Nurses' Views on Family Presence during Resuscitation: A Qualitative Approach

An Honors Thesis (HONRS 499)

By

Tia LeAnn Berglan

Thesis Advisor
Katherine Renee Twibell

Ball State University
Muncie, Indiana

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Abstract

Family-centered care has become a major focus, in regards to methodologies of care, in recent years throughout the health care profession. Family centered care focuses on viewing the client not as an entity alone but one that has very important connections with family members (not necessarily in reference to blood) that should be fostered throughout the client’s medical care. Family presence during resuscitation has become a critical area of debate for health care professionals both in positive and negative forms. I give a detailed description of all of the major studies that have been conducted on family presence during resuscitation up to this time. I also provide a summary of the qualitative study I, myself, conducted in regards to nurses’ and nursing students’ views of family presence during resuscitation.

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**Introduction**

Family-centered care has been a focus of nursing since the discovery that illness has far greater effects than the obvious considerations that come into care for the client. The entire foundation of family-centered care is based on the fact that each client is an extension of a larger unit (24). Family in this context means a person that has an established mutual relationship with the patient (not necessarily someone that is related to the client by blood) (2). “The goal of family centered care is to meet the needs of patients’ families, including their needs for information, support, and the opportunity to be near their loved ones” (24). The American Nurses Association’s Code of Ethics speaks to nurses’ primary responsibility as recognizing…”the patients place in the family or other networks of relationship” (24). By adhering to this family-centered approach, the nurse and other caregivers are clinging to a more holistic view of the patient, providing more well rounded care for the client and aiding healthcare workers to see the client not just as an entity lying in the bed but in a more personalized way.

An extension of this family-centered approach has created great debate among members of the healthcare community in the past few years: family presence during resuscitation (FPDR). Research has repeatedly shown that patients’ family members have certain needs in a health-related crisis, including but not limited to: having honest, consistent, and thorough communication with healthcare providers, being physically and emotionally close to the patient, feeling that healthcare providers care about the client, seeing the patient frequently, and knowing exactly what has been done to the client (24, 7, 19, 17, 21, 4, 3, 22). Due to multiple research studies findings that family presence
during resuscitation is positive for caregivers, family members, and patients (1, 7, 12, 15, 17, 21, 24, 4, 3, 9, 6, 16, 18), an increasing number of hospitals are now allowing family members to be present during resuscitation. Often times, decisions to allow the family at the bedside are made in a case by case manner, frequently by the nurse, in a very timely approach. Due to this fact, it is critical to ascertain how nurses are making the decision to invite family member witnessed resuscitation and what beliefs and protocols negatively or positively impact this decision.

**Literature Review**

**Negatives**

Healthcare workers (physicians, nurses, assistive personnel) often hold very different views on family presence during resuscitation (FPDR) and these views can regularly be influenced by the healthcare workers experience and previous involvement in FPDR (9, 10, 26, 3). Negative views of FPDR can stem from perceived dilemmas that one may approach in allowing the family to be present at such a critical time in the client’s life. One concern that is often expressed by health care workers in regard to FPDR is a possible of breach of the client’s confidentiality (1, 11, 7). By allowing the family to be present and possibly breaching the client’s confidentiality, potential damage to the patient-healthcare provider team’s relationship could result. The loss of the validity for this client-care giver relationship could lead to diminished public faith in the medical profession (1). In this age of litigation, the healthcare provider must also balance the possibility of breaching the client’s confidentiality with the probability of litigation (1, 7, 17, 11). According to Helmer et. Al., “We must first protect the rights of our patient to
optimal care, confidentiality, and privacy. The needs of family members, as important as they are, must come second” (11).

In accordance with this fear of litigation, studies suggest that healthcare workers are concerned that family members may misconstrue comments or gestures that are made or procedures that are performed in the resuscitation suite to be inappropriate and therefore take legal action in response (1, 17, 21, 7). Knott and Kee found that nurses often found staff behavior was different in resuscitations in which family members were present. “An emergency department nurse stated, “Just make sure nobody said anything inappropriate, that everybody maintained professionalism. Sometimes, letting off steam, you forget professionalism. That is my only concern”” (17). Helmer et. Al. found that the resuscitation suite should be free from distractions, which includes family members, and compared the critical task performance of resuscitation to piloting an aircraft (11). If a family member witnesses an error or misunderstands an action or intervention they may lose confidence in the healthcare team’s competence and be more likely to sue (7). The extreme awareness of actions and words the healthcare team uses during resuscitation could lead to increased stress and distraction from the team members’ work and perhaps even after the resuscitation has taken place (1, 7).

Additionally, healthcare workers have voiced concern that family presence during resuscitation may influence the decision to prolong a futile resuscitation effort or lead to the opposite, in which family members urge the resuscitation attempt to be stopped prematurely (1, 7, 17). Staff members may believe that they will be presented with issues of staying detached from the patient and could possibly view them more as a person (1, 7). According to Knott and Kee, a primary concern for the nurses involved in their study
was the grieving family’s behavior at the bedside and the potential for interference that could present during resuscitation (17). An overwrought family member may become hysterical, faint, or hurt themselves leading the health care team to have to deal with this distraction instead of tending to the patient (1, 7, 25, 17). Staff also voiced concern that a family member could accidentally be exposed to blood or other body fluids and could contaminate equipment (7, 1). Healthcare workers were also concerned that family would be taking up space in the resuscitation room, an environment in which space is often limited (1).

