

NURSES' KNOWLEDGE, PREFERENCES, PRACTICES, AND PERCEIVED
BARRIERS: FAMILY WITNESSED RESUSCITATION

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Chapter I

Introduction and Background

Emergency services are a major component of the healthcare system (Garcia, Bernstein, & Bush, 2010). The demand for emergency services in the United States (U.S.) continues to rise as the population increasingly uses the Emergency Department (ED) as the first stop to access care. Statistics show that 116.8 million visits to hospital EDs occurred in the U.S. during 2007 (Garcia et al., 2010). According to the Medical Expenditure Panel Survey (MEPS), the average cost for a visit to the Emergency Room was \$1,265 in 2008 (Agency for Healthcare Research and Quality, 2008).

EDs are available to provide a critical service to persons in need of immediate, often life-saving treatment, as well as other emergent needs (Garcia et al., 2010). The most common reason people seek treatment in the ED is for the abdominal pain (Niska, Bhuiya, & Xu, 2010). Some other common reasons people visit the ED include cough, back pain, headache, and other common ailments that could be resolved by seeing a physician in primary care (Niska et al., 2010).

A major type of an emergent visit to the ED is for cardiac alterations, including chest pain and cardiac arrest (Niska et al., 2010). Each year about 295,000 emergency medical services treat out-of-hospital cardiac arrests in the U. S. (American Heart

Association (AHA), 2011). Survival is directly linked to the amount of time between the onset of sudden cardiac arrest and cardiac resuscitation. Cardiac resuscitation is an emergency procedure consisting of external cardiac massage and artificial respiration. Cardiac resuscitation begins with CPR, and is followed by defibrillation as soon as it is available (American Heart Association (AHA), 2010). The purpose of CPR is to resuscitate patients who had sudden cardiac arrest, but were otherwise in good physiologic condition (Winslow, Beall, & Jacobson, 2001). Cardiac alterations are a legitimate reason to visit the ED.

CPR is one of the most frequently performed care interventions in the world. Approximately 30% to 40% of hospitalized patients who are dying undergo CPR. Studies show that there is a 15% worldwide average survival rate following CPR (Winslow et al., 2001). When a patient is experiencing cardiac arrest upon entering the ED, healthcare providers must work very quickly to increase chances of survival (AHA, 2010). The cardiac arrest team has traditionally not included family members (American Heart Association (AHA), 2005; Halm, 2005; Holzhauser & Finucane, 2007; Kingsnorth, O'Connell, Guzzetta, Edens, Atabaki, Mecherikunnel, & Brown, 2010; Madden & Condon, 2007).

Over the past decade, the practice of excluding relatives during cardiopulmonary resuscitation (CPR) has been questioned (Halm, 2005; Madden & Condon, 2007; Mazer, Cox, & Capon, 2006). National guidelines and professional organizations have recommended that healthcare professionals consider allowing family members to be present during resuscitation and invasive procedures (IPs) (American Association of Critical Care Nurses (AACN), 2010; Basol, Ohman, Simones, & Skillings, 2009; Halm,

2005; Mian, Warchel, Whitney, Fitzmaurice, & Tancredi, 2007). Supporters of family witnessed resuscitation (FWR) stress it is a basic human right of patients and patients' families to be present (Halm, 2005; Maxton, 2008).

Evidence is increasing that family presence during resuscitation and invasive procedures is beneficial to patients, families, and staff (AACN, 2010; Halm, 2005; Madden & Condon, 2007; McGahey-Oakland, Lieder, Young, & Jefferson, 2007; Mian et al., 2007). Meeting psychosocial needs in a time of crisis focuses on inclusion of patients and families in care (AACN, 2010). Resuscitation team members should be sensitive to the presence of family members during resuscitative efforts by assigning a staff member to the family to answer questions, clarify information, and offer comfort (AHA, 2005).

FWR is supported by many nursing and medical organizations, including the Emergency Nurses Association (ENA), and the American Heart Association (AHA). Organizations support the premise that FWR facilitates the grieving process of family members who witness resuscitation efforts, and encourage FWR in all emergency departments (Madden & Condon, 2007). Despite support by professional organizations and critical care experts, only 5% of critical care units in the U.S. have written policies allowing FWR. Surveys of nurses' practices have found that most nurses receive requests from family members to be present during resuscitation and invasive procedures. Further, nurses support FWR, despite the lack of formal hospital policies (AACN, 2010).

The ENA created guidelines for healthcare providers regarding FWR. The guidelines were developed to assist and support healthcare providers in making decisions about patients and families experiencing an invasive procedure or resuscitation event. In

the position statement regarding FWR, the ENA discussed the importance of having written guidelines. Without written policies or guidelines, healthcare providers may show inconsistencies in practice, and deprive patients and families of emotional support (Emergency Nurses Association (ENA), 2009). Although the guidelines were created, it was found in a recent study that only 27% of nurses were even aware the ENA had guidelines for FWR (Mian et al., 2007).

The American Association of Critical Care Nurses (AACN) provides expectations for nursing practice including:

Family members of all patients undergoing resuscitation and invasive procedures should be given the option of presence at the bedside, and all patient care units should have an approved written practice document for presenting the option of family presence during resuscitation and bedside invasive procedures (AACN, 2010, p. 1).

The expectations help guide nurses practices when confronted with a situation when FWR is an issue.

The development of formal guidelines to support the option of FWR allows for a consistent approach for nurses to support the needs of patients and families. Assessment of healthcare professionals' familiarity, comfort, attitudes, concerns, and beliefs about FWR provides important information to guide discussions, develop formal guidelines, and design strategies for guideline implementation (Basol et al., 2009; Madden & Condon, 2007; Mian et al., 2007). Further study is needed on nurses' knowledge and practice of FWR for policy development.

Background and Significance

FWR originated in Foote Hospital Emergency Room in Jackson Michigan in the 1980's, based on a critical incident. One relative refused to leave a family member while riding in the ambulance, and another begged to be with a husband who was a police officer who had been shot (Boehm, 2008). Staff allowed the family to be present, and found positive feedback from both family and staff regarding this experience. Consequently family members of patients that died in the ER were then surveyed to determine what family members perceived about FWR. Seventy-two percent had wanted to be present. This created an interest in FWR, collecting a growing body of evidence in support of FWR (Walker, 2008).

During the 1990's, research studies were conducted that assessed families' perspectives and benefits of FWR (Boehm, 2008; Halm, 2005). At the same time, other studies to evaluate healthcare providers' beliefs were conducted (Boehm, 2008). The studies supported FWR from professional organizations.

In 1993, the Emergency Nurses Association (ENA) adopted a resolution to support the option of having patients' families present during CPR and invasive procedures. An educational program for implementing this practice within organizations was created 2 years later by the ENA. Guidelines on family presence have been incorporated into the ENA curriculum for trauma nursing core courses and emergency pediatric courses (MacLean, Guzzetta, White, Fontaine, Eichhorn, Meyers, & Desy, 2003). The guidelines state "family member presence during invasive procedures or resuscitation should be offered as an option to appropriate family members and should be

based on written institution policy” (ENA, 2009, p. 5). The American Heart Association also recommends providers offer patients’ family members the choice of staying with the patient during resuscitation efforts (AHA, as cited in MacLean et al., 2003). The guidelines and recommendations provide the means for exploring the benefits and problems of FWR (Meyers et al., 2000).

Over time, the rights of patients have evolved to become more family centered. Families are requesting to stay with relatives during invasive procedures and resuscitation efforts. Public opinion polls have found that 50% to 96% of consumers believe family members should be offered the opportunity to be present during emergency procedures and at the time of death (AACN, 2010).

The movement to FWR has progressed because of the ongoing public demand from relatives to be present during resuscitation efforts, and an increasing body of knowledge about benefits from healthcare professionals. The benefits of FWR, to both patients and families, have been recognized as providing support, patient-family connectedness, bonding, and facilitating the grieving process (MacLean et al., 2003; Mian et al., 2007). Regardless of the benefits, the practice of FWR remains an ethical, moral, and legal dilemma.

