

NURSES' PERCEPTIONS OF FAMILY PRESENCE
DURING CARDIOPULMONARY RESUSCITATION

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ABSTRACT

RESEARCH PAPER: Nurses' Perceptions of Family Presence During Cardiopulmonary Resuscitation

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The subject of family presence during resuscitation (FPDR) has been controversial worldwide, thus causing mixed attitudes and practices in clinical settings. National clinical guidelines and professional organizations have recommended allowing FPDR. However, numerous healthcare personnel, especially nurses, have reported ambivalent beliefs about FPDR. To elucidate the debate, more information is needed on nurses' perceptions of FPDR. The purpose of this study was to investigate nurses' perceptions of FPDR and the relationships of these perceptions to chosen demographic variables. This study was a partial replication of a study by Twibell et al. (2008). Guided by family system theory, data for this study were collected from 125 registered nurses working in three hospitals in southeastern Indiana. Nurses completed a survey that assessed selected perceptions related to FPDR, including benefits, self-confidence, current practices, and risks (Twibell et al.). Findings will aid nurse managers, nursing administrators, and patient care providers in understanding variables that influence nurses' decision-making related to FPDR. Applications for future education of health care professionals will be revealed.

Chapter One

Introduction

Allowing patients' family members to be present at the bedside during resuscitation is a controversial practice worldwide (Gunes & Zaybak, 2009). Healthcare professionals often find themselves in the middle of difficult ethical positions that include conflict between the preferences of critically ill patients, patients' family members, and healthcare providers who manage resuscitation measures (Nibert, 2005). Various professional organizations have publicly agreed to support family presence during resuscitation (FPDR) through guidelines and position statements. Research has suggested that families believe it was their right to be present and that benefits of being present outweighed any risks (McGahey-Oakland, Lieder, Young, & Jefferson, 2007). However, healthcare providers at times oppose family presence, suggesting that more disadvantages than advantages exist (McClement, Fallis, & Pereira, 2009).

In 1982, a hospital in Michigan started the practice of allowing family members to be present during resuscitation if they chose. Studies have since researched those families who were present. Results reflected that families believe it was their legal right to be present and that it emotionally benefited those present (McGahey-Oakland et al., 2007). Existing practices in the majority of hospitals have historically prohibited families from being present during the resuscitation of a loved one in an attempt to allow the staff to focus and prevent trauma to the family. However, studies have found that families felt grieving was made easier because of being present during resuscitation. (Doyle et al., 1987; Robinson, Mackenzie-Ross, Campbell-Hewston, Egleston, & Prevost, 1998; Belanger & Reed, 1997).

Several professional organizations have formally given support to FPDR through position statements and guidelines. The American Heart Association (AHA), the Emergency Nursing Association (ENA), and the American Association of Critical-Care Nurses (AACN) have recommended FPDR. Organizations have suggested the development of a policy addressing FPDR, although not many hospitals have a policy supporting FPDR at the present time (Tamekia, 2008).

Research on FPDR has mainly been descriptive in nature, focusing on the beliefs of stakeholders. Some lucidity has transpired on the perspectives of the families. The perspectives of health care providers remain not clearly defined. A shortage of rigorous research adds to the lack of agreement and continuing dispute among health care providers regarding FPDR. This study added to research on health care professionals' perceived risks, benefits, and self-confidence related to FPDR (Doyle et al., 1987).

Background and Significance

Cardiopulmonary resuscitation (CPR) of an individual whose life is in jeopardy from inadequate breathing or circulation frequently occurs as an emergency situation. In a CPR event, a multidisciplinary group of healthcare professionals provide knowledge and skills in an attempt to save the patient's life. The debate of whether or not the patient's family should be present during resuscitation is the focus of a worldwide dispute in the health care settings.

History of Cardiopulmonary Resuscitation. Cardiopulmonary resuscitation is an emergency first aid protocol for an unconscious person on whom neither breathing nor pulse can be detected. CPR has been known in theory, if not practice, for many hundreds, if not thousands, of years; some claim it is even described in the Bible, discerning a superficial similarity to CPR in a passage from the Books of Kings (II Kings 4:34), wherein the Hebrew prophet Elisha warms a dead boy's body and places his mouth over his.

However, it was not until the middle of the 20th century that the wider medical community started to recognize and promote CPR as a key part of resuscitation following cardiac arrest. The truth remains that while CPR is an integral part of the resuscitation process, it cannot be used to replace other resuscitative adjuncts, such as defibrillation, airway management, and intravenous drug therapy (Cooper, Cooper, & Cooper, 2006).

At least 350,000 people suffer cardiac arrest each year in the United States, 1 every 90 seconds. Many then undergo cardiopulmonary resuscitation (CPR) by bystanders and emergency medical services in a desperate attempt to restore life. Numerous studies have reported that the majority of these efforts do not succeed. Prolonged anoxia, the inability to restore spontaneous circulation, neurological devastation, and other complications combine to limit survival. Nonetheless, thousands have surmounted these obstacles and resume normal lives. CPR is a triumph of medicine but also is frequently performed in vain (Cooper et al., 2006).

Resuscitation has developed over thousands of years, following experimentation and observation, which converged in the 1950s to bring about the era of modern CPR. The frontiers continue to be advanced in the quest to revive “hearts too good to die” (Cooper et al., 2006). The rate of successful resuscitation has remained disappointing, and aggressive dissemination of the current CPR guidelines has continued because evidence-based recommendations have been shaped by numerous observations and studies that share the common goal of improving resuscitation outcomes (Cooper et al., 2006).

History of Families and FPDR. Traditionally, when a patient went into a cardiopulmonary arrest in a hospital, the family was steered away from the loved one into a waiting room while life-saving measures were initiated. When a nurse or doctor was able to break away from the resuscitation efforts, the family was updated on the patient’s status. But the scenario is changing, as families exercise their right to be present during resuscitation. Permitting family members to be present at the bedside during CPR is a controversial issue in the United

States and has stimulated widespread debate. In less than two decades however, the movement to allow FPDR has steadily unfolded because of support from professional organizations, consideration from the media, and research on the topic (Clift, 2006).

Family presence during resuscitation can be traced back to 1982 at Foote Hospital in Michigan, where there were family members from two separate situations who demanded to be present during their loved one's resuscitation. Following both incidents, there was an evaluation of the situations, and both family and staff felt there was a positive impact from the family being present. A program was initiated at Foote Hospital, followed by an evaluation three years later involving 47 family members who had been present during resuscitations. Results were:

1. 76% felt their adjustment to death was made easier.
2. 64% felt their presence was beneficial to the dying family member.
3. 94% felt they would choose to be present again during resuscitation if given the opportunity (Hanson & Strawser, 1992; Doyle et al., 1987).

Further research began to produce more studies on FPDR. Multiple studies found that FPDR was emotionally valuable to the family. The advantages included meeting the emotional and spiritual needs of patients, increasing understanding of the patient's condition, reducing anxiety for the family, and allowing them the opportunity to be with the dying family member (Doyle et al., 1987). Families felt they were involved in the dying process and were better to obtain closure. No psychological trauma was reported by family members. Despite the positive outcome found by these studies, controversy remains among health care professionals on the subject of FPDR (Fitzgerald, 2008).

