providers’ Perspectives toward FPDR**

Evidence shows that family presence during resuscitation is beneficial for patients and their families. However, many healthcare providers are hesitant to invite family presence because of possible disruption, interference, and stress to the resuscitation team.
The purpose of the study by Duran et al. (2007) was to explain and evaluate the attitudes and beliefs of healthcare providers, patients’ families, and patients regarding family presence during resuscitation.

The study took place at the University of Colorado Hospital. Units included in the study were the neonatal intensive care unit, emergency department, and medical, surgical, neurosurgical, and burn/trauma intensive care units. Surveys were sent to 1095 healthcare providers by intercampus mail or placed in specific mailboxes. A total of 202 participants completed and returned the surveys. The healthcare providers that completed the surveys consisted of 98 nurses, 98 physicians, and 6 respiratory therapists. The majority of healthcare respondents were female (65%), white (88%), and had a mean age of 40 years (SD = 11.22). Sixty-six percent had experienced family-witnessed resuscitation, and 86% had experienced family presence during an invasive procedure (Duran et al., 2007).

A total of 62 patients and 72 family members responded to the survey. Sixty-nine percent of the family members were white, 60% were female, 61% were married, and had a mean age of 44 years (SD = 16.13). Seventy-two percent of the patient respondents were white, 52% were female, 48% were married, and the mean age was 43 years. Excluded from the study were family members and patients that were non-English speaking, younger than 18 years of age, confused, delirious, emotionally distraught, and incapable of making a decision. Also excluded were patients that were hemodynamically unstable (Duran et al., 2007).

Data were collected to determine respondents’ attitudes and beliefs about family presence, whether or not the respondents had experienced family presence. The survey
used in this study was an adaptation of the Parkland survey from the family presence study at Parkland Health and Hospital System in Dallas, Texas (Meyers et al., 2000). The survey consisted of 74 items on the healthcare provider survey, 58 items on the family survey, and 52 items on the patient survey. As the instrument was initially developed, expert review by school of nursing faculty, a pastoral care team member, emergency department, NICU, adult ICU physicians and nurses, and a nurse research scientist established content validity of the survey. The instrument was revised after it was pilot tested among the lay public and healthcare professionals. Experts suggested specific revisions to the study. The revised survey had a Cronbach α value of .97 for the healthcare provider survey, .93 for the family survey, and .89 for the patient survey (Duran et al., 2007).

The results of the healthcare provider survey revealed that nurses had more positive attitudes than physicians regarding family presence (p < .001), and non-attending physicians had more positive attitudes than attending physicians (p ≤ .02). Other findings revealed 54% favored family presence during resuscitation and 66% believed a policy on family presence was necessary. The attitudes of healthcare providers who were involved with family-witnessed resuscitation were significantly more positive than the attitudes of healthcare providers who were not involved with family-witnessed resuscitation (p < .001) (Duran et al., 2007).

Qualitative data collected from participants were analyzed and grouped into specific themes. These themes included concerns for patient safety, families’ emotional well-being, staff anxiety, and the need for an individualized approach to family presence (Duran et al., 2007).
Responses to the surveys ranked from 1, meaning strongly disagree, to 4, meaning strongly agree. Mean scores of the family members’ responses were calculated into an overall mean family presence attitude score (M-FPAS), with the greater the mean the more positive the attitude toward family presence. The findings of the family members’ survey revealed that 31% had been present during a loved one’s resuscitation or invasive procedure. The mean family attitude score was 2.9 (SD = 0.41). Those who were present believed that being present was helpful to them (89%) and that they would do it again (95%). There was a significant difference between the scores of family members who had been present (M-FPAS = 3.06, SD = 0.42) and the scores of family members who had not been present (M-FPAS = 2.9, SD = 0.41; p ≤ 0.05) (Duran et al., 2007).

The findings of the patient surveys revealed 29% had experienced having a family member present during resuscitation or an invasive procedure. The mean family attitude score for patients was 2.65 (SD = 0.45). There was no significant difference between scores of patients who had experienced family presence and scores of patients who had not experienced family presence (Duran et al., 2007).

Duran et al. (2007) concluded that, although healthcare providers had positive attitudes toward family presence, other concerns regarding safety, emotional well-being of the family, and performance anxiety could be possible barriers for family presence to occur. Nurses’ attitudes regarding family presence were more favorable than physicians, and both patients and families had positive attitudes toward family presence. The authors suggested creating a hospital policy for family presence and providing a multidisciplinary and individualized approach for each situation.
Even though there are many studies that have examined nurses’ perceptions regarding family presence during resuscitation, very little research has been done on Canadian nurses’ opinions. McClement, Fallis, and Pereira (2009) addressed this gap by examining the Canadian nurses’ preferences and practices regarding family presence. The convenience sample for this study consisted of 944 Canadian critical care nurses who were members of the Canadian Association of Critical Care Nurses (CACCN). Approximately 450 nurses (48%) participated in this study. The majority of the respondents were female who worked full time with adult patients in a teaching hospital, were between 40 and 49 years of age, and worked as a critical care nurse for more than 15 years (McClement et al.).

The instrument for this study was an online survey sent directly to the sample. The survey consisted of 18 items that collected demographic data and asked questions regarding practices, preferences, and policies related to family presence during resuscitation. A dialogue box was added to the survey to give participants the opportunity to share their professional and personal experiences regarding family presence. No reliability or validity for the survey was reported (McClement et al., 2009).

The results of this study showed that 8% of the respondents reported that a policy for family presence was available in their hospital and 50% were aware that the CACCN had a position statement regarding family presence. Out of the 450 respondents, 242 chose to share qualitative responses regarding their experiences. These data revealed four major themes. The apparent themes were perceived benefits for family members, perceived risks for family members, perceived benefits for healthcare providers, and perceived risks for healthcare providers (McClement et al., 2009).
Regarding perceived benefits for family members, nurses noted that witnessing their loved one’s resuscitation allowed family members to observe the team’s efforts to save the patient’s life. Another benefit noted by the nurses was the ability of the family member to provide a comforting presence and emotional support to the patient. The final benefit perceived by nurses was the ability of family members to be present to say goodbye to their loved one (McClement et al., 2009).

The perceived risks for family members noted by the respondents included psychological trauma and physical harm. Nurses felt having family present without debriefing the family and offering support could cause emotional trauma to the family. The respondents also noted concern for the family for possible harm that could come their way due to the resuscitation efforts (McClement et al., 2009).