It has been found in other studies that family presence reduces anxiety, eliminates doubts about the resuscitation, and facilitates grieving (AACN, 2010; Halm, 2005; Madden & Condon, 2007; McGahey-Oakland et al., 2007; Mian et al., 2007). For many family members, the resuscitation room becomes a final opportunity to see, talk to, or touch a loved one (Madden & Condon, 2007).

Other studies have shown that almost all children preferred to have parents present during stressful medical procedures, and that children believed that having parents present was the most advantageous intervention in managing Children's pain and anxiety (MacLean et al, 2003; McGahey-Oakland et al., 2007). Adult patients report having family present helped provide comfort, and reminded healthcare providers of the patient's personhood, and upheld the patient-family bond (MacLean et al., 2003).

Healthcare providers voiced concerns including: family interfering with the resuscitation process, undesirable psychological effects on the family, increased level of stress on the emergency team, lack of support for family members, and an increased risk of legal actions (Kingsnorth et al., 2010; Madden & Condon, 2007; MacLean et al., 2003; Mian et al., 2007). Despite concerns, research shows no unfavorable effects on patient outcomes or family experiences (MacLean et al., 2003).

Health care providers who have experience with family presence reported that having family present provided an opportunity to educate families about the patients' condition, facilitated family participation in patient care, reminded staff of the patient's personhood, encouraged professional behavior and conversations at the bedside, and helped in the bereavement process. It has also been found that family presence did not increase health care provider's anxiety. On the basis of studies showing the benefits of FWR for both family members and patients, it has been recommended that to meet the needs of patients and families, programs should be developed to offer patients' families the choice of being at the bedside (MacLean et al., 2003).

Recent research shows consumers believe that patients' family members want to be, and should be, present while emergency procedures are performed on the patient at

the time of death. According to Madden and Condon (2007) nearly all families involved in FWR make the choice to be present in FWR. Regardless of all the research and support for FWR, it is not a widespread practice (Madden & Condon, 2007). Opinions and attitudes of staff influence the degree to which family members are able to implement choice in FWR (Walker, 2008). Therefore research on knowledge and attitudes of staff on FWR is warranted.

Statement of Problem

Family witnessed resuscitation remains controversial, and nurses' preferences affect policy related to what occurs at the bedside. Family witnessed resuscitation (FWR) has been supported by some physicians and nurses, but is not yet a widespread practice. ED nurses play a major role in facilitating FWR. It is therefore important to understand nurses' knowledge about practices and benefits of FWR for policy development.

Purpose of Study

The purpose of this study is to identify emergency room nurses' knowledge, preferences, current practices, and perceived barriers in regards to FWR. This study is a replication of Madden and Condon's (2007) study.

Research Questions

1. What are nurses' knowledge, preferences, and practices regarding family presence during resuscitation?
2. What are the barriers and facilitators to permitting family presence during resuscitation?

Theoretical Framework

The Guidelines for family witnessed resuscitation developed by the Emergency Nurses Association (ENA) is the framework for this study. The guidelines assist and support healthcare providers in caring for patients and families experiencing a resuscitation event or invasive procedure. The guidelines state “family member presence during invasive procedures or resuscitation should be offered as an option to appropriate family members and should be based on written institution policy” (ENA, 2009, p. 5). This framework is appropriate for this study because the study addresses ENA guidelines.

Definition of Terms

Conceptual.

Nurses' Knowledge: Nurses' knowledge is the understanding that nurses have in relation to policies and procedures in current hospital setting (Madden & Condon, 2007).

Nurses' Preferences: Nurses' preferences include choice on policy development and implementation on unit and personal choice of participating in family presence (Madden & Condon, 2007).

Nurses' Practices: Nurses practice include the nurses' current actions taken when a resuscitation event occurs with the option of having family present (Madden & Condon, 2007).

Family Presence During Resuscitation: The presence of family members in the resuscitation room (Madden & Condon, 2007).

Barriers: Barriers include any event that causes conflict with or inhibits the presence of family during resuscitation (Madden & Condon, 2007).

Operational.

The Family Presence Survey (2002), developed by the ENA will be used to evaluate nurses knowledge, preferences, and practices, as well as barriers to FWR. The survey includes demographics questions and area to write the number of times have been involved in FWR (Madden & Condon, 2007).

Limitations

The sample size used in this study will be small, and be conducted in one geographical region. Nurses' experience with FWR will vary from few to many experiences.

Assumptions

1. Nurses have positive attitudes towards family presence during resuscitation.
2. Families want to attend the resuscitation process or invasive procedure of a family member.
3. FWR has positive benefits for family, including assisting with the grieving process.
4. The benefits of FWR outweigh the barriers.

Summary

Family witnessed resuscitation (FWR) has been supported by many physicians and nurses, but is not yet a widespread practice (Madden & Condon, 2007). FWR remains controversial, and nurses' preferences affect policy application related to what occurs at the bedside. The purpose of this study is to examine emergency room nurse's knowledge, preferences, current practices, and perceived barriers in regards to FWR. The Guidelines for family witnessed resuscitation from the Emergency Nurses Association

(ENA) is the framework. Findings will provide information for policy development addressing FWR and serve in development of an educational program for nurses working in the ED on policies. Policy will provide a foundation for practice.

Chapter 2

Literature Review

Introduction

Family witnessed resuscitation first emerged in the 1980's and has been a controversial topic for over 20 years. Health care professionals and families have many different opinions on family witnessed resuscitation. It is not a widespread practice. The purpose of this study is to identify emergency room nurse's knowledge, preferences, and current practices in regards to FWR. This is a replication of Madden and Condon's (2007) research.

Organization of the Literature

The literature is organized into four sections: (a) organizing framework; (b) meta analysis of FWR; (c) attitudes and practices of FWR: nurses' perceptions; nurses' and physicians perceptions; family perceptions; nurse, physician and family; general public; intervention program.

Organizing Framework

The Guidelines for family witnessed resuscitation from the Emergency Nurses Association (ENA) (2009) is the framework for this study. The guidelines were developed to assist and support health care providers in caring for patients and families experiencing an invasive procedure or resuscitation event. In the position statement

regarding FWR the ENA discusses the importance of guidelines. Without written policies or guidelines health care providers may show inconsistencies in practice and may be depriving patients and families of needed emotional support.

The guidelines in the position statement were created based on a review of literature between 2005 and 2009. Standardized worksheets, including Evidence-Appraisal Table Template, Critique Worksheet and AGREE Work Sheet, were used to prepare tables of evidence ranking each article in terms of the level of evidence, quality of evidence, and relevance and applicability to practice. Clinical findings and levels of recommendations regarding patient management were then made by the Clinical Guidelines Committee according to the ENA's classification of levels of recommendation for practice (ENA, 2009).

Results from the studies that included health care providers' opinions indicated support for family presence during invasive procedures and resuscitation. Common themes were also found throughout the research. The most common theme was health care providers approved of family presence and believed it helped the family see the efforts of the resuscitation team and that everything that could have been done, had been done. This may help lower the risk of legal issues surrounding the resuscitation or procedure. Another theme was that health care professionals believed family presence was a positive experience, and that it humanized the patient and supported patient dignity. Many studies showed that health care professionals believed having family members present improved communications and aided education. The final theme from health care professionals was that it assisted the grief process when a loved one was lost.

It gave family members the chance to say good-bye, and facilitated families' acceptance of a death of a loved one (ENA, 2009).

Other studies showed resistance to FWR. Common reasons for the resistance include: the possibility of families interfering or disrupting care, increased performance anxiety and stress on the part of clinicians, increased difficulty with the process of teaching, the possibility that witnessing the event may be too traumatic for families, and misunderstanding of procedures and process which increases the risk of legal issues (ENA, 2009). Many healthcare providers believed the reasons were enough to prevent staff from having family present during resuscitation.

Another finding showed little effect on the care provided while families were present during an invasive procedure or resuscitation event. It was also found that staff preferred having a written policy to provide guidelines and support for staff members in a situation involving FWR.