History of Health Care Professionals and FPDR. An assortment of research studies has been performed studying the personal experiences of health care professionals related to FPDR. Differences between physicians and nurses have been apparent. McClenathan, Torrington, and Uyehara (2002) reported that, of the physicians who had participated in FPDR,

only 39% would recommend FPDR again; however, 53% of the nurses supported FPDR. Some of the apprehensions found by health care professionals included the fear that family members might interfere with resuscitation efforts, be critical of staff efforts, view staff's behaviors that could be interpreted as inappropriate, and divert the attention of the resuscitation team from the patient. Fear of litigation and violation of patients' privacy were also concerns among health care professionals (Fitzgerald, 2008).

Studies showed that regional locations with the largest support were in the Midwest, compared to the rest of the regions in the United States of America (USA). Studies have proven that educating the staff has resulted in increased support of FPDR among health care professionals. Studies have also shown that the implementation of policies in health care facilities increased the acceptance of FPDR by the staff (McClenathan et al., 2002; Madden & Condon, 2007).

Nurses' perceptions of the risks and benefits of FPDR vary greatly and are associated with how often the nurses invite the family to be present. Twibell et al. (2008) found significant differences between nurses who did and did not belong to professional organizations ($t = 5.3$, $p < .001$). Certified nurses and nurses who were members of professional organizations recognized more benefits and fewer risks than other nurses. Observations related to FPDR did not show a difference between associate degree nurses and baccalaureate degree nurses; however LPNs in comparison to RNs perceived fewer benefits, more risks, and less self-confidence.

Professional Organizations and FPDR. In 1993, the ENA (2001) adopted a policy favoring FPDR. As the first professional organization to take an official position on FPDR, the policy stated:

ENA supports the option of family presence during invasive procedures and resuscitation. ENA supports further research... (and) the development and dissemination off educational resources...concerning policies, practices, and programs supporting the option of family presence. ENA supports...educational resources for public... (and) Collaboration with other specialty organizations...to develop multidisciplinary guidelines

related to family presence...ENA supports healthcare facilities...policies and procedures allowing the option of family presence (ENA Position Statement, 2001, p.2).

In 2000, the AHA also took a stand for FPDR. The strong recommendation for allowing FPDR and recommendations for further research initiated a debate nationally and internationally.

Following the endorsement of FPDR by the ENA and AHA, the AACN released a Practice Alert on FPDR (AACN, 2004). The AACN declared that family members should be allowed to choose whether or not to be present during invasive procedures or CPR. The AACN formally signed the guidelines set by the ENA and stated that they were applicable to critical care units.

Despite the stand taken by these professional organizations supporting FPDR, some health care facilities have been slow to initiate a policy supporting FPDR. Advocates of FPDR argue that the initiation of policies would give support to the practice and allow consistency in following guidelines. In healthcare facilities with policies supporting FPDR, debate among staff decreased (Miller & Stiles, 2009; Tamekia, 2008).

Further research is needed on the perceptions of health care professionals, specifically nurses, in order to effectively design policies, provide education, and implement practices in support of FPDR. In addition, further studies of the relationships of nurses' perceptions to selected demographic variables are needed to tailor educational offerings on FPDR and adapt policies to fit cultural and geographical characteristics.

Statement of the Problem

FPDR has been controversial for several decades. Although national clinical guidelines and professional organizations have recommended allowing FPDR, numerous healthcare personnel, especially nurses, have reported ambivalent beliefs about FPDR. To elucidate the debate, more information is needed on nurses' perceptions of FPDR, specifically perceptions of

risk, benefit, and self-confidence related to FPDR. In addition, further clarity is needed on the relationships among nurses' perceptions of FPDR and nurses' demographic variables.

Purpose of the Study

The purpose of this study was to investigate nurses' perceptions of FPDR and the relationships of these perceptions to demographic variables.

Research Question

The research question in this study was "What are the relationships among nurses' perceptions related to FPDR and personal demographic variables?" The essential perceptions included risk, benefit, and self-confidence related to FPDR.

Theoretical Framework

No theoretical framework has been developed to guide practice and research on FPDR, although numerous researchers have alluded to an extensive theoretical basis for their studies. For example, Mian, Warchal, Whitney, Fitzmaurice, and Tancredi (2007) suggested the use of change theory to guide research on FPDR. Rogers' (2003) and Lewin's (1947) change theories ultimately influenced the interventions introduced in the study by Mian and colleagues. Lewin proposed three stages of change. First was the unfreezing stage, which appeared when disequilibrium emerged and necessitated a need for change. Next was the moving stage in which information was gathered and used to influence change. The final stage was the refreezing stage in which the changes were unified and equilibrium returned (Rousel & Swansburg, 2009).

Rogers (2003) expanded on Lewin's (1947) theory to five phases. The phases were awareness, interest, evaluation, trial, and adoption. Mian et al. (2007) utilized these stages and phases in enabling and assessing interventions to change staff behaviors and perspectives related to FPDR.

Further theories that could be applied to research studies on FPDR include Peplau's (1997) theory of interpersonal relations, Ray's (1989) theory of bureaucratic caring, and Ajzen

and Fishbein's (1972) theory of reasoned action as a model for predicting behavioral choices in a broad range of settings. Ajzen and Fishbein's theory stated that behaviors resulted from behavioral intentions, which in turn were based on attitudes and beliefs. Ellison (2003) associated Ajzen and Fishbein's (1972) theory with FPDR in that attitudes about FPDR could be learned by health care professionals.

Ray's (2010) theory of bureaucratic caring concentrated on nurses working in a complex organization, such as a hospital. The hospital was observed as a culture. Nurses were looked at as caring individuals performing within the organization or culture. Nurses engaged in the nurse-patient interaction and acknowledged and respected the patient's privilege to make choices. In utilizing this theory to explain FPDR, the patient was viewed as part of the whole family, and the family was seen a part of the whole of the patient (Tomey & Alligood, 2006).

Peplau's (1997) theory of interpersonal relations could also relate to FPDR. This theory offered a rational method for examining nursing roles and phases of the nurse-patient relationship. The nurse-patient relationship developed in the phases of orientation, working, and termination. Peplau included the family as the target of the nurse-patient relationship.

Through additional theory-driven investigations, a specific theory of FPDR may evolve or one of the above-mentioned theories may become a leading framework for guiding research on this topic. For the purpose of this study, a conceptual framework was used that associated nurses' perceptions related to FPDR with nurses' demographic variables. This framework was loosely based on Ajzen and Fishbein's (1972) attitudinal theory, in that personal variables influence beliefs, attitudes, and perceptions.

Definition of Terms

Family Presence During Resuscitation.

Conceptual Definition: The presence of family in the patient care area, in a location that affords visual or physical contact with the patient during resuscitation events (Fell, 2009).

Family Member.

Conceptual Definition: A person older than 18 years who had an established relationship with the patient, including the patient's family members, loved ones, and close friends (Fell, 2009).

Perceived Benefits and Risks Related to FPDR.

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

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

Self-Confidence related to FPDR.

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

Operational Definition: Nurses' perception of ability to manage patients' resuscitation in the presence of patients' family members as measured by the total mean score on the Family Presence Self-Confidence Scale (Twibell et al., 2008).

Limitations

Limitations of this study included the following:

1. Data were collected at a single site in one geographical area.
2. The sample was not randomized, which could have caused systematic bias.

Assumptions

The following assumptions directed the study:

1. Participants responded honestly to all survey questions
2. The sample represented the population being studied.
3. Respondents had awareness and knowledge of FPDR.

Summary

The debate surrounding FPDR has been intense among health care professionals worldwide. Families have a desire to be present during resuscitation of a loved one, and support of FPDR by numerous professional organizations has created more impetus to allow FPDR. Health care professionals express ambivalence about FPDR, expressing uncertainty about the risks and benefits of the practice. With readily available resources from the ENA, AHA, and AACN, educational programs can be developed along with policies to assist with implementation of FPDR and reduce resistance to the new practice.