The perceived benefits for the healthcare team noted by the nurses included allowing the team to see the person behind the patient and family acceptance of the decision to discontinue resuscitation. The comments by the nurses stated that having family present reminded the team that the patient belonged to someone. Also noted was that having family present allowed the family to understand the reasons why the team discontinued resuscitation (McClement et al., 2009).

The perceived risks to the healthcare team included feelings of inadequacy, liability concerns, constraints on the use of usual coping mechanisms, and disruption from duties. Critical care nurses reported that families observing their resuscitation efforts could cause performance anxiety and feelings of inadequacy to the team. They were also concerned that having family present could increase litigation due to mistakes or misunderstandings. Other comments made expressed the concern of family being
offended when the team used specific coping mechanisms, such as humor, to deal with the stressful situation. Finally, nurses were also concerned about the disruption family members could cause. Comments included example of family members lying on the patient, yelling at staff, and begging the team to continue (McClement et al., 2009).

The themes that were evident from the qualitative data in this descriptive study were consistent with previous research. Themes included the perceived risks for family members, perceived benefits for family members, perceived benefits for healthcare providers, and perceived risks for healthcare providers. The authors concluded that since FPDR impacts the team and family members, the perceived risks and benefits need to be considered when inviting family members to be present. The authors suggested that research needed to be done to investigate the impact of FPDR on family members and explore ways the healthcare team can be supportive toward family members (McClement et al., 2009).

The American Heart Association (2005) published guidelines that encouraged family presence during cardiopulmonary resuscitation. McClenathan et al. (2002) conducted a study to investigate whether critical care healthcare professionals supported these guidelines. No conceptual framework was cited for the study (McClenathan et al., 2002).

The convenience sample for this descriptive study consisted of 592 healthcare professionals including physicians, nurses, and allied health-care workers who attended the International Meeting of the American College of Chest Physicians in San Francisco, CA. This meeting took place from October 23 to October 26, 2000. The professionals were surveyed regarding their opinions about family witnessed resuscitation,
demographic characteristics, and cardiopulmonary resuscitation experiences. Out of the 592 professionals that completed the survey, 28 had no experience with CPR and 10 returned surveys were internally inconsistent. Therefore, these 38 surveys were excluded. Out of the remaining surveys, 494 were physicians, 28 were nurses, and 21 were allied health professionals. Seventy-one percent were male, and the remaining 29% were female. The ethnicity of the participants consisted of 293 white, 101 Asian, 24 Hispanic, 10 African, 59 other, and 67 not specified. The participants’ mean age was 43 ± 10 years (McClenathan et al., 2002).

The instrument used in this study was a six-question survey, which was purposely kept short so that participants could complete it in two minutes or less. The authors of this study reported that reliability and validity was compromised due to the lack of prior testing of the survey (McClenathan et al., 2002).

Findings of the survey indicated that 78% of all healthcare professionals did not agree with FPDR for adults. The results showed that 80% of the physicians opposed FPDR whereas 67% of allied healthcare professionals and 57% nurses opposed FPDR. When resuscitation involved a child, 86% of the physicians, 76% of the allied healthcare professionals, and 83% of nurses opposed FPDR. When differences of opinion were broken down by region, those who practiced in the Northeast United States were more likely to oppose FPDR than the rest of the regions. Those who practiced in the Midwest region were more likely than the rest of the regions to allow family members to be present during resuscitation and were also more likely to allow family to be present during pediatric resuscitation. The results of the survey also showed that there was no
difference between those professionals who practiced in the United States and those who practiced in other countries (McClenathan et al., 2002).

Other findings showed that 22% of the participants who had experience with resuscitations would invite FPDR. Forty-two percent of those who had no previous experience with resuscitation would allow family to be present. Forty percent of those who had previously experienced FPDR would ever allow it again. Reasons listed for not allowing FPDR were the psychological trauma the family experienced (79%), performance anxiety of the CPR team (27%), and medico-legal concerns (24%). Nine percent of the healthcare professionals listed additional reasons with the most common reason listed as the fear of family members being a distraction to the CPR team (McClenathan et al., 2002).

This study concluded that the majority of the healthcare professionals that were surveyed did not support the CPR guidelines. The reasons for the lack of support included the risk of psychological trauma to the family, distraction of the CPR team, and performance anxiety of the CPR team. McClenathan and colleagues (2002) believed that the reason physicians were more likely than other healthcare professionals to oppose FPDR was because they were the ones who were ultimately accountable for the outcome of their patients.

Several studies regarding FPDR focused on the perceptions of critical care nurses. Twibell et al. (2008) focused on the perceptions of nurses who worked in non-critical care units. This study addressed three specific gaps related to FPDR. The first gap addressed the lack of reliable and valid instruments to measure specific variables related to FPDR. The second gap addressed the lack of a conceptual framework for exploring
FPDR. The third gap addressed the nature of samples tapped in previous research. Prior research only used nurses who worked in critical care units and did not use nurses who worked in non-critical care units. The authors of this study listed Roger’s (1995) theory of diffusion and innovation and Bandura’s (1986) self-efficacy theory as the frameworks for the study. The following were the authors’ research questions:

1. What were the psychometric properties of two new instruments used to measure nurses’ perceptions related to family presence?
2. What were the relationships between nurses’ perceptions of risks, benefits, and self-confidence related to family presence during resuscitation?
3. What were the relationships among demographic variables and nurses’ perceptions of family presence during resuscitation?
4. What were the differences of perceptions of nurses who have and have not invited patients’ families to be present during resuscitation?

Three hundred seventy-five registered and licensed practical nurses participated in the study. The participants had to have an Indiana nursing license, be at least 18 years of age, and be able to speak English. Instruments completed by nurses were returned by mail. Over 95% of the participants were women, and over 90% were white. More than 75% of the participants had at least 6 years experience, and 50% had a baccalaureate degree in nursing. Forty-four percent worked in non-critical care inpatient units, 36% worked in critical care units, 7% worked in outpatient settings, and 6% worked in the emergency department (Twibell et al., 2008).