From findings the ENA developed the following guidelines:

1. There is some evidence that patients would prefer to have their family members present during resuscitation.
2. There is strong evidence that family members wish to be offered the option to be present during invasive procedures and resuscitation of a family member.
3. There is little or no evidence to indicate that the practice of family member presence is detrimental to the patient, the family or the health care team.
4. There is evidence that family member presence does not interfere with patient care during invasive procedures or resuscitation.

5. There is evidence that health care professionals support the presence of a designated health care professional assigned to present family members to provide explanation and comfort.
6. There is some evidence that a policy regarding family member presence provides structure and support to health care professionals involved in this practice.
7. Family member presence during invasive procedures or resuscitation should be offered as an option to appropriate family members and should be based on written institution policy (Level B) (ENA, 2009, p. 5).

The ENA also provides levels of recommendations. This recommendation, which is a level B recommendation, is considered a moderate recommendation. This means there are some minor inconsistencies in quality evidence, but has relevance and applicability to emergency nursing practice and is likely to be beneficial (ENA, 2009). This recommendation can help guide healthcare providers in practice with family presence.

Meta-Analysis of FWR

Research studies involving family witnessed resuscitation have aided in the development of clinical guidelines. The purpose of Walker's (2008) literature review was to describe emergency staffs' opinions on the positive and negative effects of family presence during adult resuscitation (Walker, 2008).

Twenty-three studies were identified for review, but five were removed due to not meeting all inclusion criteria. Eighteen studies were included in the literature review. Fifteen of the studies focused on family presence during adult resuscitation. Fifteen of

the studies used a quantitative survey design. Seventeen studies focused on the secondary environment of care. Studies took place in the USA (8), UK (5), Australia (1), South Africa (1), Sweden (1), Singapore (1), and Turkey (1) (Walker, 2008).

An electronic search of studies listed in ScienceDirect, CINAHL, Medline, EMBASE, psychINFO, and BNI database was conducted to find studies. Terms used in the search included resuscitation, witnessed resuscitation (WR), FP, relatives' presence, attitudes and opinions and A&E. The search was limited to publications between 1987 and 2007, written in English. Studies were included if emergency healthcare staff were in the target group, the study investigated the attitudes and opinions of emergency healthcare staff based in primary or secondary care environments, and focused on family or relatives' presence during an adult resuscitation attempt (Walker, 2008).

Findings were presented in themes including: seminal research, effects on the resuscitation team, effects on the resuscitation event, effects on family members, and factors influencing A&E staff opinion. Seminal research into family presence during adult resuscitation was conducted. This survey research found that 72% of families would like to be present during resuscitation. Another survey involving staff members revealed 81% had experienced family presence, and 71% endorsed it. Staff members also found the experience humanizing and workable experience (Walker, 2008).

Findings regarding the effects on the resuscitation team were broken down into categories including: inhibition of staff performance, increase in staff stress, legal repercussions, and complaints from relatives. Staff performance was a concern in studies including: the ability to train new staff with family present, staff being intimidated by family, and concern about the health care providers' well being. Although some health

care providers believed family presence was beneficial to the family, staff showed little support for family members witnessing resuscitation, and few providers regarded presence as appropriate (Walker, 2008).

An increase in staff stress was also addressed. One study showed healthcare providers who had personal experience with family presence felt extra pressure or stress. Another study found this was one of the main reasons for doctors and nurses not wanting family to be present. Another reason for resistance of family presence included the possibility of verbal and physical abuse. Another study found no “significant” differences in the stress level whether family were present or not (Walker, 2008).

Legal repercussions were also a concern among ED staff. This is another reason for staff reluctance to engage in FWR. One study found the majority of respondents believed FWR was inappropriate at all times. Another study showed 74% of respondents viewed the FWR experience as negative, and believed that it would expose caregivers to a greater risk of malpractice suits. Health care providers also raised a concern that families would be more likely to complain if families were present during a resuscitation event. Relatives might believe that: not enough, or too much was done, the resuscitation process was stopped too soon, inappropriate remarks were made by the staff, and staff didn't have caring attitudes. Staff also believed the family may not be satisfied with the experience because there is a lack of appropriate understanding of the process (Walker, 2008).

Findings regarding effects on the resuscitation event were broken down into categories including: adverse effects on the resuscitation process, safety of environment, and abandoning a resuscitation event. A major reason that health care providers have

been resistant to FWR is the fear of relatives adversely affecting the resuscitation procedures. Fears included: family interfering with or obstructing resuscitation efforts, and that the resuscitation attempt might be less effective. Safety of the environment, including the patient, relatives, and staff, was also a concern. The main concern in regards to the environment was inadequate space. Studies also found that abandoning a resuscitation event would be difficult with family present. This is another important reason for resisting FWR. A high percentage of EMS providers had experienced situations in which family members wanted resuscitation to continue even when it was deemed futile (Walker, 2008).

Findings regarding the effects on family members were categorized as psychological effects, facilitating communication, understanding, and accepting death. The majority of health care providers believed the psychological stress on the family was an important reason to resistant FWR. Witnessing a resuscitation event would be stressful, and could cause post traumatic stress and flashbacks. The majority of physicians would never advise a family member to be present during a resuscitation event. In regards to family communications, understanding, and acceptance of death, family members believed being present helped to accept the outcome of the resuscitation more gradually, and facilitated understanding that everything possible was done. The opportunity to touch or talk to the patient was also helpful for family (Walker, 2008).

Findings for factors influencing emergency staff opinion were described as preparation and support for family members, experience of FP during resuscitation, and staff training. Staff believed it was important for family to have support available when witnessing a resuscitation event. In regards to the experience of FP, staff believed

impairment of functioning was not an issue. Staff that had experience with FWR were more likely to favor it. In regards to staff training, it was found that the higher the level of the staff trainer, the higher the rate of endorsement of FWR (Walker, 2008).

The author concluded there are both positive and negative effects of FWR, but opinions show there are more risks than benefits. More nursing than medical staff are supportive of the practice. Preparation and support of family, as well as staff education, can change staffs' views of FWR (Walker, 2008).

Attitudes and Practices of FWR

Nurses' Perceptions.

The presence of family members in the resuscitation room is a controversial issue, and the subject of discussion and publicity in more recent times. This is an especially urgent issue when considering the severity of patients' conditions in emergency departments. Hallgrimsdottir (2000) conducted a study to explore the perceptions' and experiences' of nurses caring for families of critically ill patients and suddenly bereaved families.

The authors used a non-probability convenience sample. The criteria for eligibility included registered nurses in one of three predetermined accident and emergency departments. All nurses in the departments were invited to participate. A total of 108 questionnaires were distributed, and 54 (50%) were returned. Seventy-three percent were staff nurses, 13% were charge nurses, and 9% were enrolled nurses. Eleven percent of nurses had less than 5 years experience working as a nurse. Fifty-five percent had 5-15 years experience working as a nurse, and 29% had greater than 15 years experience working as a nurse. Thirty-seven percent had less than 5 years experience

working in an accident or emergency department. Forty-two percent had 5-25 years experience in an accident or emergency department, and 16% had greater than 15 years experience in this area (Hallgrimsdottir, 2000).

A questionnaire included four sections: general views and experience, resuscitation, bereavement, and classification of data regarding nurses' level of education, work experience, and nursing position. The questionnaire included 49 closed questions and 15 open ended questions. A 1-5 response set was used in the Likert scale. A pilot study was conducted to establish reliability and validity. The questionnaire was also evaluated for content validity (Hallgrimsdottir, 2000).

Findings for the first question related to perceptions of caring for families, were that 96% of participants viewed caring for a patients' family as a nurse's duty. Nurses believed it was important to patients that family be taken care of. Only 30% of participants did not believe that the nurse responsible for the care of the patient was also responsible for the care of the family. Information, reassurance, and support were stated as the most important needs of families. Only 15% of participants viewed "the need to stay near," as one of the most important needs of families. Thirty-five percent of participants' practices was evidence based, and only 30% used nursing models as a framework for practice (Hallgrimsdottir, 2000).