One of the final concerns healthcare workers raised in regard to family presence during resuscitation is the traumatic experience FPDR presents to those observing (1, 15, 12, 17, 7, 11). Family members may not only be overwhelmed by seeing the patient go through the resuscitative process but also could be affected by the unfamiliar sights, sounds, and odors that are related to being present in the resuscitative suite. Knott and Kee found that many nurses were concerned that unpleasant recollections of the resuscitation may obscure the family’s happy memories of the patient. In the Knott and Kee study, most respondents expressed concern that family members may retain memories of their loved one not as the person they were in life but as the person they were during the resuscitation, surrounded by chaos and confusion (17). Helmer et. Al. also addressed this concern, only in regard to the patient’s wishes by stating, “Dying patients may prefer loved ones to remember them as they were and not the sight of nurses and doctors gagging their throats and stamping on their chest during the traumatic event of CPR” (11). Nurses may fear that the family’s presence will cause greater stress for themselves and for the family, regardless of whether they support family presence during
resuscitation or not, and may not be willing to extend the option to families because of these concerns (1).

Positives

While there was countless medical staff that had varying arguments against family presence during resuscitation, there are many counter-arguments that point out the positive aspects of having the family in the room during what is or may be one of the most critical and life altering/ending events of the client’s life. Studies that argue that allowing the family in the room could present a breach in patient confidentiality can also be contradicted by the assertion that breach of confidentiality should not be of major concern at this crucial time (1, 12, 18, 24). Phone calls and other forms of communication between staff and family members occur often in the critical care setting in which information is received from and given to the family. Emergency department routinely phone the relatives of victims rendered unconscious by illness or accident (1).

Additionally, staff pointed out that being unconscious renders a person incompetent to participate in treatment decisions at which point a family member must become the surrogate, acting on behalf of the patient, not only participating in critical decisions but also becoming the patient’s voice (1). The family members may also be able to assist in providing the client’s medical and medication history (7). The Robinson et. Al. study found that of the three patients interviewed that survived resuscitation all “were content that a relative remained with them and felt supported by their presence.” Not one of the patients interviewed felt that their confidentiality or dignity had been breached (15). Allowing FPDR acknowledges the right of the family to be with their loved one regardless of the situation (17). No matter the circumstances, a decision must
be made by staff that weighs the consequences of breaching as opposed to safeguarding the patient’s confidentiality (1).

During the act of resuscitation, the staff often retains a very detached, less personalized view of the client in order to give that person the best care possible, in order to not place such a focus on emotional care but care based on clinical knowledge and appropriate intervention. Family members’ presence during resuscitation allows those closest to the client to provide their love, care, and support at a very important time during the patient’s life while preserving a sense of connectedness for both the family and the patient (7). Multiple studies found that with family members present at the bedside, professionals were more apt to consider the patient’s right to dignity, privacy, need for pain management, and overall view the client in a more humanized way (7, 12, 15, 17, 19, 21, 24). McGahey et. Al. stated that allowing FPDR contributed to a more holistic approach to medicine by acknowledging that the family is part of the patient (21).

Family presence during resuscitation has also been found to be effective in educating families about the reality that is resuscitation and in doing so, enables the family to make a more appropriate decision regarding the patient’s care (17). FPDR helps confirm the reality of the patient’s illness or death to the family and may increase their coping abilities (7, 12, 15, 17, 21, 24). The Robinson et. Al. study found that family members reported lower rates of posttraumatic behavior, less anxiety and depression, and more constructive grief among family members who witnessed resuscitation. In fact, the clinical team was so impressed with the benefits of the study that, after eighteen families had been observed; the study was terminated to provide all families’ access to FPDR (15, 19). FPDR provides the family with visible assurance that all that can be done, is being
done to help their family member (17, 12, 21, 7). FPDR rather than the family only receiving a verbal account of what was done may dispel family members’ doubts about the course events consequently leading to a decreased risk of legal action (21). According to Knott and Kee, “The staff’s quick response, the quantity and quality of care provided may help family members know that, regardless of the outcome, their loved one received excellent care (17). Family members may gain a sense of peace from witnessing intense resuscitation efforts (7).

Another critical finding was that family member presence during resuscitation may stimulate the patient’s will to live or provide comfort as he dies (8, 7). Common concerns in regards to FPDR were prolonging/shortening resuscitative efforts or family interference with the staff during this critical time. In the Meyers et. Al. study, seventy percent of the professionals surveyed noticed modified staff conversations at the bedside and held the belief that FPDR promoted a more careful choice of words (12). Families that are present during resuscitation often perceive that they are actively participating in this intense event (21). Duran et. Al.’s study dispelled the negative thoughts of possible interference caused by FPDR when their study found that family members and patients understood that FPDR was only an option if the family members did not interfere with care, and some family members actually moved away from the patient’s bedside if they became too emotionally distraught. The Duran et. Al.’s study’s findings suggest that patients and families not only understand their limitations but are able to determine when family presence may be inappropriate (24).