Health care professionals' perceptions of benefits, risks, and self-confidence in relation to FPDR have been discovered to be conflicting across studies. Additional studies of the perceptions of health care professionals are needed to better understand the best approaches to support FPDR, promote self-confidence of health care professionals, and implement FPDR as an expected practice. The purpose of this study was to examine nurses' perceptions of FPDR and the relationships of these perceptions in relation to certain demographic variables.

Chapter II

Literature Review

Introduction

The presence of family members at the bedside during the resuscitation of a loved one has been the focus of continuing debate among health care professionals around the world. Stakeholders in the issue hold varying opinions and perspectives. Families overpoweringly have reported the desire to be at the bedside of a loved one during resuscitation. Research has clearly indicated that families felt it was their privilege to be present and that the benefits of being at the bedside outweighed any risks (McGahey-Oakland et al., 2007). Various professional organizations have formally given support to FPDR by means of guidelines and opinion statements. Nevertheless, health care professionals sometimes oppose FPDR, suggesting more disadvantages than advantages (McClement et al., 2009). Therefore, many hospitals still exclude families from being present during resuscitation.

Consensus on the issue of FPDR is imperative, as health care facilities struggle to strengthen patient and family satisfaction, while also generating healthy work conditions for the health care professionals. Thus far, studies on health care professionals' opinions of FPDR have predominantly consisted of opinion surveys (Madden & Condon, 2007). Additional research is needed to clarify the perspectives of health care professionals and demographic factors that affect their impressions related to FPDR.

Purpose

The purpose of this study was to investigate nurses' perceptions of FPDR and the associations of these perceptions with chosen demographic variables.

Research Question

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

Organization of Literature

Following an overview of the theoretical framework for this study, the literature review was divided into two sections, specifically family perspectives on FPDR and health care professionals' perceptions of FPDR. Healthcare professionals included only physicians and nurses in this review. Although some of the studies addressed either the family or professional staff's perspective, numerous studies reported both. The research studies were allocated to sections of the literature review according to their central focus. This review does not contain the viewpoint of patients related to FPDR.

Theoretical Framework

Although a precise theoretical framework for family presence during resuscitation has not been explicated, numerous researchers have alluded to a theoretical basis for their studies. For example, Mian et al. (2007) suggested the use of change theory to guide research on FPDR. Rogers' (2003) and Lewin's (1947) change theories ultimately influenced the interventions introduced in the study by Mian and colleagues. Lewin proposed three stages of change. First was the unfreezing stage, which appeared when disequilibrium emerged and necessitated a need for change. Next was the moving stage in which information was gathered and used to influence change. The final stage was the refreezing stage in which the changes were unified and equilibrium returned (Roussel & Swansburg, 2009).

Rogers (2003) expanded Lewin's (1947) theory to five phases. The phases were awareness, interest, evaluation, trial, and adoption. Mian et al. (2007) utilized these stages and phases in enabling and assessing interventions to change staff behaviors and perspectives related to FPDR.

Other theories suggested as frameworks to guide research studies on FPDR included Peplau's (1997) theory of interpersonal relations, Ray's (2010) theory of bureaucratic caring, and Ajzen and Fishbein's (1972) theory of reasoned action as a model for predicting behavioral choices in a broad range of settings. Ajzen and Fishbein's theory stated that evident behavior resulted from behavioral intentions, which in turn were based on attitudes and beliefs.

Ellison (2003) associated Ajzen and Fishbein's (1972) theory with family presence during resuscitation in that attitudes were learned. Ellison and other nurse researchers contend that attitudes toward FPDR could be shaped by education and experience.

Ray's (2010) theory of bureaucratic caring concentrated on nurses working in a complex organization, such as a hospital. The hospital was observed as a culture. Nurses were looked at as caring individuals performing within the organization or culture. Nurses engaged in the nurse-patient interaction and acknowledged and respected the patient's privilege to make choices. In utilizing this theory to explain FPDR, the patient was viewed as part of the whole family, and the family was seen a part of the whole of the patient (Tomey & Alligood, 2006).

Peplau's (1997) theory of interpersonal relations could also relate to FPDR. This theory offered a rational method for examining nursing roles and phases of the nurse-patient relationship. The nurse-patient relationship developed in the phases of orientation, working, and termination. Peplau included the family as the focus of the nurse-patient relationship. Nurses could act as patient and family advocates in giving them the opportunities to be present during the resuscitation, if they have a desire to do so. Nurses could approach FPDR with confidence and a positive attitude, which would allow the family to see the staff is comfortable with the situation.

The nurse can keep the family informed and updated on the status of the patient, which could allow the family to start the bereavement process, if the outcome deemed that. Nurses should also be empathetic to the patients' and families' needs, no matter what the outcome.

Through additional theory-driven investigations, a specific theory of FPDR may evolve, or one of the above-mentioned theories may become a leading framework for guiding research on this topic. For the purpose of this study, a conceptual framework was used that associated nurses' perceptions related to FPDR with nurses' demographic variables. This framework was loosely based on Ajzen and Fishbein's (1972) attitudinal theory, which suggested that personal characteristics could influence beliefs and perceptions. As noted in the review of literature, previous research has suggested linkages between individual characteristics and perceptions of FPDR. This study will further examine the perceptual and demographic relationships.

Family Perspectives on Family Presence during Resuscitation

The six studies reviewed in this section explored various aspects of the family perspectives on FPDR. Grice, Picton, and Deakin (2003) conducted a study to examine attitudes of relatives related to witnessed resuscitation in adult intensive care (ICU) units. The setting was Southampton University Hospital in the United Kingdom (UK). The patients and families were approached to ascertain their thoughts about witnessed resuscitation. The patients were scheduled for elective surgery that was expected to require intensive care after surgery. The patients in the convenience sample ranged in age from 18 to 85 years. If the family was unavailable or reluctant to participate in the study, then the patient's responses were disqualified; only paired replies were analyzed.

Information for the study was obtained when each participant completed a questionnaire. The questionnaire was a structured survey that had room for open-ended comments. Validity and reliability were not reported in this study (Grice et al., 2003).

Of the 55 responses by patients and family members, 29% of the patients stated they wanted their next-of-kin present during resuscitation. Some of the reasons the patients were in support of witnessed resuscitation were to provide support, to see everything was being done, and reduce the trauma of not knowing what was going on. Reasons the patients were against their family being present were that it would be too distressing, family members might obstruct the resuscitation, and families might have a bad lasting impression. Relatives wished to stay with their relatives to provide support, to see everything was being done, and did not want their family to die alone. Relatives who did not want to be present felt it might be too distressing, that they might impede resuscitation, and they might be frightened (Grice et al., 2003).

Grice et al. (2003) concluded that only half of the relatives interviewed and a third of the patients interviewed preferred witnessed resuscitation. However, more than 90% of each group felt that healthcare teams should document the views of patients and relatives before an elective surgery requiring postoperative ICU care.

Holzhauser and Finucane (2007) conducted a study to assess and implement FPDR in clinical practice. The location for the study was a tertiary emergency department in Australia. This study examined relatives' attitudes concerning FPDR. The research question focused on family attitudes about being present during patients' resuscitation.