Findings regarding the second question related to nurses' preparations of caring for families, were that 44% of participants did not receive adequate education to meet the psychosocial needs of families. Seventy-two percent of participants found it stressful to deal with distressed families, and 48% felt in need of emotional support. About 54% of participants did not have access to emotional support at work. Sixty-one percent relied

on colleagues to deal with emotionally distressful situations, and 28% relied on family and friends (Hallgrimsdottir, 2000).

Findings from the third question, regarding involving families in care, were 71% believed there should be a clear hospital policy regarding the presence of family during resuscitation. Eighty-percent of participants believed a qualified staff member should stay with families during resuscitation. Only 13% believed families should be invited to be present during resuscitation. However, 48% were unsure about whether families should be allowed to be present during resuscitation if the family requested this (Hallgrimsdottir, 2000).

Findings from the final question, regarding evaluation of care for families, were 39% of participants have experienced family members' presence during resuscitation. Many described it as a stressful situation for nurses, other staff members, and for families. A few nurses were unable to provide sufficient support to the family due to the involved duties with the patient. Fifteen percent of participants described family presence as a reassuring experience for families. Families were able to see what was happening, and were given explanations of what was being done for the patient (Hallgrimsdottir, 2000).

In regards to bereavement, it was found that participants considered it important for families to have a comfortable area close to the patient location. Fifty-four percent of participants stated training in bereavement care was offered by the workplace, but 56% expressed a wish for a follow up program to the bereavement training. Eighty percent believed that the most difficult part of caring for families was caring for bereaved

families, and 72% believed staffing shortages gave inadequate time to care for families (Hallgrimsdottir, 2000).

Conclusions were that caring for the family was part of nurses' responsibilities, but it was very stressful during a resuscitation situation. The authors believed there should be a designated staff member to stay with the family during the resuscitation process. Most nurses were not comfortable, or fully prepared, to care for families during the resuscitation process (Hallgrimsdottir, 2000).

There has been an increase in the number of family members who want to be present during CPR and invasive procedures, but little is known about the practices of nurses. The purpose of MacLean et al.'s (2003) study was to identify nurses' attitudes and practices regarding family witnessed resuscitation, as well as presence during invasive procedures, in emergency departments and critical care units.

A random sample of 3,000 nurses that were members of the American Association of Critical Care Nurses, or the Emergency Nurses Association, was recruited. A total of 984 (33%) surveys were returned, 473 critical care nurses, 456 emergency nurses, and 55 nurses who practiced in both areas or did not specify. Nurses practiced in all 50 states and the District of Columbia. The mean age was 42 years. Ninety percent of respondents were women, and 50% held baccalaureate degrees. Seventy-four percent of respondents had greater than 10 years experience. Seventy-four percent worked full time, and 80% were staff nurses. Seventy-eight percent of respondents spent more than 75% of time performing direct patient care, and 56% worked with both children and adults. Prior to the research, the survey was piloted 4 times with 113 emergency and critical care nurses (Maclean et al., 2003).

A 30 item survey was developed for this study by MacLean et al. (2003). Twenty questions identified demographic characteristics of the respondents. Nine questions asked participants to identify practices, preferences, and hospital policies related to family presence during CPR and invasive procedures. The final question was open ended, and offered participants a chance to write any further comments. Validity of the tool was established through the use of a national panel of seven experts who rated the relevance and clarity of the survey. All seven experts found the survey to be reliable in measuring family presence practices. Several questions were revised after the panel, though none were deleted (MacLean et al., 2003).

Findings indicated only 5% of respondents worked on units in which a written policy regarding family presence during CPR or invasive procedures was present. Although written policies were not present on all the units, 45% allowed family presence during CPR, and 51% during invasive procedures. Twenty-five percent of nurses reported family presence was prohibited during CPR or invasive procedures. Nurses (37%) preferred a written policy regarding the option of family presence during CPR, and 35% during invasive procedures. Nurses (39%) wanted to have the option to have the family present during CPR, but did not want a written policy. Nurses (41%) wanted the option of family presence during invasive procedures, but did not want a written policy. Nurses (36%) brought a family member to the bedside during CPR in the past year. Nurses (18%) had not taken the family to the bedside during an invasive procedure, but would if the opportunity arose. A greater percentage of respondents that preferred a policy allowing family presence had experience taking families to the bedside during CPR or invasive procedures. Nurses (31%) stated families have asked to come to the

bedside during CPR, and 61% of nurses stated families have requested to be present during invasive procedures. Nurses (44%) made comments regarding the benefits of family presence during CPR or invasive procedures (MacLean et al., 2003).

Approximately half of the respondents worked on units in which family presence was permitted, and more than half have or would bring a family member to the bedside during CPR or an invasive procedure (MacLean et al., 2003).

Conclusions were that many nursing units do not have a policy in regards to family presence during CPR or invasive procedures, but nurses prefer family presence be permitted. After reviewing the findings, MacLean et al. also concluded there are many benefits to family presence during CPR and invasive procedures. Nurses working in critical care and emergency units should consider implementing a policy. The policies can help meet the needs of families and provide safe, consistent practices (MacLean et al., 2003).

Family witnessed resuscitation (FWR) has been supported by the Royal College of Nursing, but FWR is not yet a widespread practice. Madden and Condon (2007) conducted a study to identify emergency room nurse's knowledge, preferences, and current practices in regards to FWR (Madden & Condon, 2007).

This study took place in Ireland at Cork University Hospital. The convenience sample included 100 emergency room nurses practicing in a large, level one trauma center. Nurses had at least 6 months experience in this trauma center. Out of the 100 questionnaires dispersed, 90 (90%) of surveys were completed. Madden and Condon (2007) provided the following demographical data respondents: (83%) were females; in the 30-40 year age group; and the majority were staff nurses (80%). Also provided was

data related to positions held by the participants, 16.7% were clinical nurse managers, and 3.3% were other positions (Madden & Condon, 2007).

A questionnaire with 15 close ended questions was developed based on a previous study conducted by the Emergency Nurses Association (ENA). The questionnaire had four sections. The first section identified the demographic information of the sample. The second section investigated nurses' knowledge of both policy and practices related to FWR. The third section addressed nurses' preferences about policies related to FWR. The final section identified perceived barriers and facilitators to FWR. Validity had previously been established for the questionnaire by the ENA. To further increase reliability, a pilot study was conducted at a separate emergency room with 10 nurses. This resulted in two changes to the questionnaire establishing reliability (Madden & Condon, 2007).

Findings concerning nurses' knowledge of policies related to FWR were that 65% of the nurses believed that no policy currently existed at the facility. Determining the emergency room nurses' preferences and practices was the second objective. It was found that 58.9% of the nurses had taken family members to the bedside during resuscitation. Another 17.8% had never had the opportunity to do so, but would have. In regards to the preferences, 74% of the nurses wanted a policy to allow family members the option to witness resuscitation. Another 20% thought that families should have the option, but did not want a policy. A small group thought FWR should not be allowed, with 2.2% wanted a policy to state this. Finally, barriers and facilitators to permitting family presence during CPR were evaluated. Responses regarding barriers indicated 80% believed FWR would cause conflict within the resuscitation team, 50% believed it would

increase the stress on the resuscitation team, 39% feared legal action, and 27% thought family members could interfere with the process of resuscitation. Responses regarding facilitators indicated 96.6% believed a better understanding of the benefits of FWR would be helpful, 94% believed agreement among the resuscitation team would be helpful, 88% believed a written policy would be helpful (Madden & Condon, 2007).

Conclusions were that nurses had positive attitudes regarding FWR. There is a need for policies addressing FWR, and in developing education, include an understanding of the benefits of FWR. Madden et al. (2007) had two other conclusions. First, written policy development related to FWR is needed in clinical settings. Secondly, further education is needed related to FWR both in orientation of staff, as well as ongoing education (Madden & Condon, 2007).

Nurses' and Physicians' Perceptions.

The American Heart Association (2005) guideline for emergency cardiovascular care, and cardiopulmonary resuscitation encourage family witnessed resuscitation, and recommend that family presence be allowed during CPR. McClenathan, Torrington, and Uyehara (2002) conducted a study to assess health care professionals' opinions on family witnessed resuscitation, and whether guidelines are supported (McClenathan, Torrington, & Uyehara, 2002).