Specific Study Findings

Foote Hospital Study
Conducted in 1982, after two incidents in which family members demanded to be present during their loved ones’ resuscitation, the Foote Hospital in Jackson, Michigan, established a structured program in which selected family members were allowed to be present for resuscitation at controlled times, providing entry into the study of FPDR and development of protocols to accomplish this task (4). During the study, a designated chaplain or support person from the emergency department stayed with the family throughout the process and even afterward, providing information and facilitating discussion. Families and members of the emergency department staff were surveyed retrospectively over a six month period. Forty seven family members of thirty patients responded to surveys, ninety four percent of the respondents said that they would want to go through FPDR again and two thirds believed that their presence had helped the patient, perhaps easing death (4). Thirty six of the forty seven family members believed that their presence in the resuscitation room had helped them adjust to the death and had been helpful with subsequent grieving (3, 4).

Additionally, the Advanced Cardiac Life Support Committee found no apparent difference in the success rate of resuscitation attempts according to whether family members were present or absent. During the first nine years of the program, there were no instances of actual interference with resuscitation activities, even in the few instances in which family members were overcome with grief (3). This finding further provides evidence that discredits the reasoning to exclude family from the resuscitation room due to inference related to the grieving process. In accordance with these findings, thirty percent of the twenty one staff members of the emergency department that responded to the survey reported that they had been hampered in their activities, mainly by anxiety.
about being observed or by concern about possible emotional or disruptive behavior on
the part of the family members, but these concerns, according to findings in this study,
proved unsubstantiated (4). The concern that family members would demand longer
efforts at resuscitation was also not a finding found in the Foote Study. Eleven percent of
the family members commented that too much had been done or that the patient may
have already been dead when they saw him or her (4). The Foote Hospital Study provided
the basis for much research that has been done since its completion.

*Parkland Health and Hospital System Study*

A study as the Parkland Health and Hospital System in Dallas, Texas was
conducted in the late 1990’s to evaluate family presence during emergency procedures.
Forty seven family members observed forty three interventions (nineteen resuscitation
procedures and twenty four emergency invasive procedures). Of the thirty nine family
members that were interviewed, all stated that it was important and helpful for them to be
present (3). During the study there were zero interruptions by family members in the
resuscitation process, even though many of the health care providers involved in the
study were concerned about family member interference (3). This finding directly
correlates to the Foote Hospital study’s results that family members did not pose a threat
of interference in regard to their presence during resuscitation. With another similar
finding, in the Parkland study, ninety five percent of the family members who were
present during resuscitation said that witnessing these efforts had helped them understand
that the patient’s condition was grave and that everything possible was being done to save
their loved one’s life (3). King et. Al. summarized the Parkland study’s findings further
stating, “Healthcare providers thought family presence was important in meeting family
members' (78%) and patients' (73%) emotional and spiritual needs, understanding the patient's condition (89%) and better appreciating what the health care team members had done for the patient (93%)” (9).

Further contradicting negative beliefs about FPDR, the Parkland study found that more than half (64%) of the health care team thought that family presence encouraged more professional behavior. A common finding among research studies (3, 4, 9, 1, 7, 17, 12, 24, 10, 19, 23, 26), nurses (95%) were more comfortable than residents (64%) with family member presence during resuscitation (9). After evaluating the findings of this study, in November 1999 the Parkland Health and Hospital System implemented a hospital wide protocol for family presence during resuscitation and invasive procedures (9).

*International Meeting of the American College of Chest Physician's Study*

This study had a substantially more negative view of family presence during resuscitation due to the fact that it was a six question questionnaire conducted amongst primarily, 494, physicians, with only 28 nurses and 21 other allied health professionals being represented (10). With initial recognition to the fact that those involved with this study were primarily physicians, with reference to the aforementioned finding that physicians typically rate FPDR more negatively than nurses, this study found that the majority of all healthcare professionals surveyed (78%) opposed family presence during resuscitation for adults (10). Three hundred and forty three of those surveyed had been involved with FPDR previously and of those, one hundred and thirty six (40%) would allow FPDR again (10). Of the 554 participants, 42% of those who had no previous resuscitation experience would allow FPDR (10). According to these finding, there is no
significant difference between those healthcare professionals with experience in regards to FPDR in comparison to those that lack experience.

Findings of specific interest in this study were the regional breakdown of responses for those that responded to the study’s questionnaire. Healthcare professionals in the Northeast section of the United States were found to be less likely, by this study, to allow FPDR for an adult or pediatric client compared to the rest of the nation (10). Those from the Midwest were the most likely to allow FPDR. The study went on to speculate that the unproven reason for these differences were attributed to the ten years of research by the Foote Hospital (Jackson, Michigan) staff that may have taken root in the Midwest, making FPDR more acceptable in that region (10). The main reason for not allowing family presence during resuscitation was a concern for the potential of psychological trauma that family members could experience. Additionally, fear of distraction of staff members was another main reason chosen to exclude family members (10).