Two instruments were developed by the authors for use in this study. The first instrument, The Family Presence Risk-Benefit Scale (FPR-BS), was used to evaluate
nurses’ perceptions of the benefits and risks of family presence to the patient, family, and resuscitation team. The second instrument, The Family Presence Self-confidence Scale (FPS-CS), was used to measure the nurses’ self-confidence related to the resuscitation efforts while patients’ families were present. Specific demographic variables measured included gender, age, ethnicity, units worked, years of experience, professional certifications, roles as RN or LPN, types of patients in unit worked, and educational level. One question asked the number of times the nurse invited family to be present during resuscitation. The responses for this question were never, fewer than five times, and greater than five times. The Cronbach α reliability of the FPR-BS scale was .96. The Cronbach α reliability of the FPS-CS scale was .95. Initial construct validity for both scales was supported by the data analysis (Twibell et al., 2008).

The results of this study showed nurses’ perceptions of benefits, risks, and self-confidence were significantly and strongly interrelated ($r = 0.56$, $P < .001$). The findings also showed that nurses who had invited family presence were significantly more self-confident ($F = 36.4$, $P < .001$) in managing family presence and also perceived fewer risks and more benefits ($F = 32.6$, $P < .001$). Scores on FPR-BS were significantly different between nurses who belonged to a professional nursing organization and those who did not belong to a professional nursing organization ($t = 5.3$, $P < .001$) and between certified nurses and non-certified nurses ($t = 3.9$, $P < .001$), with certified nurses and nurses who belonged to professional organizations perceiving more benefit and less risk. Also, nurses who worked in non-critical care areas did not differ in their opinions of risks, benefits, and self-confidence in comparison to the nurses who worked in critical care units. However, fewer risks and more benefits ($F = 7.56$, $P < .001$) and greater self-
confidence \((F = 6.90, P < .001)\) were significantly perceived by emergency room nurses than nurses who worked in all other departments (Twibell et al., 2008).

Twibell et al. (2008) concluded that the two instruments used to measure the perceptions of the nurses regarding family presence could be further tested to determine validity, reliability, and the scope of the items on the scales. This research study showed that there was a correlation between nurses’ perceptions of benefits, risks, and confidence in managing family presence and nurses’ invitations for family presence during resuscitation. Nurses who were members of professional organizations, certified, or worked in an emergency department were more likely to invite family presence. The authors also suggested that strategies, such as debriefing, active learning, and encouraging certifications and memberships into professional organizations may be developed in order to increase nurses’ self-confidence regarding FPDR (Twibell et al., 2008).

Perspectives related to FPDR have been studied in health care institutions around the world. For example, Demir (2008) investigated the opinions of emergency room and intensive care physicians and nurses regarding the practice of family-witnessed resuscitation in Turkey. The participants of this study included nurses and physicians who worked in the emergency department and the cardiology and anesthesia intensive care units of an 1811-bed, university-affiliated hospital located in Western Turkey. Sixty-two out of 79 physicians and 82 out of 102 nurses participated in this study. Seventy-eight worked in the anesthesia intensive care unit, 41 in the cardiology unit, and 25 in the emergency department. Demographics of those who responded showed that 73.6% were female and 26.4% were male. The mean age was 29 years and the median
age was 27.5 years. Also, 47.9% of the participants had less than three years in their profession, 24.3% had four to seven years, 15.3% had eight to eleven years, 6.3% has twelve to fifteen years, 2.1% had sixteen to nineteen years, and 4.2% had over twenty years. Regarding nursing education, 10.9% of the participants had an Associate degree, 87.9% had a Baccalaureate degree, and 1.2% had a Master’s degree. The physicians’ positions included Research Assistants (64.5%), Specialists (24.2%), Associate Professor (6.5%), and Professor (4.8%). Nurses positions were Manager/Administrative (11.0%) and Ward nurse (89.0%).

The instrument used in this study was a survey questionnaire that consisted of 4 open-ended and 17 multiple choices questions. The open-ended questions asked why family members being present or not present was necessary, who should make the decision for the family to be present, what kind of reaction did the family have when permission was asked, and any additional comments from the respondent (Demir, 2008).

Demir (2008) reported that 82.6% of the physicians and nurses did not think it was appropriate to have the families present during resuscitation. Reasons included the family would interfere (56.3%), the procedure was traumatic (43.6%), the team would experience pressure and the pressure would cause a negative effect on their performance (22.6%), the family would incorrectly interpret the procedure (21.8%), the practice was inappropriate for the cultural background and educational level of the Turkish public (15.9%), and the family may faint or become ill causing the team to need to care for the family (15.9%). Almost 94% of the respondents stated that they did not have a written policy that allowed the presence of the family and had not received education regarding this practice. Ninety-eight percent of the participants did not know that there were
international guidelines, and 91.7% stated that they have not given permission for a family member to be present during resuscitation.

Almost all of the nurses and physicians who participated in this study did not feel that family presence during resuscitation was appropriate. Demir (2008) suggested that cultural differences and educational levels were the possible reasons for this attitude. The majority of the respondents reported that there was no policy regarding family presence in their institution. Demir concluded that having no policy could lead to misunderstanding and different practices and suggested development of policy in order to eliminate misunderstanding. In addition to developing a policy, it was suggested by the author that additional education be provided to healthcare professionals to prevent conflicting information, beginning with national guideline development projects and following with international publications and guidelines.

Another study that examined the opinions and experiences of healthcare professionals in Turkey was a study by Badir and Sepit (2007). The purpose of this study was to determine the opinions and experiences of critical care nurses in the country of Turkey regarding family presence because it has not been a topic of public interest in Turkey. The authors of this study reported that Turkey is a developing country and many changes are occurring in Turkey’s healthcare system. Their purpose was to determine the nurses’ opinions and experiences and to bring awareness of family presence to the country of Turkey. The research questions of this study were:

1. What were the experiences of critical care nurses regarding the presence of family members during CPR?
2. What were the opinions of critical care nurses regarding the presence of family members during CPR?

The study population consisted of 409 critical care nurses who worked at 10 research and teaching hospitals in Istanbul, Turkey. The hospitals did not have a policy or protocol regarding family presence during resuscitation. A total of 278 nurses participated in the study. Over 96% were female, 85% had less than 10 years experience in the ICU, 76.5% had less than 10 years experience in nursing, 33.8% worked in the ICU, 29.5% worked in the reanimation unit, and 89.2% worked in general practice. The mean age of the respondents was 27.5 years (Badir & Sepit, 2007).

The authors gathered data using a survey questionnaire developed by Fulbrook, Albarran, and Latour (2005), which consisted of 43 items within three areas of inquiry. The three areas of inquiry included demographic information, experiences in regard to family-witnessed CPR, and opinions on family-witnessed CPR. The instrument was pilot tested on 30 nurses and was determined to be appropriate, understandable, and reasonable. No validity or reliability was reported (Badir & Sepit, 2007).