This study took place in San Francisco, California at the International Meeting of the American College of Chest Physicians (ACCP). All attendees who walked through the main ACCP booth were offered the opportunity to complete the survey. Attendees included physicians, nurses, and allied health care professionals. Physicians made up 91% of the 543 participants that listed an occupation. Twenty-eight (5%) were nurses,

and 21 (4%) were allied health care workers. Seventy-one percent of the physicians surveyed were male. Physician specialties included: 388 pulmonary, 283 critical care, 20 pediatrics, 19 cardiothoracic, 18 surgery, 9 cardiology, 5 allergy, and 26 were other specialties. The mean age of participants was 43 years. Eleven years was the average number of years since the completion of training, although the number of years since training did not influence opinions on family witnessed resuscitation (McClenathan et al., 2002).

The survey to determine health care professionals' opinions on family witnessed resuscitation included six questions addressing CPR experience, opinions on family member presence, and demographical data. The survey was not rigorously controlled (McClenathan et al., 2002).

Findings from the 554 surveys analyzed showed 78% of all the health care professionals were against family witnessed resuscitation of adults, and 85% against witnessed resuscitation of children. Only 14% of physicians would allow family present during a child's resuscitation, compared to 20% during an adult resuscitation (McClenathan et al., 2002). This same trend continued with nurses. Only 17% of nurses would encourage family presence during resuscitation with children, compared to 43% with adults (McClenathan et al., 2002).

Healthcare professionals practicing in the northeast United States were less likely to allow family presence during an adult or pediatric resuscitation, compared with the rest of the nation. Health care providers from the Midwest (37%) were more likely to allow family presence during resuscitation of an adult and child than providers from the rest of the nation. Twenty-two percent of the participants that had previous experience with

resuscitation would allow family presence during an adult resuscitation. Forty-two percent with no previous resuscitation experience would allow family presence during resuscitation. Fifty-nine participants had previously been involved in family witnessed resuscitation, and 40% would allow family presence again. Seventy-nine percent that disapproved of family presence believed the main reason was due to the psychological trauma to the family witnessing the resuscitation. Other reasons included legal concerns (24%), and performance anxiety affecting the CPR team (27%) (McClenathan et al., 2002).

Conclusions were that the majority of the health care professionals do not support the current recommendations provided by the American Heart Association.

McClenathan et al. speculated the reason for the attitudes towards family presence may be related to the fact that physicians have the ultimate responsibility for the outcomes of the resuscitation effort. The authors encouraged a widespread study of family witnessed resuscitation prior to implementation of the recommendations (McClenathan et al., 2002).

Families' Perceptions.

Families are participating in the resuscitation process more often, including families of pediatric patients. The purpose of McGahey-Oakland et al.'s (2007) study was to describe experiences of family members with children undergoing resuscitation events, identify critical information about family experiences, and to assess mental and health functioning of family members.

The study took place in the ED of a large pediatric tertiary hospital in Houston Texas. The sample included family members of pediatric patients who required resuscitation over a 1 year period. Families were English or Spanish speaking. Twenty-

five family members qualified for the study. Of the 25 qualified, 10 family members were interviewed. Nine declined due to lack of emotional readiness. Family members who participated included seven mothers, two fathers, and one great grandmother. Seven of the family members were present during the resuscitation effort. Family members' ages ranged from 23-63 years, and childrens' ages ranged from 3 months to 10 years. Three children had chronic illnesses, and seven had an acute life-threatening event. All 10 children died following the resuscitation event (McGahey-Oakland et al., 2007).

Several different methods were used to collect data. The first tool was the Parkland Family Presence During Resuscitation/Invasive Procedures Unabridged Family Survey. This questionnaire is a 32-item family survey with 10 demographical items, and 22 open-ended questions regarding family presence. This survey was previously validated and considered reliable. The second questionnaire was the Family Presence Attitude Scale, that consists of 15 items rated on a Likert scale. This questionnaire assesses attitudes, problems, and benefits of family presence. Three different measures were used to assess psychological and mental health status including: The Brief Symptom Inventory, The Short Form Health Survey, and The Post Traumatic Stress Disorder. Interviews were also conducted with family members (McGahey-Oakland et al., 2007).

Findings from the quantitative analysis showed all family members expressed the importance of the option to be present during resuscitation. The Family Presence Attitude Scale showed support for family presence. The tools used to assess psychological and mental health revealed higher stress levels but the absence of traumatic stress (McGahey-Oakland et al., 2007).

Findings from interviews revealed that, whether family members were present or not, individuals expressed the importance of being present during resuscitation. Findings also revealed five themes regarding parents' reactions and concerns. The first theme was "It's My Right to Be There." All 10 family members believed it was a right and responsibility to be with the child. Family members believed presence was crucial in all aspects of the child's life, and resuscitation was no exception. Family members would recommend family presence to others, and if presence would be detrimental to the child, would leave if asked (McGahey-Oakland et al., 2007).

The second theme was "connection and comfort makes a difference." Family members believed the child wanted parents present, and that it provided strength for the child. Being present during the resuscitation gave family the opportunity to give the child permission to die. Not only is presence helpful to the child, but the physical connection facilitated healing for the family member (McGahey-Oakland et al., 2007).

The third theme was "seeing is believing." Family members that were present during resuscitation were reassured that all possible options to help the child were implemented, and that being with the child during this process helped provide closure. Family members who were not able to be present wondered if the outcome would have been different if present. Many family members began the process of accepting the child's death while being present during the resuscitation. This allowed the family to realize the child was not coming back; the family was grateful to spend the final moments with the child (McGahey-Oakland et al., 2007).

The fourth theme was "getting in." Family members' physical locations during the resuscitation process varied. Some family members who were not present were either

traveling to the hospital, or asked to wait outside. Family members believed this was the longest few minutes of life. Other family members were invited to be in the room. The family members of chronically ill children knew the system, and insisted on being present (McGahey-Oakland et al., 2007).

The final theme was “information giving.” None of the family members involved in the study felt prepared to face the event of resuscitation. During the resuscitation effort, family members focused on the child, and not the process of the resuscitation. This made the timing for information from the health care team critical. Family members also believed it would be helpful to have a family facilitator to answer questions and explain things when requested (McGahey-Oakland et al., 2007).

Conclusions were that there are many common concerns about experiences among family members of pediatric patients undergoing resuscitation. The authors concluded that family members have a right to be present, and family should be connected with the patient. However, family members should not get in the way, or interfere with the care of the child (McGahey-Oakland et al., 2007).

Few studies have asked parents of children in the PICU to express experiences of being present or absent during the resuscitation of a child, and how this affects coping and understanding. Maxton (2008) conducted a study to provide in-depth understanding of the meaning for parents of presence or absence during resuscitation of a child in the PICU.

This study was conducted on a 20-bed PICU within a tertiary referral pediatric metropolitan hospital in Australia. This unit housed children ages newborn to 16 years with many different conditions. During the study, the unit policy was to offer the parents

the option to be present during the resuscitation with support. The policy was not always followed. Purposive sampling was used to select parents of children who had been admitted to the PICU and required CPR. Eight parent couples were recruited, and two parent couples declined. There were children who survived, and children who did not. At least one parent from each couple was present during the resuscitation effort, and the parent that was not present was either prevented by staff, or was not in the hospital at the time of resuscitation. The children ranged between 6 months and 5 years (Maxton, 2008).

This author used a hermeneutic phenomenological approach (van Manen). Data were collected using in-depth, unstructured interviews conducted with either one or both parents, for a total of eight separate interviews. Interviews were audio-taped and transcribed verbatim. The interviews were approximately 90 minutes long, and performed in a private setting. Parents were given debriefing time (Maxton, 2008).

Finding revealed four themes that explained the parents' experiences. The first theme was "being only for a child." "Being there for the child," by providing comfort and support, was a need for parents. The second theme was "making sense of a living nightmare." Parents needed to see what happened during the resuscitation to understand the efforts to save the child. The third theme was "maintaining hope in the face of reality." Maintaining hope and being positive throughout the resuscitation provided a positive coping mechanism for the parent. The final theme was "living in a relationship with staff." Parents sought physical and emotional support from different sources, including other family members and staff (Maxton, 2008, p. 3170).