A concurrent finding with many other inquiries, this study found that nurses were more likely to allow for FPDR than physicians (3, 4, 9, 1, 7, 17, 12, 24, 10, 19, 23, 26). Interestingly, this study attributed this finding to the fact that nurses’ decreased legal liability compared to physicians or because nursing students generally receive greater emphasis on patient-family dynamics during training than medical students do (10). Of the advocates for FPDR in this study, many recommended that FPDR only be allowed after all invasive lines and tubes, such as central venous catheters, arterial lines, and endotracheal tubes had been placed (13).
Emergency Department of Massachusetts General Hospital Study

The primary findings in this study were in regard to the negative views health care providers held on FPDR. Practice concerns, in this study, were similar for both nurses and physicians, with the greatest being concern for the patient’s family getting upset watching residents and with interfering with the teaching of residents (19). Nurses, however, again showed more positive attitudes toward family presence than physicians showed in both surveys conducted. Also of interest, the study found that nurses initially opposed to family presence had a change in attitude after witnessing the connection between the patient and the patient’s family and after establishing their own relationship with the patient’s family (19). This finding contributes to the thinking that if nurses work hard to create a family-centered focus to the care they provide, a possible increase in positive perceptions of FPDR and an increase in actual practice of this policy may be achieved.

Duran et. Al. Survey of Healthcare Providers, Patients’ Families, and Patients

Clinicians, patients; families, and patients in the emergency department, adult intensive care unit, and neonatal intensive care unit of a 300-bed urban academic hospital were surveyed in regard to their views of family presence during resuscitation. There were 202 health care workers involved: 98 nurses, 98 physicians, and 6 respiratory therapists. Nurses, again, displayed a more positive attitude toward FPDR than physicians (3, 4, 9, 1, 7, 17, 12, 24, 10, 19, 23, 26). The responses to the surveys did not differ significantly between the units (emergency department, ICU, and NICU). The majority (54%) supported FPDR and invasive procedures (69%) (24). Interestingly, there is a connection here between an increase in the support of FPDR and procedures of lower
acuity levels. Nurses favored policy development more than physicians, with 46% of physicians and a great majority (86%) of nurses viewing a family presence protocol favorably (24). The majority (66%) of health care providers surveyed felt a policy on FPDR was needed at their institution (24).

Twibell et. Al. Study on Nurses' Perceptions about FPDR

A sample of 375 nurses (regardless of education level obtained) was surveyed. This sample was representative of varying units within a Midwestern regional medical center, not limited to critical care areas. Findings indicated that slightly over one half of the sample agreed or strongly agreed that FPDR was a right both of patients and families (26). Certified nurses and members of professional organizations perceived greater benefit and less risk, and greater self confidence than non-members and non-certified nurses in regard to family presence during resuscitation (26). There were no differences related to FPDR between registered nurses with an associate’s degree, a baccalaureate degree, or an advanced nursing degree however, LPN’s perceived less benefit and greater risk when compared to all registered nurses (26). This finding is of interest due to the fact that regardless of the differing educational levels of registered nurses, they still hold a more positive perspective on family presence during resuscitation than licensed practical nurses do.

Additionally, the number of years experience or the nurse’s age was not related to perceived risk or benefit of FPDR (26). Nurses who worked in critical care settings did not differ in perceptions from nurses who worked in non-critical care inpatient units (26). Due to this fact, one could conclude that the training to become a registered nurse and membership in professional organizations could have more of an impact on a nurse’s
view of FPDR than any other factor. Groups of special interest, ER nurses and nurses in outpatient ambulatory settings perceived significantly lower risk and greater benefit of FPDR than the nurses of other units (26). The greater number of times nurses had invited FPDR, the greater their self confidence and the benefit perceived (26). Overall, findings from this study suggested that the profile of a nurse that is most likely to invite FPDR is an RN that is certified, possibly a member of a professional organization, and working in the emergency department (26).

*Professional Organizations that Endorse FPDR*

After many years of research, professional organizations and specific hospitals systems are creating policies and protocols to handle the issue of FPDR. The American Heart Association, in its 2000 Guidelines for Cardiopulmonary Resuscitation, recommended that the option of family presence during resuscitation be made available (3). According to these guidelines, “Parents or family members seldom ask if they can be present unless they have been encouraged to do so. Healthcare providers should offer the opportunity to family members whenever possible” (6). Although the AHA Guidelines do recommend family members be included, they do have their limitations because they do not describe when it is appropriate for family members to enter the resuscitation suite (10). In addition to the American Heart Association, the Emergency Nurses Association, the American Association of Critical-Care Nurses, the Emergency Medical Services for Children, and the National Association of Social Workers support family presence in their publications, resuscitation guidelines, and position statements (6, 7, 16, 18, 24).

However, even with all of this support, there is still significant discord about this topic, even among these organizations. Helmer et. Al. surveyed 1629 members of the
American Association for the Surgery of Trauma (AAST) and the Emergency Nurses Association (ENA) to determine the members’ opinions on family presence during trauma resuscitation and ENA members were significantly more open to family presence than AAST members (11). Both AAST and ENA members thought that the option of FPDR should be extended only after all invasive procedures were complete. Those surveyed in the Helmer et. Al. study also relayed they thought FPDR caused increased stress on staff (11). In a recent study of emergency and critical care nurses, researchers found that only 5% of hospitals had a policy on FPDR and only 27% of nurses were aware of the guidelines issued by the Emergency Nurses Association in 1995 (20). It is evident that the low awareness of policies made by organizations as well as the differing opinions between said entities could be a major cause of confusion and not only for members of those groups but also those not involved in these parties.