Information for the randomized controlled trial was acquired in a pre- and post-test intervention design using survey methodology. The intervention consisted of an event of FPDR. Participants were relatives over the age of 18 years who were related to the patients meeting the criteria. Relatives were randomly assigned to the experimental or control group. The control group followed the established procedure of placement in the relatives' waiting room, while the experimental group was given the option to be present during the resuscitation with a support officer for assistance. Open-ended and Likert scale items were included in the survey. Reliability and validity of the survey were not reported (Holzhauser & Finucane, 2007).

Results from Holzhauser and Finucane (2007) revealed that family members believed a key advantage of FPDR was that family members could provide a patient history promptly. The patient and relatives seemed at ease with the process and reported positive responses to FPDR. Further results were divided into three areas of questions related to demographics, relatives' experiences, and support while in the emergency department (ED). The majority of the relatives were the spouse/partner (55.2% for experimental group; 51.7% for control group). Those participants over the age of 50 years from the experimental group were 50.9% and 64.3% for the control group. Of the experimental group, 22.8% worked in the health care field, while the control group had 31% health care workers. A total of 11 respondents were nurses, distributed across both groups. Other healthcare workers consisted of an ambulance worker, social worker, and administration staff.

Holzhauser and Finucane (2007) entered a total of 58 families into the experimental group who were present during resuscitation. Only 12% of relatives in the experimental group and 10% of the control group were involved in the patient's resuscitation prior to their arrival at hospital. Respondents who had experiences with resuscitation prior to this event numbered 14% for the control group and 24% for the experimental group.

Holzhauser and Finucane (2007) concluded that families believed there were benefits for relatives being present during resuscitation. Of the relatives who were present, 100% were glad they were present during their relative's resuscitation. It was reported that 96% of the families present during resuscitation felt their presence assisted them to come to terms with the patients' outcomes. When the control group was questioned whether or not their presence would have helped them cope with the outcome, 71.2% felt it would have helped.

In a similar study that focused on parents and children, McGahey-Oakland and colleagues (2007) explored the following objectives:

1. Describe the experiences of family members whose children underwent resuscitation in a children's hospital ED.
2. Pinpoint critical information about family experiences to improve circumstances for future families.
3. Measure the mental well-being of the family members post resuscitation.

Participants in the convenience sample consisted of 10 family members of resuscitated patients. Seven were mothers of the patient, two were fathers, and one was a great-grandmother. Seven of the participating family members were actually present during the resuscitation (McGahey-Oakland et al., 2007).

Data for this descriptive retrospective study were collected one to two years after the resuscitation of a patient through a one-hour audio-taped interview of ten family members. In addition, the sample completed a family presence attitude scale, Brief Symptom Inventory (Derogatis, 2001), Short Form Health Survey (Ware, Kosinski, Turner-Bowker, & Gandek, 2002), and Post Traumatic Stress Disorder Scale (Breslau, Peterson, Kessler, & Schultz, 1999). Reliability and validity for each of the scales had been established (McGahey-Oakland et al., 2007).

Findings showed support for the development and implementation of family witnessed resuscitation policies to allow the family the option of being present. Family members expressed that it was their right to be present, demonstrating they had a special bond to the child. They felt that seeing or not seeing the events of the resuscitation influenced family members' ability to believe the outcome. Families did not want to be delayed in being with their family member and believed their child would have wanted them present during the resuscitation. Measures of mental and health functioning were comparable to population norms.

There were five thematic categories identified:

1. It's my right to be there

2. Connection and comfort make a difference
3. Seeing is believing
4. Getting in
5. Information giving

Family members indicated being present with their child was an unequivocal right, an innate and instinctual responsibility. The caregiver connection to a child was characterized as unique.

Family members believed their children wanted them there and believed they provided strength for their child. Family members felt by being present “seeing is believing”. Family members felt reassured that all possible options to help their child were exhausted. Family members’ physical locations varied at the time of the resuscitation; however, all families felt the process of “getting in” to their loved one’s room was different with each occurrence. Families felt that “information giving” should wait until after the resuscitation was over because no matter the circumstances, no family was prepared to face the event of resuscitation (McGahey-Oakland et al., 2007).

McGahey-Oakland et al. (2007) concluded that instituting guidelines or policies that facilitated FPDR could ensure the needs of patients, family members, and health care providers were met during a traumatic event. The authors believed that more research was needed concerning the perspectives of family and healthcare professionals related to FPDR.

In a similar study on the perceptions of parents of critically ill children related to FPDR, Maxton (2008) explored parents’ meaning of presence or absence during resuscitation of a child in the Pediatric Intensive Care Unit (PICU). A descriptive design was used based upon Van Manen’s (1990) interpretative phenomenological approach.

The setting was a 20-bed PICU within a tertiary referral pediatric metropolitan hospital in Australia. The unit admitted children from newborn to sixteen years with a variety of conditions. Approximately half of the admissions were planned for correction of congenital cardiac anomalies. At the time of the research, the unit policy was to offer parents the option to stay

throughout the resuscitation. In reality, this option was not always offered. The sample for the study consisted of parents who had children admitted to the PICU who later required resuscitation. Eight parent couples were recruited for the study (Maxton, 2008).

Information from the study was collected through in-depth, unstructured interviews conducted with either one parent or both parents generating a total of eight separate interviews. Interviews were audio-taped and transcribed verbatim. Answers were entered into a program for qualitative data management. Interviews lasted approximately 90 minutes each and were usually conducted in the parents' home or in a quiet room near the hospital unit. Debriefing was incorporated into the interviews to discuss any concerns about their thoughts. Analysis was conducted utilizing Van Manen's (1990) framework, which led to the construction of thematic statements and ultimately four themes (Maxton, 2008).

Careful consideration was given as to when to contact the family members to be interviewed. Initial contact with parents whose child survived was made approximately one week after the resuscitation, following consultation with healthcare personnel. Parents then chose a suitable time and place for the interview. When the resuscitation was unsuccessful, contact was implemented through the social worker approximately three months after the loss of their loved one. When parents agreed to participate, they were contacted by letter, and then a follow up phone call was made a week later (Maxton, 2008).

Findings from Maxton's (2008) analysis captured four themes from the parents' experience:

1. Being only for a child.
2. Making sense of a living nightmare.
3. Maintaining hope in the face of reality.
4. Living in a relationship with staff.

Being there for the child, providing comfort and support for the child, and thus comforting themselves were needs of parents. This theme related to the parents' distress and uncertainty at being present, yet their desire to understand the procedure and terminology and make sense of their feelings. Maintaining hope and remaining positive were important when coping with the immediacy of the resuscitation. Parents wanted physical and emotional support from numerous sources in order to cope more effectively with the resuscitation. The findings gave insight into the uncertainty and confusion for parents present during their child's resuscitation.

Maxton (2008) concluded that the parents' strong need to be with their child took priority over any apparent fears they may have had about being present during resuscitation. This need was a natural, unconscious response, and the alternative of not staying in the room was not an option to parents. Clinical practice guidelines must reflect the crucial importance of the family and support parents' decisions throughout the PICU stay, as well as during resuscitation.

Health Care Professionals' Perspectives on Family Presence during Resuscitation

While many professional guidelines have supported the implementation of FPDR, few studies have shared effective strategies for adopting and sustaining the practice (Mian et al., 2007). McClenathan and colleagues (2002) conducted a study to evaluate whether critical care professionals supported the recommendations from professional organizations to allow FPDR. The setting for the study was the International Meeting of the American College of Chest Physicians in San Francisco, California, from October 23 to 26, 2000. Participating health care professionals completed a short pen-and-paper survey about their CPR experience, their opinions on FPDR, and demographic characteristics. The opinions of 592 physicians, nurses, and other allied professionals were compared, and differences in opinions based on demographics were observed (McClenathan et al., 2002).