There was a great need for parents to choose to be present during a child's resuscitation to help make sense of the situation. Parents' distress was based more on the possibility of losing a child rather than the resuscitation scene. The authors concluded that parents not present during the child's resuscitation could be more distressed than parents who were. Parents need a support person who can provide technical information during the resuscitation process as opposed to spiritual council. Intuitive nurses best fulfilled this role (Maxton, 2008).

The standard practice in most emergency departments is to allow family to be present during emergency procedure, but it is estimated only 5% of emergency departments have a written policy regarding FWR. The purpose of Kingsnorth et al.'s (2010) study was to determine the feasibility of implementing a family presence policy and procedure during trauma team activations and medical resuscitations based on national guidelines, and determine the feasibility of this practice to ensure appropriate family behavior and uninterrupted patient care (Kingsnorth et al., 2010).

This study took place in a level one pediatric trauma center in the mid-Atlantic region. The first 100 families that experienced a resuscitation event were eligible for inclusion in the study. One hundred-six family presence events were evaluated, but 10 events were excluded for various reasons. Seventy-two percent of families were involved during trauma activations, and 28% during medical resuscitations (Kingsnorth et al., 2010).

Families were evaluated by the family presence facilitator using the Family Presence tool. The tool addressed demographic data, such as the type of event, number of family members present, and relationship of family members. Issues also addressed

were questions for staff regarding the feasibility of implementing the steps in the family presence intervention while ensuring patient safety. Emergency room staff were educated on the implementation of the policy and procedure and the EBP project (Kingsnorth, et al., 2010).

The authors found from the demographical data that 90% of families arrived in the emergency department at the same time as the child, and 96% were screened for family presence prior to entering the room. All families requested to be present. Ninety-two percent of families were prepared for family presence prior to entering the room, but 8% went into the room immediately without any preparation because the family presence facilitator was not present. Mothers (74%) were the most common family member present, with fathers (28%) following. While in the room, the families were evaluated by the family presence facilitator. Fifty-three percent were quiet, 33% anxious but cooperative, 17% distracted but able to follow directions, and 14% distressed and crying but consolable. One family member became overwhelmed with the situation and asked to leave the room. Patient care was never interrupted by a family member, and patient safety was maintained at all times. The authors found it was feasible to implement a family presence intervention while ensuring patient safety (Kingsnorth et al., 2010).

The authors concluded steps should be taken to implement a family presence intervention. The intervention should be developed to protect patient safety by ensuring uninterrupted patient care (Kingsnorth, et al., 2010).

Nurse, Physician, and Families' Perceptions.

Including family members in resuscitation efforts and invasive procedures is a controversial issue in the healthcare field. Meyers et al. (2000) conducted a study based

on the Emergency Nurses Association (ENA) guidelines to evaluate the attitudes and experiences of nurses, physicians and family members, including perceived benefits and problems, regarding family presence (Meyers et al., 2000).

The study took place in the emergency department of a 940 bed level one trauma center in the Southwest. The convenience sample included 39 family members, and 96 health care providers (60 registered nurses, 22 physician residents, and 14 attending physicians) involved in family presence. Family members eligible to participate had to share an established relationship with the patient. Family had to be 18 years or older, English speaking, non-combative, emotionally stable, and may not be in an altered mental state. Forty-three instances of family presence were included in the study. Of the 43 instances, 24 were invasive procedures, and 19 were CPR cases. Patients in both groups were comparable in age, gender, race, and primary diagnosis. Sixty-two percent of respondents were nurses, and 38% were physicians. Providers in the invasive procedure and CPR group were also comparable in job title, age, and gender (Meyers et al., 2000).

A separate survey, based on ENA guidelines, was used for families, and for health care providers. A 37 item family survey was used to evaluate family members' perceived benefits and problems of FP. A separate 33 item survey was used to evaluate health care providers' perceptions. The surveys also included open-ended questions to gather other data regarding perceived benefits and problems of FP. Validity was established by five nurse experts and two physician experts rating the relevance of each item. Research team members then revised the surveys based on the results (Meyers et al., 2000).

Findings regarding family members' perceptions and attitudes were that 97.5% of family members believed families have the right to be present during invasive procedures and CPR, and would do it again. Family members (100%) indicated it was important and helpful to be with a loved one during invasive procedures and CPR. Ninety-five percent said the visitation helped to understand the seriousness of the patients' condition, and to know every intervention possible has been done. Family members (95%) believed family presence helped the patient. Family members believed presence affected the health care providers by reminding staff the patient was not just an individual, but was part of a family. Family members believed this encouraged health care providers to try harder in the efforts to revive the patients. Family members (17%) believed the experience was not what was expected, however 29% did not know what to expect. Ninety-five percent believed the experience was not too upsetting (Meyers et al., 2000).

Health care providers also had positive attitudes toward family presence (FP). Nurses reported significantly more positive attitudes than physicians. Attending physicians had a more positive attitude than residents. Most of the health care providers showed support for FP during invasive procedures (73%) and CPR (76%), and 88% believed the FP program should be continued at the institution. About 80% of health care providers believed family presence met family members and patients' emotional and spiritual needs. Health care providers (89%) believed FP assisted family members in understanding the patients' condition, and 93% believed it helped family members appreciate the care provided by the health care team. Nurses described the family presence experience as conveying a sense of personhood about the patient. Health care providers (38%) had concerns regarding families interrupting invasive procedures or

CPR, but no disruptions occurred. Health of care providers (85%) were comfortable with having family present (Meyers et al., 2000).

General Public's Perceptions.

Research has been conducted on healthcare providers' opinions, as well as retrospective research on family members' opinions after witnessing resuscitation, but few studies have examined the attitudes of the general public. The purpose of Mazer, Capon, and Cox's (2006) study was to determine the general public's attitudes and perceptions concerning witnessed resuscitation (Mazer et al., 2006).

This study included 408 participants. Respondents had to be 18 yrs or older, and were randomly chosen from a list of residents living in one of the postal zip codes within Memorial Medical Center's service area in rural southwest Pennsylvania. Of the respondents, 70.1% were female, and 29.9% were male. Sixty-three percent were married, and 91.9% had at least a high school level of education. Annual household income levels were fairly evenly distributed. Eighty-seven percent of respondents declared a religious affiliation, and 97.1% were Caucasian. Only 43.6% had taken part in some type of end of life planning, whether it was an advanced directive or durable power of attorney. Eighty-five percent would want CPR to be performed, whereas 13.5% would not (Mazer et al., 2006).

The survey had three sections. The first section included questions related to demographic characteristics. It also included the respondents' assessments of general health and willingness to want CPR performed on themselves, as well as questions about end of life planning. The second portion of the survey asked respondents to rate the level of agreement on the following five questions:

1. I believe family members or friends have the right to be present in the room while a loved one is undergoing CPR.
2. I would want to be in the room with a loved one during CPR.
3. I would want family members or friends with me if I were undergoing CPR.
4. The presence of family members or friends during CPR would benefit the patient.
5. The presence of family members or friends during CPR would benefit the family members or friends (Mazer et al., 2006, p. 2926).

The final section of the survey asked the participants to rank who should have the most authority in the decision to allow witnessed resuscitation, the physician, patient, family or friends.

The findings from the second section of the survey indicated only 49.3% desired to be present during CPR, and only 37.3% believed being present would benefit the family and friends. Associations were noted between respondents who would want CPR performed on themselves, and the likelihood to believe that family or friends should be allowed to be present. Respondents were also more likely to want family or friends present while undergoing CPR than participants declining CPR. Respondents desiring CPR believed strongly that the presence of family or friends during CPR would benefit the patient. Positive views of witnessed resuscitation were also found to be more likely among individuals who were either married, widowed, or never married (52%), as opposed to individuals who were divorced or separated (29%). Positive views were also more likely among individuals less than 26 years of age (70%), or over 65 years of age (56.1%) (Mazer et al., 2006).