The findings regarding the nurses’ experiences revealed that 63.7% of the nurses had not experienced family presence and none of the respondents had invited family members to be present during resuscitation. Seventy-eight percent reported that family members did not request to be present. Among the nurses who had experienced family presence, only 10.8% reported positive experiences. The opinions of the nurses revealed that 83.1% felt family presence was unnecessary, 69.1% did not want family presence, and 78.8% felt physicians were reluctant to have family presence. Other opinions showed that 56.9% did not feel it was the nurses’ responsibility to invite family members,
55% felt it was the physician’s responsibility, and 77.7% felt it was the whole team’s responsibility. Opinions regarding concerns of nurses showed that 88.1% were concerned about confidentiality, 88.5% were concerned that the family would not understand the resuscitation, and 75.9% felt that family members should not make decisions regarding the care of the patient (Badir & Sepit, 2007).

Regarding the effect of family member presence on healthcare providers, 87.8% stated the resuscitation was stressful for the family members; 74.1% felt that family members would become upset by decisions made by the team; and 78.8% felt that family presence was not helpful for the patient. Other concerns listed were family presence would cause stress to the team (84.2%), family members may interfere with the team (64.7%), not enough staff would be available to help the family (71.5%), not enough space (70.9%), and family-witnessed CPR was not a common occurrence (83.1%) (Badir & Sepit, 2007).

The results of this study revealed that the hospitals had no policy regarding family witnessed CPR, and that Turkish nurses were not familiar with family presence during resuscitation. Most of the nurses did not feel that it was beneficial for family members to be present during resuscitation and did not want the family to be present. The majority of the nurses were concerned about patient confidentiality, adverse emotional effects upon the family, and misunderstanding by family members regarding the resuscitation which could possibly cause problems for the team. The authors concluded that Turkish nurses needed to be educated and hospitals needed to develop policies regarding family presence during resuscitation (Badir & Sepit, 2007).
Günes’ and Zaybak’s (2009) study also explored the Turkish nurses’ attitudes and experiences regarding FPDR. This study was a replication of the studies by Fulbrook et al. (2005) and Badir and Sepit (2007). The authors noted that there is much debate concerning FPDR, and despite international guidelines that encourage FPDR, Turkish healthcare professionals do not support FPDR and are not knowledgeable about the topic (Günes & Zaybak).

This study took place from February 2007 through September 2007 in the province of Izmir, Turkey. The recruited participants were critical care nurses who worked in the emergency and intensive care units of two university hospitals. Excluded from this study were nurses with less than two years of experience. Out of the 255 eligible nurses who were enrolled in this study, 62 nurses declined and 58 were on leave. The overall response rate was 135 nurses, which was 53% of the target population. All participants were female and between the ages of 21 to 50 years of age. Regarding experience, 86.7% of the nurses had less than ten years experience in nursing, and 84.4% of the nurses had less than ten years of experience in the intensive care and emergency room settings (Günes & Zaybak, 2009).

The authors of this study used a structured questionnaire to explore the attitudes and experiences of Turkish nurses. This questionnaire was developed by Fulbrook et al. (2005) and consisted of 43 items within 3 areas of inquiry. The sections included sociodemographic characteristics, nurses’ experiences of family presence, and nurses’ attitudes on family presence regarding resuscitation decisions, processes, and outcomes. Content validity was established by a panel of experts, and reliability was established in sections 2 and 3 of the structured questionnaire (Günes & Zaybak, 2009).
The results of the study revealed that only 22.2% of the Turkish nurses had experienced family witnessed resuscitation, and 66.7% of those had one or more negative experiences. All of the nurses reported having no policy regarding family presence, and 94.8% had never invited FPDR. The findings regarding the nurses’ attitudes showed that 88.1% felt family members should not be offered to be present during resuscitation. Participants also reported that family presence could cause problems with confidentiality (88.1%), family members would most likely argue with the team (72.6%), and family members should not be involved with decisions regarding the patient (90.3%) (Günes & Zaybak, 2009).

Regarding the resuscitation processes, 76.3% believed that family members would interfere, 91.1% felt that the team would have difficulty concentrating, and 64.5% thought that the team would be negatively affected by family presence. Regarding the CPR outcomes, nurses reported that family members would experience negative emotional effects (92.6%), legal litigation would increase (90.4%), and family presence did not create a stronger bond between nurses and the family (67.4%) (Günes & Zaybak, 2009).

The authors of this study concluded that very few of the nurses who participated in this study had experienced family presence during resuscitation. Possible reasons listed were because of the lack of policy and that both hospitals had no protocol regarding family presence. The majority of the nurses in this study had negative experiences when family members were present, and most disagreed that family members should be offered to be present during resuscitation. Reasons Turkish nurses opposed family presence were performance anxiety among the team, increased legal litigation, distraction among the
team, and negative emotional effects among the family. Suggestions made by the authors included implementing policies and protocols regarding family presence, offering educational opportunities for the staff, and researching further with a larger sample that included family members and physicians (Günes & Zaybak, 2009).

Family-witnessed resuscitation is not only a topic of interest in Turkey, but it is also a topic of interest in Germany. However, in Germany, the research regarding family presence and the perceptions of nurses is limited. Köberich et al. (2010) explored the attitudes and experiences of German intensive care nurses regarding family-witnessed resuscitation in a research study. Qualitative and quantitative data were collected. The research questions included:

1. What were the experiences of German intensive care nurses regarding family-witnessed resuscitation?
2. What were the attitudes of German intensive care nurses toward family-witnessed resuscitation?

This study occurred during September, 2008, at an intensive care nursing congress in Southern Germany. The convenience sample of 394 intensive care nurses completed a questionnaire to determine their experiences and attitudes regarding family presence. A total of 166 (42.1%) nurses returned the completed questionnaire. Sixty-eight percent of the nurses were female with a mean age of 37 years (SD ± 8.9) and had a median work experience of 16 years (Köberich et al., 2010).

The instrument of this study consisted of a questionnaire developed by Fulbrook et al. (2005) that was translated into German. The survey consisted of four sections. These included biographical data, nurses’ experiences, nurses’ attitudes, and an area for
written comments related to the topic. The section that inquired about nurses’ attitudes was comprised of 30 items divided into three sub-sections. The three sub-sections included decision-making, processes, and outcomes of family witnessed resuscitation. No reliability or validity was reported (Köberich et al., 2010).