The study by McClenathan et al. (2002) compared the perceptions of health care

professionals across various demographic groups. The level of statistical significance for the study was set at < 0.05 . For analysis of regional variations, the USA was divided into Northeast, Midwest, South, and West regions using the USA Census Bureau methodology.

Findings from McClenathan et al. (2002) revealed that neither gender nor ethnicity influenced the survey responses. There was not a significant difference in opinions based on the size or type of the hospitals participating. Regardless of the occupation, the majority (78%) of health care professionals who participated opposed FPDR. There were differences in opinions based on the regional location of the hospital. Health care professionals in the Northeast were less likely to allow FPDR; Midwestern professionals were more apt to allow the families to be present. Three hundred forty-three participants (59%) had previously been involved in FPDR; of those participants, 40% would allow FPDR again.

McClenathan et al. (2002) concluded that the majority of the health care professionals surveyed were opposed to FPDR. Reasons for opposing FPDR were fear of psychological trauma to the family, increased legal ramifications, performance anxiety among the resuscitation team, and distraction of the resuscitation team. The authors encouraged rigorous scientific study of FPDR before adoption and implementation.

Mian and colleagues (2007) conducted a study to design and implement a FPDR program in an ED and to research the attitudes and behaviors of the staff and family prior to and after the implementation of the program. The implied underlying conceptual framework of this study was attitudes of staff and family pre and post initiation of the FPDR program.

The setting was an 898-bed urban academic medical center in the northeast. The ED was a level I trauma center with 50 beds that received more than 77,000 visits per year. The sample included all nurses and physicians currently employed in the ED who were willing to participate

in the surveys in January 2002 and May 2003. The initial survey was completed by 86 nurses and 35 physicians, and the follow-up survey was completed by 89 nurses and 14 physicians.

Demographics for both surveys were similar (Mian et al., 2007).

An anonymous survey consisted of three parts designed to measure the major factors thought to influence healthcare professionals' willingness to participate in FPDR. The questionnaire's three parts were:

1. Professional attitudes, values, and behaviors; this part consisted of a 30-item Likert scale, with each question having five potential responses.
2. Personal and professional experiences with FPDR; this part contained 12 questions.
3. Demographic questions included respondents' age, gender, educational level, and years of practice in the ED.

Content validity was supported through expert review, and internal reliability was acceptable for the total items and the subscales (Mian et al., 2007).

Findings from Mian et al.'s (2007) initial survey showed that nurses reported greater support for families to be present than did the physicians (71% vs. 51%). Some of the concerns voiced by the physicians and nurses included the emotional distress for families, family interfering with teaching the residents, and increased anxiety among the staff. However, health care providers in this study did not report concerns about confidentiality or malpractice suits.

Findings from Mian et al. (2007) on the follow-up survey after the implementation of a family presence program in the ED were that nurses' support for family presence was greater. The physicians were less supportive on the follow-up survey; however, only a small number of them responded to the survey. Nurses' beliefs about the benefits to family members were still low, and the physicians voiced more concerns about practice issues than they had shown on the initial survey. On the post-test, a smaller number of both nurses and physicians expressed concerns about interference with teaching.

Mian et al. (2007) reported that, despite the concerns of the nurses and physicians, the implementation of FPDR program was successful and had become an usual practice in the ED. Crucial factors in the implementation of this program were support from administration and the availability of the research team. When the program was initially started, family were present in the resuscitation room only a few minutes; however, as the staff became more accepting of the practice, some family members stayed for the entire resuscitation. The authors found that FPDR was a nurse-motivated practice. The key to change was a continuous reinforcement of the new practice, along with support and optimistic validation for the staff as well as the family.

In another study of emergency care nurses, Madden and Condon (2007) conducted a study to examine current practices and understanding of FPDR. The setting was the ED at Cork University Hospital, Republic of Ireland. The authors interviewed 90 ED nurses with at least six months of ED experience who were working in a large level one trauma center.

Madden and Condon (2007) utilized quantitative methods in this study. A survey questionnaire, developed by the ENA, was distributed to the 90 participating ED nurses. Content validity was previously supported by the ENA through expert review. The tool for the study was previously tested for reliability and validity in a different ED.

Findings from Madden and Condon (2007) were that ED nurses often took families to the bedside during the resuscitation of a family member (58.9%). The majority of the respondents (74.4%) preferred a written policy allowing the option of family presence during CPR. The main barrier to FPDR that arose from the study was conflicts occurring within the ER team. The most noteworthy method to promote FPDR was a greater understanding of health care professionals on the benefits of FPDR to patients and families, signifying the need for education of the personnel.

Madden and Condon (2007) concluded that there was a need for the development of written policies and guidelines on FPDR to meet the needs of patients, families, and staff by providing consistent, harmless, and caring practices for all involved in the resuscitation event.

Recommendations by the authors included the development of a written policy and an educational program on the implementation and practices of FPDR.

In a publication that focused on a different population of health care professionals, Walker (2008) conducted a literature review to identify the pros and cons of FPDR as reported by accident and emergency health care providers (A & E). The underlying conceptual framework for the study consisted of accident and emergency health care staff's opinions of the positive and negative effects of FPDR.

The literature review included 18 research studies from database such as CINAHL, Medline, EMBASE, psychINFO and BNI database. The studies included were published between 1987 and 2007. Studies were incorporated if they included:

1. A & E healthcare staff in the target groups.
2. Investigated the attitudes and opinions of A & E healthcare staff based in primary care environments.
3. Focused on family's and relatives' presence during an adult resuscitation attempt (Walker, 2008).

Information for this study was obtained by a database search using a variety of databases and search terms associated with FPDR. Eleven studies were included in the review. Several limitations of the studies were noted, however. First, factors influencing external validity, such as sample size and characteristics of the respondent groups, limited the degree to which the findings could be generalized beyond those studies. Another deficit related to the percentage of participants who had experienced FPDR. In the 11 reports provided, only half of the A & E staff who was surveyed had been exposed to FPDR. The validity of the surveys used also questioned due to the difference in definitions of FPDR (Walker, 2008).

Findings from Walker (2008) emerged as three outcomes, which were divided into three categories: effects on the resuscitation team, effects on the resuscitation event, and effects on

family members. Effects on the resuscitation team found by Walker were inhibition of staff performance with the family present. It was found that among doctors the likelihood of allowing family presence increased with seniority. Overall, there was little support from all providers for FPDR and few regarded the family presence as appropriate. Findings from Walker also showed the increase in staff stress with FPDR. However, more nurses were in favor of the possibility of allowing family to be present compared to less than half of the medical staff. Legal repercussions were a particular concern among the ED staff and were cited as a reason for not allowing the family to be present during a resuscitation of a loved one. Walker also found that physicians were concerned that families would be more apt to complain if they witnessed the resuscitation.

Effects on the resuscitation event found by Walker (2008) were fear that relatives' presence might adversely affect resuscitation procedures. It was felt that FPDR might hinder, interfere with, or obstruct resuscitation efforts. Another concern was the safety of the patient, relatives, and staff during the resuscitation. Walker also found that staff believed ceasing resuscitation efforts would become more difficult in the presence of the family members, but were not actually shown to occur.

Findings in this study also showed the effects on the family members who witnessed resuscitation. The main reason the family was discouraged from viewing the resuscitation was the psychological distress of the traumatic experience. Staff in the study also felt that by the family not being present the outcome of the resuscitation could be communicated more gradually. It was also found that by the family being present, they would know that every effort was made to resuscitate their loved one Walker (2008).