In the final section of the survey findings indicated 43% of respondents believed the physician should have the authority to decide if the family should be present during CPR. On the same item, 40% believed the patient should have the authority, and 17% the family or friends. Fifty-two percent of men believed that the patient should have the most authority, whereas 39.1% of women believed the same. Forty-five percent of women believed that the physician should have the most authority, compared to only 28.6% of men (Mazer et al., 2006).

The authors concluded that a large segment of the general public desires presence during resuscitation, and believes it to be beneficial. Even though healthcare providers have mixed attitudes regarding family witnessed resuscitation, programs and protocols should be developed to accommodate patients and families who wish to remain together during CPR (Mazer et al., 2006).

Intervention Programs.

Few studies show effective strategies that help change practice and help in the implementation of family presence during resuscitation. Mian et al. (2007) conducted this study to evaluate the attitudes of staff members in an ER prior to the implementation of a family presence program, and following the program. Also evaluated were the differences in attitudes between physicians and nurses (Mian et al., 2007).

The study took place in an emergency department that is a level one trauma center with 50 beds. The emergency department records more than 77,000 visits each year, and is part of an 898 bed medical center. The sample consisted of nurses and physician employed in an ER. A two-group pretest and posttest design was used. There were 86

nurses and 35 physicians that completed the initial survey, and 89 nurses, and 14 physicians completed the follow-up survey (Mian et al., 2007).

Demographical data were similar for both the initial survey and follow-up survey. Of the 86 nurses involved, 86% were female and 14% male. Thirty-four percent of physicians were female, and 66% male. Age ranges of the nurses were between: (24%) 20-29, 34% 30-39, 30% 40-49, and 11% greater than 50 years of age. The physicians' ages were between: (37%) 20-29, 46% 30-39, 6% 40-49, and 11% were greater than 50 years of age. Seventy-four percent of physicians were residents, and 26% were attending physicians. Nurses' educational levels were 7% diploma, 18% associate's degree, 65% bachelor's degree, and 10% master's degree. Thirty-nine percent of nurses had 1-5 years of experience, 6% with 5-10 years, 12% with 10-15 years, 12% with greater than 15 years experience. Physicians' experiences' included 1-5 years experience (54%), 5-10 years (9%), 10-15 years (3%), greater than 15 years experience (3%) (Mian et al., 2007).

The survey consisted of three parts that measured the major factors thought to influence professionals' willingness to adopt FWR. The first part of the survey evaluated professional attitudes, values, and behaviors, using a 30 item questionnaire with a Likert scale. The second section evaluated personal and professional experiences. The final section evaluated demographic characteristics. The survey was developed by a team including a psychiatric clinical nurse specialist, two staff nurses, and an attending physician in the ED. Validity was established through expert review. Twelve former emergency room nurses pretested the initial survey, and minor revisions were made (Mian et al., 2007).

Findings on the initial survey revealed nurses showed stronger support for the rights of the patients to have families present than did physicians. Nurses (71%) were more supportive of the rights of family members to be present, but were less supportive of family presence during invasive procedures, and the belief that family presence helps the patient's family. Physicians were also less supportive in regards to family presence during invasive procedures, and the belief that family presence helps patients' families. Physicians were divided (51%) in regards to the patient's right to have family members present during medical resuscitation. Nurses and physicians were both concerned about families being present during the learning process of the residents, and the anxiety the families may cause staff (Mian et al., 2007).

Findings on the follow-up survey showed nurses' support for family presence was greater, but beliefs about the benefits for the family were still low. The nurses' concerns did not change on the follow-up survey. Nurses (39%) reported having a more positive attitude toward family presence after the educational program. A small number of physicians responded to the follow up survey, and only one physician participated in the educational program. Physicians showed less support for family presence, and more concerns about practice issues. Ninety-two percent of physicians reported no change after the program implementation (Mian et al., 2007).

Mian et al. concluded that family presence is a nurse-driven practice. Nurses are advocates for patients and families. It is important to provide staff with an educational program. One educational program will not change practice but ongoing education can reinforce the practice of family presence during resuscitation (Mian et al., 2007).

Few studies address FWR after an intervention program. The purpose of this quasi-experimental study by Holzhauser and Finucane (2007) was to identify staffs' attitudes regarding FWR in an emergency department, both before and after an intervention that encouraged presence.

The study took place in Queensland, Australia, in an emergency room that sees approximately 45,000 patients per year. All nursing and medical staff who permanently worked in the emergency department were surveyed to avoid possible bias related to non-probability sampling. A pretest was distributed to 63 participants. Respondents for the pretest were 54% nurses, and 41.3% medical staff. An intervention was created, and a policy put into place that both allowed and encouraged family presence during resuscitation. This intervention included open communications regarding family witnessed resuscitation, and education on dealing with grieving families. Six months into the intervention, participants were given a post-test to see if and how opinions had changed. Only 36 participants responded, 61.1% nurses, and 38.9% medical staff (Holzhauser & Finucane, 2007). The post-test was a 10 question tool created by the researchers. All questions were dichotomous or multi-dichotomus, open-ended, or a Likert scale. The questionnaire was piloted on a small group (Holzhauser & Finucane, 2007).

A correlation was found between nurses' comfort levels with grieving families and opinions regarding family presence during resuscitation in the pre-test, but no correlation was found in the post-test. Staff were asked about circumstances that would allow relatives to be present during resuscitation. In the pre-test, the majority of the comments pertained to allowing family presence after the patient has been stabilized. In

the post-test, fewer comments pertained to waiting on family presence until the patient was stabilized. After the intervention, the majority of respondents had positive experiences with relatives present during resuscitation. Four staff members did not feel comfortable with family present. Only three staff members had negative experiences, two did not believe family should be present, and the other was unsure. Change in staffs' attitudes pre and post intervention was not found to be statistically significant. When reviewing findings from staff comfort levels in dealing with grieving family members, only four participants reported feeling uncomfortable. One had a negative experience. The change in staffs' comfort levels with grieving family members was not statistically significant between pre and post intervention (Holzhauser & Finucane, 2007). The authors concluded that staff attitudes toward family presence can be positive however negative attitudes still are identified (Holzhauser & Finucane, 2007).

Summary of Findings

Meta Analysis of FWR.

The purpose of Walker's (2008) literature review was to identify accident and emergency staffs' opinions on the positive and negative effects of family presence during adult resuscitation. Staff performance was a concern, including the ability to train new staff with family present, staff being intimidated by family, and concern about the health care providers well being. Increased stress levels and legal repercussions were also concerns among ED staff. A major reason that health care providers have been resistant to FWR is the fear of relatives adversely affecting the resuscitation procedures. The majority of health care providers believed the psychological stress on the family was an important reason to resistant FWR. Staff believed it was important for family to have the

support available when witnessing a resuscitation event. The author found both positive and negative effects of FWR, but opinions showed there were more risks than benefits. More nursing than medical staff are supportive of the practice (Walker, 2008).

Attitudes and practices of FWR.

Nurses' Perceptions: Hallgrimsdottir (2000) conducted a study to explore the perceptions and experiences of nurses caring for families of critically ill patients and suddenly bereaved families. Findings showed that almost all nurses believed caring for the family was part of the duty as a nurse, but found it very stressful during a resuscitation situation. Nurses also believed there should be a designated staff member to stay with the family during the resuscitation process. The authors concluded most nurses were not comfortable or fully prepared to care for families during the resuscitation process (Hallgrimsdottir, 2000).

The purpose of MacLean et al.'s (2003) study was to identify nurses' attitudes and practices regarding family witnessed resuscitation, as well as presence during invasive procedures, in emergency departments and critical care units. The authors found most units did not have policies in place regarding family presence, but nurses preferred having a policy in place and the option to take families to the bedside during CPR and invasive procedures. The authors concluded there are many benefits to family presence during CPR and invasive procedures, and nurses working in critical care and emergency units should consider implementing a policy in regards to family presence (MacLean et al., 2003).

Madden and Condon (2007) conducted a study to identify emergency room nurses' knowledge, preferences, and current practices in regards to FWR. Findings were

that nurses had positive attitudes regarding FWR and wanted a policy regarding FWR. The authors concluded there is a need for policies addressing FWR and in developing the policies education can be instituted to give staff a greater understanding of the benefits of FWR (Madden & Condon, 2007).