Findings concerning nurses’ experiences revealed that 42.2% had experienced family presence during resuscitation, and 65.7% reported that the experiences were negative. Only one nurse had invited family to be present, and ten reported having a policy available in their hospital. Findings related to decision making showed at 67.5% of nurses disagreed with family presence, 54.9% did not want family to be present, and 66.9% felt the decision to include the family should be made together with the medical staff. Other findings showed that nurses were concerned about confidentiality (69.9%) and misunderstandings that may cause disruption (62.7%). Although 66.3% felt family presence should not occur so family could make decisions about their loved ones, 34.3% agreed that family members would support withdrawing treatment if they were present. Findings related to the sub-section of process revealed that 79.5% of nurses felt family members could interfere with the resuscitation, and 74.7% disagreed that family presence should be a standard practice. Almost 74% believed that the family should have a designated team member to care for them, and 50.6% believed that staffing was inadequate for supporting family presence. Findings related to the sub-section on outcomes showed that 57.3% of nurses believed family members could possibly suffer negative emotional effects, and 43.3% feared increased litigation due to family presence. However, 60.8% of the respondents agreed that family presence could help families know that everything possible was being done to help their loved one (Köberich et al., 2010).
The qualitative responses on the survey were organized into four themes. These included individualized decision-making, supporting family members, physical and violent threats, and involvement of families. The qualitative responses concerning individualized decision-making showed that nurses felt that decisions made to allow family presence should occur on an individual basis. Nurses believed family presence should occur if adequate staff was available. Responses regarding physical and violent threats showed that respondents were fearful that family members would exhibit violent behaviors due to the stressful situation. Nurses believed family participation or presence was helpful for families in reaching a decision to terminate the resuscitation (Köberich et al., 2010).

Köberich et al. (2010) concluded that German intensive care nurses had reservations regarding family presence during resuscitation due to past experiences, perceptions, and outcomes of the practice of family presence. German nurses were also concerned about litigation and performance anxiety. The authors concluded that possible ways to reduce the nurses’ anxieties included simulation training, educational strategies, and including family presence in nursing curricula.

Healthcare Providers’ Perspectives Regarding Family Presence during Pediatric Resuscitation

The Pediatric Advanced Life Support manual was revised in 2002 to support family presence during pediatric resuscitation. However, many healthcare professionals continued to hold conflicting perceptions regarding this practice even though most parents have reported that they would prefer to be present. The two-phase study by Jones, Parker-Raley, Maxson, and Brown (2011) examined health care professionals’
perceptions regarding pediatric resuscitation. The research questions for this study included:

1. How do health care professionals view family presence during pediatric
   resuscitation?
2. What perceptions do health care professionals have of their opponents on the
   issue of family presence?
3. How do health care professionals believe that family presence during pediatric
   resuscitation may affect the patient’s family?
4. How do health care professionals believe that family presence during pediatric
   resuscitation may affect the trauma team?

Phase 1 of the study addressed the first two research questions using a
quantitative approach to determine the health care professionals’ perceptions regarding
family presence. The participants consisted of 137 health care professionals, which
included physicians, medical students, and nurses who worked at a Children’s Medical
Center in Austin, Texas. Ethnicity of the sample included white (110), Hispanic (11),
Asian (5), African American (2), Native American (1), and unknown (8) (Jones et al.,
2011).

Phase 2 addressed the last two research questions. A qualitative approach was
used to determine the beliefs of health care professionals regarding the effects of family
presence on families and the resuscitation team. Participants from Phase 1 were asked to
complete an interview during which they were asked about their beliefs about family
presence. Twelve respondents, specifically 5 male physicians, 6 female physicians, and 1
female nurse, agreed to participate in a private interview (Jones et al., 2011).
A 23-item family presence survey was designed to be used in Phase 1, which included two parts. The first part described a resuscitation scenario and asked participants if they agreed or disagreed with physicians’ decisions to allow family presence. Assessments measured included concern for legal problems, concern for family, sympathy for family, sympathy for trauma team, and potential risk. The second part of the survey consisted of 22 items that assessed the participants’ views as well as their opponents’ views regarding sympathy for professionals and families. The family presence survey had a coefficient alpha of 0.72 (Jones et al., 2011).

Results of the first part of the survey revealed that 95 health care professionals agreed with the decision to allow family presence and 42 disagreed. No significant demographic differences were noted between the group in favor of family presence and the group opposed to family presence. To answer the second research question, the findings showed that the healthcare providers in favor of family presence perceived that the providers who opposed family presence lacked sympathy for the family. Supporters of FPDR perceived that they had more sympathy than professionals who opposed it (p < .001). However, opponents of family presence perceived that the supporters lacked sympathy for the resuscitation team. Opponents of family presence perceived that they had more sympathy for the team than the supporters (p < .001). Regarding legal concerns, both opponents and supporters of family presence overestimated the opponents’ legal concerns (p < .001). Providers who opposed family presence underestimated the opponents’ concerns for risks involved during family presence (p < .001). Regarding concern for the healthcare providers, both groups felt that they had a higher level of concern for providers than the other group (Jones et al., 2011).
In order to address the third and fourth research questions, respondents answered specific interview questions. Opponents and supporters of FPDR believed that family members would be affected by witnessing their child’s resuscitation. Opponents believed that families would experience a negative effect and that the team would become anxious with family presence. Supporters believed that the team would feel more appreciated and perform professionally when family members were present (Jones et al., 2011).

Jones et al. (2011) concluded that the majority of the professionals of this study supported family presence during resuscitation. Even though both groups were concerned about legal issues, supporters believed that risk for litigation would be reduced. Opponents believed that the supporters had less sympathy for the resuscitation team and the family. Both groups believed that families and providers would be affected if families were present. However, opponents believed that the effect would be negative and supporters believed that the effect would be positive. The authors suggested understanding the conflicting views of healthcare professionals regarding FPDR may allow understanding and a possible way to provide family-centered care.

In another study of the perceptions of pediatric nurses regarding FPDR, Perry (2009) evaluated the knowledge, experiences, and beliefs of pediatric nurses and identified any differences among the nurses who worked in the special care baby unit (SCBU), pediatric emergency department, or the children’s ward. Perry noted that, according to the Resuscitation Council UK (United Kingdom) (1996), family members should be offered and supported by staff to be present during their loved one’s resuscitation. Educational needs of the nurses to support parents throughout the resuscitation were also identified within this study.
The sample of this study consisted of 94 registered nurses who worked in the SCBU (5), pediatric emergency department (8), and children’s ward (18) within a hospital trust. Thirty-two nurses responded to the survey. Seven nurses had 3 years of experience or less, 10 nurses had greater than 3 years but less than 10 years, and 9 nurses had greater than 10 years. Twenty nurses had experienced family presence during resuscitation, and 24 nurses had been involved in a child’s resuscitation (Perry, 2009).