Allowing the Family in the Room

Prior to allowing a family to be present during resuscitation a nurse must discover her own feelings about death a loss. The entire team should also discuss their thoughts about having families present. There should be educational programs available that instruct on topics of crisis intervention, grief, and the grieving process because informed staff members may be more willing to support the notion of family presence during resuscitation (2). Twibell et. Al.’s study suggests that patients’ needs should be matched with nurses’ competency. The study states, “In order to optimize patient and family outcomes during resuscitation, nurses who are confident in their abilities in managing FPDR can be assigned to code teams and family care during resuscitations. Likewise, nurses who favor FPDR and are confident in the ability to manage family
presence may serve as role models for novice nurses, mentor experienced nurses, teach family presence at the bedside, serve efficiently on code teams, and lead change in units that do not practice FPDR” (26). Education will play an important role in regard to health care providers and their acceptance of formalized programs for family presence during resuscitation (3). As mentioned in the Twibell et. Al. study, nurses that are certified or that are members of professional organizations are more likely to invite family presence during resuscitation. In response to this finding, membership in professional organizations can be encouraged (26).

According to the findings of Knott and Kee, family presence during resuscitation depends on the conditions or circumstances surrounding the need for resuscitation (17). The suddenness of the event, the family’s medical knowledge, and the age of the patient all affected the nurses’ decisions to include the family. The nurses believed that each of the aforementioned factors affected the family’s coping skills (17). Guiding family members through the resuscitation process is integral if they are to witness resuscitative events. A variety of personnel, such as a volunteer, chaplain, social worker, or nurse, can act as a support person (21). Caring for the patient’s family should be the support person’s sole focus. The act of having a staff member focus on dual roles, as a member of the resuscitation team and as a support person for the patient’s family, is difficult (21). The support person/facilitator should assess the family’s readiness, tell them what to expect, drape the patient to minimize bloody areas if possible, escort the designated family member in to the treatment area, set limits, if the code team requests a family member to leave escort them out quickly, and should stay with the family afterward (2).
After family members have been present during resuscitation, debriefing should be offered as an option to family members. Debriefing offers a forum for families to express perceptions, questions, and fears about their loved one’s illness or injury and life-saving attempts they observed (7). Debriefing can provide further learning opportunities and a chance to reflect and develop confidence for staff members as well (26). A bereavement team to make follow-up phone calls or send condolence cards that include an offer for family conference if desired can also be considered (7).

Creating a Protocol

Many of the studies found that a way to universally state one’s stance (whether it be a small healthcare facility, large hospital system, or an entire professional organization) on FPDR is establishing a formal program (creating a protocol) for healthcare workers to adhere to (3, 2, 7, 17, 19, 21). Such programs should include an assessment to determine the family’s emotional and behavioral suitability and wishes, preparation of the family members for what they will witness, and support for them during and after the experience (3). According to the findings of the Knott and Kee study, “Having policies in place reduces the possibility of a decision based on individual staff’s personal opinions and experiences and provides guidance for the health care team when determining the feasibility of FPDR for each patient and family (17).

To create a protocol, one should start by assessing the attitudes and beliefs of staff nurses and physicians to find out under what circumstances they support- or do not support- family presence (7). A comprehensive literature search on the topic should be conducted and time should be set aside for frank discussion of issues with unit leaders and the multidisciplinary health care team (7). During this research process, consultations
with experts in the field who have successfully implemented a family presence policy or protocol should be arranged. Distribution of an informal survey or questionnaire about family presence to the staff should also be highly considered as a method of gathering information (7). If the general consensus is in favor of trying the family presence approach, the development of the family presence during resuscitation protocol can begin.

Laskowski-Jones et. Al.’s study makes many suggestions as to what the family presence during resuscitation protocol should include. The study suggests that the protocol should spell out circumstances that might preclude family presence. The option must be denied in any circumstance that would jeopardize the patient or the staff and should always take into account whether hospital security should be notified or not (7). Exclusion criteria, according to the Mian et. Al. study would be combativeness, agitation, extreme emotional instability, altered mental status, and intoxication. Family members that do wish to participate should be supported (19). The protocol should take into account cultural preferences. According to Laskowski-Jones et. Al., the protocol should assign staff member roles and responsibilities, making sure to have back-up personnel for this role if the designated support person is not available. The protocol should also define who will be called to provide continued family support if the patient is transported to another area (ex. Surgery) (7). Options for staff members opposed to family presence should also be defined in the protocol.

Writing scripted responses to common questions using everyday language should be considered (7). Mian et. Al (19) presents the following Sample Family Agreement Tool that the protocol could include for facilitators to utilize:
“Before we go into the treatment area we need to agree that:

- I will stay with you the entire time you are in the treatment area
- Because of the medical activity, you may only be able to stay a few minutes
- I will try to get you as close to “[patient’s name]” as possible
- You can leave any time you want, but as medical care is our priority, I will have to ask you to leave if there is any interference with the patient’s medical care.
- The medical team is always in charge of the treatment. I will explain the patient’s medical care when we are in the treatment area and I will answer all of your questions.
- We can only have one to two family members in the treatment area.”

By utilizing prepared responses such as the ones presented above, facilitators will be able to present information to family members in a concise way that will best inform the family and fit into the time constraints presented by the resuscitative process.