Walker (2008) concluded that FPDR is far from being readily accepted with fewer medical staff than nursing staff in favor of it. Overall, A & E healthcare staff established that both positive and negative outcomes are apparent with FPDR; however, they believe that there are

more risks than benefits. Walker felt that the need for continual research is recommended to better be able to understand FPDR.

In yet another study of the perceptions of health care professionals about FPDR, Basol, Ohman, Simones, and Skillings (2009) conducted a research study to explore the attitudes, concerns, and beliefs related to FPDR in a broad sample of professionals. The setting of the study was a Magnet-designated hospital in the Midwestern USA. The staff that was incorporated in the study consisted of staff nurses, nurses in management, physicians, nurse anesthetists, respiratory therapists, and spiritual care staff from a variety of patient care units. There were 1,402 surveys distributed; 625 of the surveys were returned, which was a 45% response rate. The majority of the participants were white (97.3%), female (80.3%), and nurses (78.8%). The participants ranged from 23 to 81 years in age; most had their current position for more than 10 years; and 72.2% had been involved in four or more resuscitations.

Data for the study was obtained using the 16-item Family Presence and Support: Staff Assessment Survey (ENA, 2001). This survey was utilized to identify the attitudes, concerns, and beliefs of healthcare personnel concerning FPDR. There were also three additional questions in relation to the benefits, influence, and support of a hospital policy implemented. The study also used a Likert scale that provided psychosocial and emotional support (Basol et al., 2009).

Findings from Basol et al. (2009) demonstrated support for family presence by critical care and emergency department nurses. Support for a policy giving families the option of being present during resuscitation was reported at 61.3%. Comments suggested by the participants were to: (a) have a designated team member to assist the family, (b) define “family member”, (c) consider cultural background, (d) acknowledge that pediatrics is different from adults, (e) articulate that parents should have a choice, and (f) institute callbacks to the families by the primary RN. Two negative comments by the participants were that some healthcare workers would quit if FPDR became common practice, and some nurses felt, if there was support for this

concept, then there should be more social workers and psychologists to treat the dysfunctional families.

Basol et al. (2009) concluded that a policy that details the responsibilities of nurses during FPDR would be valuable, providing organization and consistency to the entire facility. The authors also concluded that further research should focus on data collection through close-ended questions, rather than open-ended, to lessen the variety of responses that are produced by open-ended questions.

Perry (2009) carried out a study to discover the knowledge and experience of children's nurses related to FPDR. The setting was three acute pediatric units in one hospital, with all 94 nursing staff receiving the survey. Of the 94 nurses, only 32 (34%) nurses responded to the survey. Most were registered children's nurses; the remainder consisted of registered nurses with pediatric experience or healthcare support workers.

A postal survey was utilized, using a structured questionnaire with various open-ended questions. The values and beliefs of the nurses were assessed by means of a five-point, 15-statement Likert scale. The Statistical Package for Social Sciences was used to analyze the objective data. The values and belief tool was designed for this study, since no available tools were found specific to this subject. Therefore, the tool had limited reliability and needed to be piloted to detect any problems (Perry, 2009).

Findings from Perry (2009) were that two-thirds of the respondents expressed an optimistic outlook concerning FPDR. The majority of participating nurses had been involved in the resuscitation of a child where the family members had been present. The majority of these nurses felt capable to be an experienced support person, as required in the ENA guidelines. Regardless of seniority, the nurses who participated in the study reported a need for education and knowledge about FPDR. Nurses furthermore reported increased tension during a FPDR circumstance and recommended formal counseling and informal debriefing sessions be made

available for staff and parents. Perry concluded that the lack of knowledge of children's nurses about FPDR must be addressed to assist in improving the care of parents who witness resuscitation of their child.

In another research study that focused on nurses in critical care and emergency units, Gunes and Zaybak (2009) examined the experiences and attitudes of nurses in relation to FPDR. The authors noted that, despite some benefits the practice of FPDR, the issue remained an ethical, moral and legal predicament, especially in Turkey, where this study was conducted. The study was a descriptive study carried out between February and September of 2007. The setting was in the province of Izmir, the third biggest city in Turkey, population around 2.5 million. Critical care nurses from intensive care and the emergency department in two university hospitals were chosen. Nurses needed to have more than two years of experience to participate in the convenience sample. There were 255 eligible nurses invited to be in the study; 62 declined and 58 were on leave. Therefore, the response rate of the study was 53%.

Information was collected utilizing a structured questionnaire, consisting of 43 items focused on three areas of inquiry:

1. Sociodemographic characteristics-age, area of practice, and years of experience
2. Nurses' experience with FPDR
3. Nurses' attitudes toward FPDR

Content validity of the questionnaire was supported by a panel of experts consisting of five academic and five critical care nurses who rated the relevance and clarity of the questionnaire. Cronbach's alpha was utilized to estimate internal consistency reliability of the question; however the coefficient was not published. Descriptive statistics were used to characterize the sample and each of the survey items (Gunes & Zaybal, 2009).

In Gunes and Zabal's (2009) study, all subjects were female, ranging in age from 21-50 years, and 86.7% of the nurses had less than 10 years of experience. Of the nurses participating,

22.2% had experienced a situation where family members were present during resuscitation of a loved one. Approximately 94.8% had encouraged a family member to be present during resuscitation efforts. All of the nurses in the study reported that they had no protocol on FPDR. It was reported that 88.1% of participating nurses disputed that family should always be offered the opportunity to be with the patient during resuscitation. The majority of nurses (91.1%) agreed that nurses did not want family members to be present.

Gunes and Zabal (2009) concluded that many Turkish critical care nurses had no experience with FPDR and did not encourage the practice. Neither of the participating hospitals had protocols or a policy concerning FPDR. Turkish nurses disagreed with FPDR for many reasons, including fear of psychological trauma, legal litigation, performance anxiety, and distraction of the resuscitation team. The authors noted that further studies were needed in larger samples and should include physicians and family members.

In another study published the same year on the perceptions of critical care nurses related to FPDR, McClement et al. (2009) conducted an online survey in Canada, where surveys were distributed to 944 nurses, and approximately 450 (48%) of the nurses responded to the survey. The majority of them were female between the ages of 40 and 49 years, worked full time as staff nurses, and had been in practice as critical care nurses for more than 15 years. The majority of Canadian provinces and territories were represented in the sample. Eight percent of the participants indicated that their facility had a written policy for FPDR.

Information was collected from an 18-item survey showing the demographic data and assessing the nurses' practices, preferences, and hospital/professional organization policies related to FPDR. Participants were also allowed to describe in writing their experiences with FPDR. A company that specialized in online surveys was utilized to collect the data. Data analysis of written responses was completed using content analysis and constant comparison techniques (McClement et al., 2009).

Findings from McClement et al. (2009) were that, of the 450 critical nurses who completed the survey, 242 chose to share qualitative comments regarding their experiences with FPDR. There were four chief themes that materialized from the data:

1. Perceived benefits for family members
2. Perceived risks for family members
3. Perceived benefits for healthcare providers
4. Perceived risks for healthcare providers

McClement et al. (2009) concluded that the practice of FPDR influenced both family members and members of the resuscitation team. Nurses considered these effects when deciding whether or not to bring family members to the bedside. The authors also concluded that more research was needed that gave voice to those who have firsthand experience with the practice of FPDR and its effects on the psychological health of family members. They also called for more research on ways the healthcare teams can be supportive to the families during FPDR.