The tool used in this study was a 15-statement questionnaire that was distributed and collected by the hospital internal post. Letters were sent explaining the purpose of the survey, and posters were placed in each area to remind staff of the study. The questionnaire included open-ended questions to allow respondents to describe their experiences with family presence. The instrument was pilot tested and later revised. The revised survey had a Cronbach α value of 0.876 (Perry, 2009).

Findings of the study revealed that 69% of the nurses had positive attitudes regarding family presence. There were no significant differences regarding attitudes among nurses grouped by years of experience and among nurses grouped by unit worked. Nineteen respondents reported that having family presence would cause stress. However, 26 respondents reported that they would offer family to be present during their child’s resuscitation (Perry, 2009).

Regarding support requirements, none of the respondents felt family members were unable to cope with being present during resuscitation. Twenty-five of the respondents believed that parents had the right to be present, and 30 agreed that staff for family support should be available and was necessary. Out of the 32 respondents, only 4 reported that they had received formal teaching regarding family presence during
resuscitation. Respondents were asked what support was necessary for nurses. The responses included education (22), communication skills (14), and specific knowledge (10). Respondents reported additional life supports skills, bereavement training, and formal counseling would be necessary to provide support throughout and after the resuscitation event (Perry, 2009).

Perry (2009) concluded that two-thirds of the nurses had positive attitudes regarding family presence during resuscitation and believed that they were responsible to provide family support. Even though most of the respondents believed that they could be the experienced support person for the family, only 4 had received formal training to do so. Nurses believed that debriefing sessions and formal counseling should be available to staff and families during and after the resuscitation event. The author’s recommended suggestions included providing education regarding the care of the family during resuscitation updates or discussion groups, encouragement to nurses to take bereavement and advanced life support courses, reviewing all resuscitation events for counseling or debriefing, and implementing bereavement care best practices.

**Interventions and Practices related to FPDR**

Many studies have explored the attitudes of nurses and physicians regarding family presence during resuscitation. However, few studies have reported successful educational programs that were implemented to allow the presence of family members during resuscitation. A study by Mian et al. (2007) not only evaluated the differences of nurses’ and physicians’ attitudes but also designed a family presence program and evaluated their attitudes prior and after implementation of the program in the emergency department.
This study was conducted in an 898-bed hospital with a level 1 adult and pediatric trauma center located in the Northeast. This emergency department received more than 77,000 visits per year and had an affiliated emergency residency program. The convenience sample consisted of the physicians and nurses who worked in the emergency department and agreed to complete an anonymous survey. Thirty-nine percent of the nurses and 54% of the physicians had less than 5 years professional experience, and the majority of the nurses and physicians were less than 50 years of age. Eighty-six nurses and 35 physicians completed the initial survey, and 89 nurses and 14 physicians completed the follow-up survey. Each staff member received a packet containing the surveys with a cover letter explaining the purpose and risks. Those who wanted to participate in the study completed the survey and placed the survey in a secured drop-off box located in the staff lounge (Mian et al., 2007).

The survey consisted of three parts that measured professional attitudes, values and behaviors, personal and professional experiences, and demographics. The survey statements were organized into nine subscales, and the subscales were then subsequently grouped into three domains. These domains consisted of core values, practice concerns, and psychological distress. The follow-up survey included two additional questions to evaluate the effectiveness of the educational program. All emergency medicine residents, nurses, and attending physicians received the survey prior to implementation of the family presence program and one year later after implementation of the program. Content validity of the instrument was supported by experts, and reliability was acceptable for all items, including the subscales (Mian et al., 2007).
After staff members received and completed the initial survey, an educational program was implemented by the psychiatric clinical nurse specialist and the attending physician during a three-month period. A one-hour program was offered for physicians and nurses, which included current research findings, a video that presented family experiences and healthcare providers’ opinions, and family presence guidelines. In addition to the one-hour program, a role-playing opportunity was offered. The role-playing occurred during an actual resuscitation with family presence, and a member of the educational team played the role as a family facilitator. The family facilitator provided feedback and support to the team after the resuscitation. Awareness regarding family presence was also elevated in the emergency department by placing posters in the break room, presenting a case during nursing rounds, and including FPDR as part of the new nurses’ and residents’ training (Mian et al., 2007).

The results of the initial study revealed that nurses had more positive attitudes regarding family presence than physicians and were more supportive of family presence. After the educational program was implemented, a follow-up survey was given to the participants to evaluate whether or not their perceptions had changed. Scores of the follow-up survey showed that 39% of the nurses reported having more positive attitudes toward FPDR after the program, and 36% of the nurses felt more positive about FPDR after the implementation of the educational program. Other findings showed that nurses were more supportive of family presence during invasive procedures, medical, and trauma resuscitations on the follow-up survey. Thirty-five physicians completed the initial survey, and 14 completed the follow-up survey. However, only one physician completed the educational program. Ninety-two percent of the physicians reported no
change in their opinions after program implementation. However, support for the statements that FPDR was beneficial to families was greater on the follow-up survey (Mian et al., 2007).

The core value domain included personal values, patients’ and families’ rights, and staff members’ beliefs. Support for staff members’ beliefs and patients’ rights was greater for nurses on the follow-up survey than the initial survey. However, the nurses’ mean score for personal values and families’ rights was unchanged. The overall group mean scores for core values differed significantly from the initial survey to the follow-up survey (p < .05) (Mian et al., 2007).

The practice concern domain included three subscales: legal and malpractice issues, benefits to patients’ families, and interference with teaching of residents. Scores suggested that nurses perceived more benefits after the program than the initial survey. Physicians and nurses perceived the greatest concerns as distress to families and interference from families. Nurses’ practice concerns were fewer after the program, but physicians’ practice concerns increased. The physicians’ mean scores for benefits to families remained the same. However, the physicians showed less concern about legal and malpractice issues and increased perceptions of interference with teaching of residents on the follow-up survey (Mian et al., 2007).