The protocol should also take into account infection control precautions. The protocol should answer the following questions: Should the family member be required to wear gloves, a gown, eye protection, etc. to prevent exposure to blood or body fluids? Where in the room should the family member stand and, when should they be given the opportunity to touch/communicate with the patient (7). Mian et. Al. suggests that the facilitator (staff member assigned to tend to the family) will be the one to define the role the family will play in the resuscitative suite to the family members. The study states,
"The facilitator will present the clinical situation, explaining what the family members can expect to observe during the patient's treatment. The facilitator will explain to the family that patient care is top priority, the time limitations, where family members may stand, situations in which they would be escorted out of the room, and reassurance that they may leave at any time. Family members must understand and agree to the structure of the visit prior to being allowed in the room" (19). Be prepared for a family member's unexpected reactions. Assertions to keep a chair close at hand if the family member feels faint and/or needs to sit down should be instituted in the protocol (7). Policies for debriefing of family members and staff, as well as staff follow-up post resuscitation (phone calls, etc) should also be outlined in the protocol. The protocol should also include provisions to facilitate prompt review and intervention by the risk manager if a legal issue arises during the resuscitation attempt (7).

After extensive research and development, the protocol should be sent for review by multidisciplinary team leader, the risk manager, and the hospital's attorney who can identify potential areas of liability (7). When finalized, multidisciplinary staff education is essential to promote a consistent approach to family presence. One educational program alone does not change practice (19). Ongoing educational strategies such as posters and nursing rounds are important reinforcement. Key strategies for practice change must continually be reinforced. A collaborative approach, facilitated role playing, nurse managers and physician directors valuing practice, developing a critical mass (in this case, nurses who saw the value of family presence and its benefits to families), and ongoing support and validation for staff were all successful strategies in
implementing a family presence program in the Mian et. Al study. Options should also be addressed to staff members who are uncomfortable with family presence.

**Methods**

*Sample, Setting, and Procedure*

Participants were (n=92) were registered nurses, licensed practicing nurses, and student nurses living in one Indiana county. Many were employed and interviewed at one Midwestern regional medical facility. Not one of the participants was working for a company that had a policy on family presence during resuscitation. Some of the facilities the nurses and students were employed or had clinical at routinely practiced family presence, while others did not. The only criteria to be included in the study were that the participants be at least 18 years of age or older, be able to read and speak English, and hold a nursing license or presently be in good standing at an accredited nursing school in Indiana.

The study was approved by an institutional review board. Nurses and students were informally interviewed, outside of the facility when they were not in the professional setting. Participation was voluntary and the qualitative data was kept confidential.

*Introduction and Questions formed*

A basic history into the debate of family presence during resuscitation as well as recent proposals for policy development regarding FPDR were introduced to those involved with the survey prior to being questioned. The following were the questions used to elicit responses from the sample:

A. What is your view of FPDR?
B. Have you ever been involved in any form of resuscitation in the past? (# of times involved if possible)

C. (If YES in response to question B) Have you invited families into the room to observe during resuscitation events?

D. (If YES or NO in response to question C) What helped you make the decision to allow/ not allow the family in the room?

E. (If answered NO in response to question B) Do you feel you would invite a family to observe their family member’s resuscitation if you were in that situation?

F. (In response to question E) Why or why not?

G. Have one of your family members ever had to undergo resuscitative procedures?

H. Were you able to/ did you want to observe?

I. (In response to question H) Why or why not?

J. (If YES to question H) Through your involvement having had watched one of your own family members undergo resuscitation, does this change your view as a (future) nurse?

K. (If NO to question G and H) If you had observed one of your own family members going through resuscitative procedures, do you feel that would change the way you view FPDR as a (future) nurse?

L. (In response to questions J and K) What makes you feel that it would/ would not change the way you view FPDR?
Demographic variables were measured by questions and observations that addressed gender, ethnicity, educational level, role as RN, LPN, or student, current professional certifications, and years of experience in the nursing field.

**Characteristics of the Sample**

A total of 92 nurses and student took part in the study. The sample was 91% female and over 92% Caucasian. There were 52 nurses total, two of which were licensed practicing nurses. Five of the nurses were from a Critical Care Unit or the Emergency Department, seven of the nurses were in a specialty field, upper level management, or had received a Master's Degree, five nurses were nursing instructors locally at the collegiate level, thirty one were nurses on inpatient units, three were nurses that were registry and floated throughout the hospital, and there was one home care nurse that was interviewed. Thirty one of the nurses (over 59%) had invited family presence during resuscitation at least once, 19 of those nurses (or over 36% of the population of nurses) had invited family presence more than five times. Thirty of the fifty two nurses (over 57%) held specialty certifications or were members of professional organizations. 39 of the 52 nurses (75%) had ten or more years experience as a nurse.

100% of the student nurses were working toward a degree as an RN. Seven of the student nurses (over 17%) were seeking a two year RN degree at a local community college; thirty three of the student nurses (over 82%) were seeking four year degrees at state schools, one of which was attending a four year program at a Christian college. Twelve of the forty students (30%) had experience with family presence at least once in their tenure studying nursing, not one had experienced this more than once.

**Summary of Findings**
Being that this survey was conducted in an informal, qualitative regard, much of the information collected included very personal stories and insights into the nursing field that are not often collected when administering a written survey or conducting formal interviews. All interviews were conducted outside of hospital and classroom settings via private meetings with those interviewed; after clocking out from a day’s work, during a lunch break, at scheduled meetings outside of the professional setting. After giving a brief summary to each nurse or student interviewed about the meaning of family presence during resuscitation and the current debate in the health care field regarding this issue, I then asked members of the sample to describe their view of FPDR. Twenty of the student nurses (50%) stated that they had not considered the issue of family presence in the past. They stated they had never thought about the necessity of them making a decision regarding FPDR and after being presented with the brief introduction to the issue were considering it as a major issue to contemplate for practice in the future. All of the nurses stated that they had considered the option of FPDR in practice.