Nurses' and Physicians' Perceptions: McClenathan et al. (2002) conducted a study to assess health care professionals' opinions on family witnessed resuscitation and whether guidelines are supported. Findings showed the majority of the health care professionals surveyed did not support the current recommendations provided by the American Heart Association. McClenathan et al. speculated the reason for the attitudes towards family presence may be related to the fact that physicians have the ultimate responsibility for the outcomes of the resuscitation effort (McClenathan et al., 2002).

Families' Perceptions: The purpose of McGahey-Oakland et al.'s (2007) study was to describe experiences of family members with children undergoing resuscitation events, identify critical information about family experiences, and to assess mental and health functioning of family members. It was found that there were many common concerns among experiences of family members of pediatric patients undergoing resuscitation. Family members expressed the importance being present during resuscitation. The authors concluded that family members believe it is a right to be present, and that family are connected with the patient. Family members should not get in the way or interfere with the care of the child (McGahey-Oakland et al., 2007).

Maxton (2008) conducted a study to provide in-depth understanding of the meaning for parents of presence or absence during resuscitation of a child in the PICU. The authors found memories of the resuscitation were not long lasting, and parents'

distress was based more on the possibility of losing a child, rather than the resuscitation scene. Parents not present during the child's resuscitation were more distressed than parents who were. Parents wanted a support person who could provide technical information during the resuscitation process as opposed to spiritual council, and that intuitive nurses best fulfilled this role. Conclusions indicated a great need for parents to be able to choose to be present during a child's resuscitation to help make sense of the situation (Maxton, 2008).

Determining the feasibility of implementing a family presence policy and procedure during trauma team activations and medical resuscitations based on national guidelines, and determining the ability of this practice to ensure appropriate family behavior and uninterrupted patient care was the purpose of Kingsnorth et al.'s (2010) study. The authors found it is feasible to implement a family presence intervention. The intervention was also shown to protect patient safety by ensuring uninterrupted patient care (Kingsnorth et al., 2010).

Nurse, Physician, and Families' Perceptions: Meyers et al. (2000) conducted a study using the Emergency Nurses Association (ENA) guidelines to evaluate the attitudes and experiences of nurses, physicians and family members, including perceived benefits and problems, regarding family presence. Authors found families believed it was a right to be present, and that it is a beneficial experience. Most health care providers had a positive attitude and support future family presence. Conclusions were that family presence was a beneficial experience for family members regardless of demographical characteristics (Meyers et al., 2000).

General Public's Perceptions: The purpose of Mazer et al.'s (2006) study was to sample a large population of the general public to determine attitudes and perceptions concerning witnessed resuscitation. The authors concluded that a large segment of the general public desires witnessed resuscitation, and believes it to be beneficial. Even though healthcare providers have mixed feelings regarding family witnessed resuscitation, it would be sensible to consider developing programs and protocols to accommodate patients and families who wish to remain together during CPR (Mazer et al., 2006).

Intervention Programs: Mian et al. (2007) conducted this study to evaluate the attitudes of staff members in an ER prior to the implementation of a family presence program, and following the program. Also evaluated were the differences in attitudes between physicians and nurses. Findings prior to the program revealed nurses showed a stronger support for the rights of the patients to have families present than did the physician. Findings following the implementation of the program showed nurses' support for family presence was greater, but beliefs about the benefits for the family were still low. Mian et al. concluded that family presence is a nurse-driven practice. Nurses are advocates for patients and families (Mian et al., 2007).

Identifying staffs' attitudes regarding FWR in an emergency department, both before and after an intervention that encouraged presence, was the purpose of this quasi-experimental study by Holzhauser and Finucane (2007). A correlation was found between nurses' comfort levels with grieving families and opinions regarding family presence during resuscitation in the pre-test. No correlation was found in the post-test. The change in staffs' comfort levels with grieving family members was found not

statistically significant between pre and post intervention. The authors concluded that results from the study were similar to other studies that staff attitudes toward family presence were positive and similar positives, and negatives were identified (Holzhauser & Finucane, 2007).

Chapter 3

Methodology

Introduction

Family witnessed resuscitation (FWR) has been supported by many physicians and nurses, but is not yet a widespread practice. FWR remains controversial, and nurses' preferences affect policy application related to what occurs at the bedside. The purpose of this descriptive study is to identify emergency room nurses' knowledge, preferences, current practices, and perceived barriers in regards to FWR. This study is a replication of Madden and Condon's (2007) study. This chapter includes information about the population, sample, procedure, measurements, and design used to guide this study.

Research Question

1. What are nurses' knowledge, preferences, and practices regarding family presence during resuscitation?
2. What are the barriers and facilitators to permitting family presence during resuscitation?

Population, Sample, and Setting

The study will take place at Indiana University Health Ball Memorial Hospital in Muncie, Indiana in the emergency department (ED). The ED staff see approximately 300 patients each week. On average, about 10 codes a week are conducted. The staff

includes 50 nurses. The anticipated sample will include 25 nurses with greater than 6 months experience in the ED, and nurses that have had the experience of bringing a family member to the bedside during a resuscitation effort.

Protection of Human Rights

The study will be submitted for approval to the IU BMH Institutional Review Board and the Ball State University Institutional Review Board. Consent will be obtained from the Director of Nursing and Clinical Nurse Manager at the Ball Memorial Hospital Emergency Department. Nurses will not be required to participate in the study, and if nurses do not participate, the job will not be affected. Confidentiality will be respected throughout the study, and all data will be anonymous. Participants will be given a cover letter with the survey explaining the purpose and significance of the study. No risks have been identified. Benefits of the study include receiving information about FWR, and having the opportunity to provide input to guide policy development.

Procedures

After approval from the IRBs, and meeting with the director of the ED, the survey will be introduced to the Director of Nursing and the Clinical Nurse Manager for approval to collect data. The ED nurses will be informed about the survey prior to administering the surveys by placing an information sheet about the study, including the purpose and importance of the study in nurses' mailboxes. The researcher will also attend a staff meeting prior to the start of the study to explain the purpose, importance, and procedures of the study. Surveys will be placed in the mailboxes of all nurses by the researcher. Nurses will be requested to complete the survey within 2 weeks. After completion, nurses will place surveys in a designated box in the ED. The researcher will

check the box daily for new surveys. Contact information will be provided so nurses can contact the researcher with any questions.

Methods of Measurement

The Family Presence Survey (2002), developed by the Emergency Nurses Association (ENA), is a questionnaire with 15 close-ended questions, based on a previous study by the ENA (Madden & Condon, 2007). The questionnaire has four sections. The first section includes five questions that identify demographic information of the sample. The second section includes five questions investigating nurses' knowledge of both policy and practice related to FWR. Questions are answered with "yes, "no," or "don't know." The third section includes five questions addressing nurses' preferences about policies related to FWR. The questions are answered by circling one of the written statements. The final section includes five questions that identify perceived barriers and facilitators to FWR. Questions are answered with "yes, "no," or "don't know." Validity has previously been established for the questionnaire by the ENA.

Research Design

A quantitative descriptive design will be used in this study. In descriptive research the aim is to describe a phenomenon. A descriptive study establishes no associations between variables or manipulation of variables (Burns & Grove, 2009).

Method for Data Analysis

Demographical data will be tabulated using descriptive statistics, with frequencies and percentages. Descriptive statistics are generally used to summarize a set of data, to describe the basic features in a study, as well as aiding in organizing data (Burns &

Grove, 2009). The Statistical Package for Social Scientists will be used to analyze data from the ENA questionnaire.

Summary

This study will examine emergency room nurse's knowledge, preferences, and current practices in regards to FWR. It will take place at Indiana University Health Ball Memorial Hospital in Muncie, Indiana. The study will ensure that the participants have adequate information about the survey, and participants have a good understanding of survey questions. The targeted sample is 25 ED nurses. Findings will provide information for policy development addressing FWR and serve in development of a policy on FWR for nurses working in the ED. Policy is a foundation for practice.

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