Summary of Findings

Although the practice of FPDR has acquired approval from many professional organizations and family members argue fervently for the opportunity to be present, uncertainty remains among health care professionals. The purpose of this study was to examine the FPDR-related viewpoints of healthcare professionals. In providing a context for this study, this chapter reviewed twelve studies on FPDR from the approach of both the families and health care professionals.

Several demographic factors were found to be related to perceptions of FPDR, including area of clinical specialty, membership in a professional nursing organization, clinical certification, RN rather than LPN (Twibell et al., 2008). Overall, nurses were more supportive of FPDR than physicians, and Emergency Department nurses had a better attitude concerning FPDR than nurses in other departments (McClenathan et al., 2002).

Multiple health care institutions did not have a policy pertaining to FPDR, although professional organizations such as the ENA and AACN recommended that institutions have a policy supporting FPDR. Most health care professionals favored a policy advocating FPDR (McClement et al., 2009).

The studies that concentrated on family perceptions all supported FPDR. Families believed that observing the attempted resuscitation assisted in the grieving process. Families felt that it was their right to have the opportunity to be in attendance at the resuscitation of their family member. Families did not perceive that being present during loved ones' resuscitation resulted in any increased stress or mental anguish (McGahey-Oakland et al., 2007; Maxton, 2008).

The studies that focused on the opinions and thoughts of health care professionals exhibited some support for FPDR; however, most concluded that further research was recommended to better understand reactions to FPDR. Some of the conclusions were that resuscitation could possibly cause psychological distress for the family; increased litigation; diminished safety for the patient, staff and family; hindrance of resuscitation efforts by the family; and increase in staff stress with family present (McClenathan et al., 2002; McGahey-Oakland et al., 2007). Mian et al. (2007) assessed health care professionals thoughts prior to and after the implementation of an education course on FPDR in the emergency department. The study found that, following the course, there were actual positive changes in the opinions of the staff concerning FPDR.

More research is also needed to clarify nurses' perceptions of FPDR and how perceptions are associated with demographic factors. Then educational approaches can be tailored to specific nurse characteristics, in an effort to resolve barriers to FPDR.

Chapter III

Methodology and Procedures

Introduction

Cardiopulmonary resuscitation (CPR) can be a demanding event for health care professionals. Performing effectively in a tense, fast-paced context can be challenging. The presence of families in the room during CPR can increase stress on the resuscitation team. Perceptions of nurses in relation to FPDR vary from favorable to unfavorable. FPDR is supported by a number of professional nursing organizations, including the AACN and ENA. Comprehending and comparing nurses' perceptions of FPDR as associated with nurse demographics may aid in planning education for nurses to support FPDR. This study partially replicates a research study by Twibell et al. (2008). The purpose of this study was to explore nurses' perceptions of FPDR and the relationships of these perceptions to selected demographic variables.

Research Question

The research question that directed the descriptive correlational study was "What are the relationships among nurses' perceptions related to FPDR and personal demographic variables?"

Population, Sample, and Setting

Nurses from three different hospitals in southeastern Indiana participated in this study. The population consisted of registered nurses employed full time as staff nurses in the emergency department and the critical care units. The participating nurses were all 18 years of age or older and could all read English. The three participating hospitals did not have a policy in place

supporting FPDR. The emergency department and critical care units of the hospitals rarely utilized FPDR. The hospitals that participated in the study were all 500-bed facilities that maintained Magnet status and employed 250 registered nurses. The convenience sample was made up of approximately 250 nurses, based on a power analysis.

Protection of Human Subjects

Documents for the study were presented to each of the three hospitals' Institutional Review Boards for approval prior to the onset of the study. Following the approval by the Institutional Review Board, the information was given to the Chief Nursing Officers and managers of each participating unit of all three hospitals. Packets containing all necessary information for the study were distributed by email to potential participants. The information packets were readily available in hard copy form on each unit. Advertisements about the study were made at unit meetings and by email.

The packets contained the survey, as well as a cover letter explaining the purpose of the study, participant rights, and the expected return date. Returning the survey served as consent to participate in the study, as stated in the cover letter.

Participation in the study was voluntary, and the participants were informed that they could withdrawal from the study at any time. All data collected were confidential and only viewed by the researchers and those entering the data. The survey was anonymous. The demographic variables collected consisted of gender, ethnicity, and education level, current certifications, type of unit where employed, and number of years of experience as a nurse. The participants could decide to omit any question about which they did not wish to disclose information.

There was neither reward nor punishment for participating or not participating in this research project. The only benefit to participating was to donate to professional knowledge on the subject of FPDR. The only risk was the remote possibility that participants could be

identified by unique demographic data. The diversity of the large sample pool provided assurance that an individual participant could not readily be identified through demographic data. Participants were informed that no effort would be made to determine who did and did not participate in the study.

The importance of the study was mentioned in the cover letter and included the expansion of knowledge about nurses' perceptions of FPDR, which only nurses can provide. The risk: benefit ratio was considered satisfactory.

Participants placed the completed instrument in a sealed envelope and deposited it in a collection box located in the participating nursing units. Completed surveys were kept in a locked file drawer in the locked office of the principal investigator. At the end of the study, the data will be destroyed by shredding and by deleting computer files.

Procedures

The researcher made information packets available on each of the participation nursing units; packets contained a copy of the cover letter explaining what each participant was to do in order to complete the surveys. A sealable envelope was given to each participant in which to place the completed survey; instructions were included to return completed surveys to a designated drop box centrally located in the departments. There was no interaction between the researcher and the participants pertaining to the study, unless the participant contacted the researcher to ask a question about the study.

Instruments and Methods of Measurement

Two instruments were utilized to measure nurses' perceived benefits and risks, nurses' self-confidence as related to FPDR, and chosen demographics. The Family Presence Risk-Benefit Scale (FPR-BS) constructed by Twibell et al. (2008) was used to measure nurses' perceptions of risks and benefits of FPDR. This tool consisted of 26 items utilizing a 5-point Likert scale ranging from strongly disagree (1) to strongly agree (5). The second instrument was

a 17-question Family Presence Self-Confidence Scale (FPS-CS) (Twibell et al. 2008). This instrument measured nurses' self-confidence in participating in the resuscitation of a patient with the family present. This instrument used the same Likert scale as the FPR-BS. Both instruments for the study were designed and evaluated for validity by a team of clinical experts in FPDR, statistical experts, and academicians. A pilot study was conducted with 20 nurses, which caused some modifications of both instruments preceding the use in the Twibell et al. study. Reliability and validity were supported in a test of the two tools in a sample of nurses ($n = 375$) from a variety of clinical settings in a hospital in the Midwest. Therefore, it was anticipated that the tools would be valid and reliable in the present study.

A tool that measured demographic variables was used. The variables consisted of age, gender, ethnicity, level of education as an RN or LPN, current professional certifications, type of unit, number of years experience and type of patients on their unit. An additional item questioned the number of times the participant had requested a family to be present during resuscitation efforts. The 3-point response scale for this item was never, less than five times, or greater than five times.

Data Analysis

Data were recorded into an SPSS program. Negatively worded items were reverse scored. Analysis of the construct validity of the FPR-BS and FPS-CS instruments (Twibell et al., 2008) was accomplished by a factor analysis with varimax rotation to explore the factor structure of the two scales. When the underlying structure of the scales was confirmed, Cronbach's alpha coefficient value was used to assess internal consistency reliability of scales. Descriptive analysis was used to explain demographic variables. Pearson r connections were utilized to assess relationships between scores on perceptual scales and the demographic variables measured at interval level. For data not measured at the interval level, other correlations were

chosen, and t-tests or analyses of variances were calculated to check for differences among groups. Significance was set at $p < .05$.