89 of the 92 sampled (96%) viewed FPDR in a positive light. Many of the nurses shared feelings related to the family being just as important in the care of the client as the health care team, many expressing the family held an integral right to be in the room during any critical procedure if the client has given consent and the family member is of sound enough being to be present. Three sampled viewed FPDR in a negative light. Two men did not agree with family presence because they felt the family members would get in the way in the resuscitation suite and that FPDR would cause the staff to be distracted. The other person against FPDR was a nurse that had witnessed her own mother go through resuscitation and pass away, stating that she, even as a nurse, was unable to hold
on to the happy memories of her mother, but often remembered the chaos and sadness surrounding her death. This nurse stated that she did not ever want anyone to have to remember someone they cared about in this way, especially if they were not members of the health care field and did not have the medical knowledge she had entering into the resuscitation.

One factor that influenced those interviewed to invite FPDR was the view that it was the right of the family and the patient for family to be present at any point of the client’s care as long as the client had consented to the practice (even if consent was assumed). Additionally, one nurse stated, “This may be the last life experience the client goes through. If having their family member there makes them more comfortable, even in the slightest extent, I am all for extending the option to families. I know I would feel more comfortable to see someone I care about as the last person I interact with before I die, there to comfort me and make me feel loved, than to be all alone with members of the code team that I do not even know.” The findings of this study concur with past research in regard to the allowance of FPDR and educational level and professional organization involvement. All nurses that had a Master’s degree or higher, specialty training or were members of professional organizations (n=31) stated they would allow family presence during resuscitation which is slightly higher than the 96% of those surveyed overall that would allow FPDR. Three nurses sampled worked in the Emergency Department and one of these nurses was opposed to FPDR because they felt it interfered with optimal care of the client.

26 members of the sample (28%) of the sample had been present in a family member role during resuscitation. All of those interviewed that had been offered the
option of FPDR had accepted. Of those that had been involved in FPDR as a family member, all but one of those interviewed (96%) stated that it was a positive experience. These 25 people that had had positive experiences with FPDR stated it would affect their decision to allow for FPDR in a positive way. One student stated, "My father had a heart attack and I was able to watch the team of health care providers save his life. I watched them perform CPR, give him drugs, and execute many life saving procedures. It helped me to appreciate the care they had given him and helped me put a picture in my mind of all that my father had gone through in a much different light. After watching my father endure so much, my appreciation for his life, my own life, and love for all increased substantially. Being present in that room led me to want to be a nurse because it helped me see what a profound impact I could have on someone's life."

Of those that had not experienced holding the role themselves as a family member that was present during resuscitation (n=66), all of those interviewed said this would affect their view of FPDR but many were unsure what effect it would have. Many of those interviewed stated that if they were a family member present in the room, they did not know how they would view FPDR afterward. One nurse said, "If I had to watch my grandmother undergo CPR and she did not make it I would be left with that memory for the rest of my life. Although I would always remember her for what a great person she was, I could never forget all she went through prior to her passing. That would definitely affect my decision to allow FPDR because I would always weigh in the back of my mind the positives of being there for a person when they are taking their last breaths with the life altering effects it would have on me by experiencing it first hand. I would like to say that whatever experience I would have with FPDR would not affect my decision to allow
family presence for someone else, but now, considering the depth of the issue, I would struggle to say that it would not influence the decision in some way—whether it is positively or negatively.” Others interviewed stated that their theoretical presence as a family member during resuscitation would not impact their decision to allow for FPDR because being present during this time would allow them to be closer to their loved one and provide them with a final way to either support that person in life or death. They stated that this fact would lead them to want to be present as a family member and to allow for family presence regardless of the situation (as long as no interruption to patient care took place) because they could only see positive attributes to the practice of FPDR.

All of those interviewed stated they felt the development of a protocol or directive from patients in regard to family presence during resuscitation should be researched and implemented. They stated that by being informed of the debate surrounding FPDR and looking into the issue insightfully by viewing FPDR personally from a family member’s view, they felt it only right that some direction be given in regard to inviting/ not inviting family presence. Even the three members of the sample opposed to FPDR stated they felt it was important more research and policy development stem from the issue of FPDR.

**Limitations**

In interpreting the results of this survey with thought into future research, it is important to notice that this study could be improved. This study did not account for years of nursing experience, only in the different levels of educational attainment. This study is limited because it is qualitative in nature and therefore is dependent on nurse’s personal views and statements. Although much of this information can be correlated with one another, there is a greater diversity in answers that a type written survey or formally
conducted interview would have. Researchers in the future could administer written surveys with questions pertaining to healthcare team members experience with resuscitation in general, as the qualitative study did, instead of focusing solely on the professional resuscitative role. Many of those in the sample of this study suggested that future research should not only focus on the development of protocols for staff within the hospital but also on possibly including instructions for FPDR in advanced directives. Many stated that FPDR could become a notation in the directives just as Code, No Code, Chemical Code, etc. have become common terms in the medical profession.