The psychological distress domain included staff members’ distress and perceptions of families’ distress. Mean scores were for families’ distress were unchanged after the program, as reported by nurses and physicians. However, nurses’ mean scores were lower for families’ distress and staff members’ distress on the follow-up survey.
Consequently, the nurses perceived less distress for families and staff after the program was implemented (Mian et al., 2007).

The authors of this study concluded that the nurses showed more positive attitudes regarding family presence than physicians on both the initial survey and the follow-up survey. The nurses showed stronger support for family presence than physicians. The physicians’ support for family presence was lower on the follow-up survey than the initial survey, but support for the benefits of family presence increased on the follow-up survey. One limitation discussed by the authors was the low response rate by physicians. Mian et al. (2007) reported that after the study, the family presence program became the standard of practice for this emergency department.

In another study that explored practices related to FPDR, MacLean et al. (2003) conducted a study to determine emergency and critical care nurses’ practices and preferences regarding family presence during resuscitation and invasive procedures. This study also evaluated the preferences of patients’ families and the frequency of policies regarding family presence within the emergency departments and critical care units. Qualitative responses by nurses were categorized into specific benefits and concerns regarding experiences with family presence.

A random sample of 1500 critical care registered nurses who were members of the American Association of Critical-Care Nurses and 1500 emergency registered nurses who were members of the Emergency Nurses Association received a survey by mail. Surveys were completed by 984 nurses of which 456 were emergency nurses and 473 were critical care nurses. The nurses who returned the surveys practiced in all 50 states. Ninety percent of the respondents were female and had a mean age of 42 years. Other
characteristics of the sample included: 50% had a baccalaureate degree, 74% had more than 10 years of experience, 80% were staff nurses, and 74% worked full-time. Only 5% of the nurses worked in institutions that had a policy regarding family presence during resuscitation (MacLean et al., 2003).

The instrument used in this study was a 30-item survey that was developed by the authors. It consisted of questions about the demographic characteristics of the sample, as well as questions regarding the respondents’ practices, preferences, and policies regarding family presence. Another section was included to allow respondents to comment about their experiences with family presence. The survey was mailed to the random sample with specific definitions of family presence, a cover letter explaining the study, and a request to return the study in a postage-paid return envelope that was enclosed. The sample received a postcard after the initial mailing to remind them to return the survey. Content validity of the survey was supported by a panel of experts that consisted of 3 emergency nurses, 3 critical care nurses, and 1 physician (MacLean et al., 2003).

Results of the survey showed that written policies that prohibited family presence were rare. Forty-five percent of the nurses reported that their units allowed family presence, and 37% preferred a policy allowing family presence during resuscitation. When asked how often nurses brought families to the patient’s bedside during resuscitation, 36% reported a mean of 3 times in the preceding year, and 21% did not bring families to the bedside but would if the opportunity occurred. A total of 31% of the respondents reported that families asked to be present during resuscitation, and 61% requested to be present during invasive procedures (MacLean et al., 2003).
The comments of the respondents revealed specific benefits and concerns for allowing family presence during resuscitation. Benefits included emotional support for patients and families, a positive experience for patients, families, and staff, guidance and increased understanding regarding the situation, assistance for families to make decisions about resuscitation and know everything was being done to help, and closure and healing for the family. Concerns listed by respondents were issues with privacy and family-related issues: staff issues, such as stress and inadequate staffing; environmental issues, such as lack of space and chaos; and legal issues, such as lawsuits and family complaints (MacLean et al., 2003).

The authors of this study concluded that most of the respondents did not have a written policy regarding FPDR but their units did allow family presence. Most of the respondents supported FPDR and would consider inviting family to be present during resuscitation. The authors recommended that policies or guidelines for family presence during resuscitation and invasive procedures be written (MacLean et al., 2003).

Summary of Findings

The topic of family presence during resuscitation has been debated among healthcare professionals but has been encouraged by many professional organizations. In addition, the American Heart Association (2005) and the Emergency Nurses Association (1995a) have published guidelines for healthcare professionals regarding FPDR. While research suggests that nurses are more supportive of FPDR than physicians, there is no clarity in what nurses specifically see as the risks and benefits of FPDR. In this literature review, twelve studies were examined to provide insight into healthcare professionals’ opinions and attitudes regarding FPDR, with a particular focus on nurses.
Jones et al. (2011) compared the perceived perceptions of FPDR between professionals who supported FPDR and professionals who opposed FPDR when the resuscitation involved a child. While professionals in both groups perceived that families were affected by resuscitation, supporters of FPDR believed that the effect was positive and those who opposed FPDR believed the effect was negative.

Countries that were represented in these studies included the United States, Canada, UK, Turkey, and Germany. The literature showed that little support for FPDR was evident in Turkey and Germany due to possible cultural influences and lack of policy (Jones et al., 2007).

Both qualitative and quantitative data were collected in the studies, and most studies were descriptive in design. The majority of the healthcare professionals’ perceived risks regarding FPDR, included performance anxiety for the resuscitation team, increased litigation, family emotional well-being, and distraction to the team. Most of the healthcare professionals’ perceived benefits regarding FPDR, including decreased litigation, support for the patient, and support for the team. Twibell et al. (2008) showed that nurses’ professional characteristics influenced FPDR-related perceptions. Specifically, nurses who were certified and were members of a professional organization reported improved self-confidence to allow family presence.

Only one study in this review explored a specific variable that was implemented to improve the professionals’ attitudes toward FPDR (Mian et al., 2007). The authors of this study used an educational program that consisted of education, role-playing, and ongoing support to the staff. The education sessions included a video of a family’s experience with FPDR, family presence guidelines, and current research findings that
provided evidence-based practice regarding FPDR. Nurses and physicians were surveyed prior to and after implementation of the educational program to evaluate the providers’ perspectives. Nurses’ opinions were more favorable toward FPDR after the family presence program. Mian et al. (2007) suggested that providing ongoing reinforcement and educational strategies to nurses were possible ways to change practice and implement family presence.

Many of the studies suggested the development of policies, educational opportunities for staff, and further research to investigate and improve attitudes regarding FPDR. For example, the study by MacLean et al. (2003) study focused on specific practices and policies and discovered that, even though most respondents reported no policy was available, FPDR was allowed and most respondents had a favorable opinion of it.