Summary

As a replication of the study performed by Twibell et al. (2008), this correlational study surveyed nurses' perceptions of FPDR and the relationships of these perceptions to selected demographic variables. Nurses who participated in the study ($n = 250$) completed two instruments. Data analysis incorporated psychometric testing of instruments, followed by correlations among study variables to address the research question. Results could shape learning strategies to advocate nurses' self-assurance in supporting in FPDR.

References

- Ajzen, I., & Fishbein, M. (1972). Attitudes and normative beliefs as factors influencing behavioral intentions. *Journal of Personality and Social Psychology*, *21*(1), 1-9.
- American Association of Critical-Care Nurses. (2004). Practice Alert: Family presence during CPR and invasive procedures. Retrieved from <http://www.aacn.org/AACN/practiceAlert.nsf/vwdoc/pa2>
- American Heart Association (2000). Guidelines 2000 for Cardiopulmonary Resuscitation and Emergency Cardiovascular Care. *Circulation*, *102*(8 suppl), I-1-I-291.
- Basol, R., Ohman, K., Simones, J., & Skillings, K. (2009). Using research to determine support for a policy on family presence during resuscitation. *Dimensions of Critical Care Nursing*, *28*(5), 237-247.
- Belanger, M. A., & Reed, S. (1997). A rural community hospital's experience with family-witnessed resuscitation. *Journal of Emergency Nursing*, *23*(3), 238-239.
- Breslau, N., Peterson, E. L., Kessler, R. C., & Schultz, L. R. (1999). Short screening scale for DSM-IV posttraumatic stress disorder. *American Journal of Psychiatry*, *156*(6), 908-911.
- Clift, L. (2006). Relatives in the resuscitation room: A review of benefits and risks. *Paediatr Nurse*, *18*(5), 14-18.
- Cooper, J. C., Cooper, J. D., & Cooper, J. M., (2006) . Cardiopulmonary resuscitation: History, current practice, and future direction. *Circulation*, *114*(25), 2839-2849.
- Derogatis, L. R. (2001). *Brief symptom inventory-18: Administration, scoring, and procedures manual*. Minneapolis, MN: NCS Pearson.

- Doyle, C. J., Post, H., Burney, R. E., Manio, J., Keefe, M., & Rhee, K. J. (1987). Family participation during resuscitation: An option. *Annals of Emergency Medicine*, *16*(6), 107-109.
- Ellison, S. (2003). Nurses' attitudes toward family presence during resuscitation efforts and invasive procedures. *Journal of Emergency Nursing*, *29*(6), 515-521.
- Emergency Nurses Association (2001). *Family presence manual: presenting the option for family presence* (2nd ed.). Des Plaines, IL: The Association.
- Fell, O. (2009). Family presence during resuscitation efforts. *Nursing Forum*, *44*(2), 144-150.
- Fitzgerald, K. (2008). Should families be present during resuscitation? *Medsurg Nursing*, *17*(6), 431-433.
- Grice, A. P., Picton, P., & Deakin, C. D. (2003). Study examining attitudes of staff, patients and relatives to witnessed resuscitation in adult intensive care units. *British Journal of Anaesthesia*, *91*(6), 820-824.
- Gunes, U., & Zaybak, A. (2009). A study of Turkish critical care nurses' perspectives regarding family-witnessed resuscitation. *Journal of Clinical Nursing*, *18*(12), 2907-2915.
- Hanson, C. S., & Strawser, D. (1992). Family presence during cardiopulmonary resuscitation: Foote Hospital emergency department's nine-year perspective. *Journal of Emergency Nursing*, *18*(2), 104-106.
- Holzhauser, K., & Finucane, J. (2007). Staff attitudes to family presence during resuscitation: Part A: An interventional study. *Australasian Emergency Nursing Journal*, *10*(3), 124-133.

- Lewin, K. (1947). Frontiers in group dynamics II. Channels of group life; social planning and action research. *Human relations*, 1(2), 143-153.
- Madden, E., & Condon C. (2007). Emergency nurses' current practices and understanding of family presence during CPR. *Journal of Emergency Nursing*, 3(5), 433-440.
- Maxton, F. (2008). Parental presence during resuscitation in the PICU: the parents' experience. *Journal of Clinical Nursing*, 17(5), 3168-3176.
- McClement, S., Fallis, W., & Pereira, A. (2009). Family presence during resuscitation: Canadian critical care nurses' perspectives. *Journal of Nursing Scholarship*, 41(3), 233-240.
- McClenathan, B., Torrington, K., & Uyehara, C. (2002). Family member presence during cardiopulmonary resuscitation a survey of US and international critical care professionals. *Chest*, 22(6), 2204-2211.
- McGahey-Oakland, P. R., Lieder, H. S., Young, A., & Jefferson, L. S. (2007). Family experiences during resuscitation at a children's hospital emergency department. *Journal of Pediatric Nurse Practitioner*, 21(4), 217-225.
- Mian, P., Warchal, S., Whitney, S., Fitzmaurice, J., & Tancredi, D. (2007). Impact of a multifaceted intervention on nurses' and physicians' attitudes and behaviors toward family presence during resuscitation. *Critical Care Nurse*, 27(1), 52-61.
- Miller, J. H., & Stiles, A. (2009). Family presence during resuscitation and invasive procedures: The nurse experience. *Qualitative Health Research*, 19(19), 1431-1442.
- Nibert, A. (2005). Teaching clinical ethics using a case study family presence during cardiopulmonary resuscitation. *Critical Care Nurse*, 25(1), 38-43.

- Peplau, H. (1997). Peplau's theory of interpersonal relations. *Nursing Science Quarterly*, 10(4), 162-167.
- Perry, S. E. (2009). Support for parents witnessing resuscitation: Nurse perspectives. *Paediatric Nursing*, 21(6), 26-31.
- Ray, M. (2010). *A study of caring within an institutional culture*. Boca Raton, FL: Lambert Academic Publishing.
- Robinson, S. M. Mackenzie-Ross, S., Campbell Hewston, G. L., Egleston, C.V., & Prevost, A.T. (1998). Psychological effect of witnessed resuscitation on bereaved relatives. *Lancet*, 352(9128), 614-617.
- Rogers, E. (2003). *Diffusion of innovations (5th ed.)*. New York, NY: Free Press.
- Roussel, L., & Swansburg, R. C. (2009). *Management and leadership for nurse administrators (5th ed.)*. Sudbury, MA: Jones and Bartlett Publishers.
- Tamekia, L. (2008). Family presence: To stay or not to stay? *Nursing*, 38, 6-8.
- Tomey, A., & Alligood, M. R. (2006). *Nursing theorists and their work (6th ed.)*. Louis, MO: Mosby.
- Twibell, R., Siela, D., Riwtis, C., Wheatley, J., Riegle, T., Bousman, D...Neal, A. (2008). Nurses' perceptions of their self-confidence and the benefits and risks of family presence during resuscitation. *American Journal of Critical Care*, 17(2), 101-111.
- Van Manen, M. (1990). *Researching lived experience: Human science for an action sensitive pedagogy*. Suny Press.
- Walker, W. (2008). Accident and emergency staff opinion on the effects of family presence during adult resuscitation: Critical literature review. *Journal of Advanced Nursing*, 61(4), 348-362.

Ware, J., Kosinski, M., Turner-Bowker, D., & Gandek, B. (2002). *SF-12: How to score version 2 of the SF-12 Health Survey*. Lincoln, RI: Quality Metric Incorporated.