Additionally, the limited ethnicity of those involved in this study as well as the geographic setting of the study restricts the ability to generalize these results. Greater than 92% of the participants in this study were Caucasian which did not accurately depict the ethnic composition of the region in which data collection occurred. Religious affiliation was not taken into account with this survey. There has not been research conducted in regard to nurses’ religious beliefs and their possible invitation to family presence. A study into a possible religious tie to the practice of FPDR should be conducted. Replication of this study, possibly combining a written survey and verbal interview, in other regions of the world with multi-ethnic and multiple religious backgrounds, as well as medical experience is recommended.

Implications

This study’s findings coincide with past research indicating that family presence is more likely to be invited by nurses with higher educational levels that hold memberships in professional organizations or certifications (26). The importance of this finding being upheld is related to the possible increased urging of nurses to become
members of professional organizations or certified in order to increase their likelihood to invite family presence during resuscitation.

Many of the nursing students interviewed (50%) had not ever considered the option of family presence during resuscitation. Upon introduction of the basic background of FPDR as well as current research findings suggesting development and implementation of protocols, all of these nursing students were stunned that had not even considered many of these options in the past. Many students suggested that while being taught the medical procedure CPR and involvement in a code team they were never thought to consider the psychosocial aspects that are involved with this process. Development of educational programs with a truly family-centered approach to care could increase the knowledge base and decision making abilities of nursing students in regard to FPDR.

Considerations of personal involvement in FPDR, especially with regard to that experience (even if theoretical) had not been conducted in the past. This study’s findings suggest that when one looks at the decision to involve family during resuscitation in a personal light, in reference to one of their own family members, opinions may change concerning the decision to allow for family presence during resuscitation. When allowing the family in the room, the nurse should always consider their own views on family presence, in a broad spectrum, including their own involvement in said practice (2, 3, 7, 17, 19, 26). This study suggests that while education and awareness into the medical and ethical issues surrounding FPDR are important and should be stressed to staff, introspection into one’s own experiences and beliefs is integral to the practice of FPDR in the health care field. Research into whether personal involvement in family presence
during resuscitation increases a nurse’s confidence in the practice of FPDR as a whole should be conducted as well.

In regards to future research, an investigation into how different questions can render drastically different responses concerning family presence during resuscitation should be conducted. The manner in which one asks a question; in a written survey, formal/ informal interview, in the health care facility, etc. can greatly affect responses the researcher will receive. Future research should be conducted through multiple venues and should include many open ended questions, in (in the ideal situation) an environment that allows for a thoughtful response that is not limited by time constraints. These questions should allow for personal reflection, and an educated insightful approach to a response by the nurse.

**Personal Reflections**

Upon initiating this study, I knew that I did not want to limit the questions I asked of nurses to those that had been asked in the past. When I first chose this topic for research I had not definitively collected research questions to ask the sample. The nurse I was with simply asked me about course work that I was involved in and I began to describe to her the study I had just arranged to become a part of. She sat patiently listening and I really was not expecting a response. I was under the impression I was just sharing information about my collegiate career when, after providing her with a background into the work I was preparing for, she immediately stated she would be opposed to the practice of FPDR. This statement was shocking to me because much of the information I had read stated that FPDR was widely viewed as a positive practice by nurses. I asked her why she felt that way and her response was what guided the rest of
my research: her own involvement, as a family member with FPDR. She stated that it was a memory that she wished she never would have had to make and felt there was no way she could subject any family to witnessing they loved one go through resuscitation, even if it was their wish. She stated she wanted to be in the room when her mother underwent resuscitation and this was now a vision that haunted her on a daily basis. My eyes were then open to the possible affects of a nurse (or nursing student) being affected by their own (even if theoretical) involvement as a family member with FPDR and how this could possibly affect their decision making process.

After this conversation, I set about to create a set of questions to utilize, even if not word for word, to informally interview the sample. I was sure to include past experience with FPDR, factors associated with decision making, actually taking part, as a family member in family presence during resuscitation, and if this involvement as a family member (even if abstract) could/ would affect future decisions as a nurse in the practice of FPDR. After development of questions I began interviewing everyone and anyone I knew associated with the nursing profession around me. Interviews would often turn into hour long conversations about family presence, it’s possible impact (positive or negative) on the client’s health care as a whole, impacts on family members involved, etc.

Many of the nurses and students had not stepped into a family members shoes and placed themselves as a family member watching their loved one go through resuscitation. It was riveting to watch those so opposed to family presence think about the issue in regard to their own family and begin to watch their viewpoints change. It was interesting to see those that were so adamant about inclusion of the family into the resuscitation
process suddenly become much more reserved when they thought about it in regard to their own family members. Through the research, I felt that I was not the only one benefiting from collecting participants’ responses but that I also created a new pathway for those involved in the study to introspectively consider the issue of FPDR themselves.

This study aided my discovery into how the research process truly works. As I have approached the end of this study it has been amazing to see the amount of research that goes into just completing a small qualitative research study such as this and gives me great appreciation for the studies that have been and will be done on this topic and others in the future. I learned a lot about myself, about my work ethic, about my views as a student, as a nurse, as a family member, and ultimately as a person. The study helped me to focus more on not only family-centered approach to research but also a family-centered approach to care as a future Registered Nurse. This research provided me with a culminating experience to my collegiate career, allowing me to interact with my peers and nurses in informal conversations that created bond between myself, those that I interviewed, and this topic that will last a lifetime.
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