Additional research regarding policy development, education, and the influence of professional characteristics such as certifications may help determine effective ways to improve attitudes regarding FPDR. This study proposes to examine the opinions of nurses regarding FPDR and to determine if nurses’ opinions change after implementation of an educational program that consists of guidelines by the American Heart Association and Emergency Nurses Associations.
Chapter III

Methodology and Procedures

Introduction

Family presence during resuscitation has been a controversial topic among healthcare professionals. While the American Heart Association (AHA) and the Emergency Nurses’ Association (ENA) have published guidelines to encourage family presence, debate regarding the benefits of family presence still exists within the hospital setting. Many studies have researched the perceptions of healthcare professionals regarding this practice. However, few studies have evaluated the attitudes of nurses prior to implementing an educational intervention and after the program had been established.

This study is a partial replication of the study by Mian et al. (2007). The purpose of this study was to evaluate the opinions of nurses before and after receiving education about the AHA and ENA guidelines.

Research Question

The research question for this study was:

1. What were the differences in nurses’ opinions toward FPDR before and after an educational session that included the ENA and AHA guidelines?
Population, Sample, and Setting

This study took place in a large teaching hospital in the Midwest of the United States. The population of this study consisted of approximately 200 registered nurses that worked in the Emergency, Critical Care, and Cardiology Units. A hospital policy for support of family presence existed within the hospital.

The convenience sample consisted of 100 registered nurses. There were no exclusion criteria based upon age or gender, but all participants had to be registered nurses and able to read English and be employed in at least one of the target units.

Protection of Human Subjects

Prior to initiation of this study, approval was given by the Institutional Review Board of the hospital. Approval and support was also given by the Chief Nursing Officer and Medical Director. The study was discussed with nurses at each department’s staff meeting and during staff huddles. Posters were placed in staff lounges and staff locker rooms announcing the study. Nurses were reminded by email and departmental bulletins, and a packet was placed in each nurses’ mailbox. The packet contained a letter explaining the study, an invitation to participate in the study, and two anonymous surveys. The initial survey was to be completed three days before initiation of the educational intervention. The follow-up survey was to be completed within one week following the educational intervention. Consent to participate was indicated when the surveys were returned. Nurses were not penalized for refusing to participate, and no specific benefit was received for participating.

The only risk to participants was the possibility of determining personal identities based upon demographic information. Demographic data included age, gender, years of
practice, and educational level. The risk is minimal. Since nurses are the only persons who can report nurses’ perceptions regarding a clinical issue such as FPDR, the risk:benefit ratio is acceptable. Respondents were instructed that participation was voluntary and that withdrawing from the study could occur at any time.

Nurses placed the pre-education completed survey in a sealed envelope and placed them into a secured drop-off box located in the staff lounge. Collection of the surveys from the drop box was done by members of the research team.

Participants were instructed to complete the follow-up survey a week after nurses received education that included the AHA and ENA guidelines. Nurses were reminded about the surveys during staff meetings, by e-mails, and through departmental bulletins. Respondents were instructed to place the completed surveys in sealed envelopes and place them in the secured drop-off box again. Members of the research team collected the sealed envelopes from the box. Data from both surveys were maintained as confidential by keeping them in a locked file in the locked office of the principal investigator. At the end of the study, the data will be destroyed by shredding and by deleting computer files.

**Procedures**

A study packet was placed in each nurses’ mailbox. The packet consisted of a cover letter, invitation to participate, two surveys, and envelopes for the surveys. The cover letter explained the purpose of the study and instructions informing participants of the designated time frames of when the surveys were to be completed. The study was discussed at each unit’s staff meeting, during staff huddles, and reminders were sent by email and departmental bulletins. Nurses were informed to place completed surveys into
the secured drop-off box during the designated time frame. Members of the research team removed the sealed envelopes during a specific time to prevent interaction between the respondents and the research team.

After participants completed the initial survey, all nurses in each department received education about the AHA and ENA guidelines for family presence during resuscitation. The one-hour educational session took place during each unit’s staff meeting and was led by the Clinical Nurse Specialist and Nurse Educator of the research team. The session consisted of a power point presentation that discussed AHA and ENA family presence guidelines, reported case studies of specific resuscitation events that included family presence, and evidence-based research that supported practice regarding FPDR.

The follow-up survey was completed a week after all staff nurses received education about the guidelines. Nurses were reminded about the follow-up surveys during staff meetings, by e-mails, and through departmental bulletins. Respondents were instructed to place the completed surveys in sealed envelopes and place them in the secured drop-off box again. Members of the research team collected the sealed envelopes from the box.

**Instruments and Methods of Measurement**

This study’s instrument included a 3-part survey to measure factors that influenced nurses’ attitudes toward family presence. The same instrument was given at two different time frames to determine if nurses’ opinions had changed after implementation of an educational session. The first part included professionals’ attitudes, values, and behaviors. In order to measure the variables, a 30-item Likert scale was used.
Responses ranged from 1 meaning “strongly agree” to 5 meaning “strongly disagree.” The second part of the survey included twelve questions that asked the nurses about their personal and professional experiences regarding FPDR. The third part of the survey asked specific demographic questions. Respondents were asked age, gender, educational level, and years of practice.

The survey used in this study was based upon the survey used in the study by Mian et al. (2007). The instrument had been pilot tested on emergency room nurses, and reliability was acceptable on all items of the survey. Content validity of the instrument was supported by expert review.

**Data Analysis**

The survey statements about values, attitudes, and behaviors were clustered in nine subscale groups based upon expected factor groupings from prior research. The subscales then were grouped into three domains. These included core values, practice concerns, and psychological distress. The core value domain consisted of individuals’ beliefs, what they believed were the rights of families and patients, and what they believed they or their own families would want in the same situation. The subscales within this domain consisted of staff members’ beliefs, personal values, patients’ rights, and families’ rights. The practice concern domain included three subscales: legal issues, interference, and benefits to families. Staff members’ distress and families’ distress were the two subscales included in the psychological distress domain.

Mean scores for each subscale for the initial and follow-up surveys were computed. Through an analysis of variance (ANOVA), mean scores of the initial survey
were compared to the mean scores of the follow-up survey and among survey scores and demographic variables. Level of significance was set at p < .05 (Mian et al., 2007).

Summary

To summarize, this study’s method and procedures were based on a partial replication of the study by Mian et al. (2007). Data were collected by utilizing one instrument at two different times to determine nurses’ opinions toward FPDR and if those opinions changed after receiving education about the AHA and ENA guidelines. Data were analyzed using ANOVA to determine statistically significant differences in mean subscale scores between the initial and follow-up survey and among survey scores and demographic variables. Findings helped to determine if educational programs can be utilized to improve nurses’ attitudes toward family presence during resuscitation.
References


