FAMILY PRESENCE DURING RESUSCITATION: WHY OR WHY NOT?

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Family presence during resuscitation (FPDR) has been a controversial issue worldwide over the past two decades. Health care institutions have differing practices regarding FPDR. Health care team members are often not in consensus about FPDR. Research has not yet clarified the perceptions of nurses from diverse geographic areas regarding FPDR. This study proposed to expand what was known about nurses’ perceptions of risks and benefits regarding families being present during resuscitation efforts. This study took place in one large health care system in one Midwestern state. It was a partial replication of Twibell et al.’s (2008) study. The framework for the study was the Resiliency Model of Family, Stress, Adjustment, and Adaptation (McCubbin & McCubbin, 1996). The convenience sample for this correlational study was 300 registered nurses. Instrumentation included the Family Presence Risk-Benefit Scale (Twibell et al.). Results illuminate nurses’ perceptions that may influence practice decisions and institutional policies regarding FPDR. The information may give nurse educators, managers, and clinical leaders guidance in developing policies and procedures for FPDR.
Chapter One

Introduction

Family-centered care is a type of health care delivery that strives for excellent patient outcomes. It was first defined in 1987 as an initiative advanced by the former Surgeon General of the United States of America, C. Everett Koop. The initiative is a care delivery model built on relationships and intended to promote family-centered, community-based, coordinated care. It was originally designed for children with special needs and their families, yet is relevant for all ages in all health care settings (McCullough, 2010). The underlying premise of family-centered care is that each patient is an extension of a larger unit: specifically, his or her family. Families’ needs have been well documented when loved ones are hospitalized (Madden & Condon, 2007). Nurses, as key members of the health team, strive to meet the needs of patients’ families, including needs for information, support, and the opportunity to be near loved ones during illness.

The process of moving toward family-centered care, particularly during hospitalization, has created a controversial issue in family presence during resuscitation (FPDR). Widespread debate has been continuing over two decades, since the inception of the practice of FPDR. Differences of opinion generally revolve around the risks and benefits of having family present in the room during a life-threatening resuscitation attempt. Research on FPDR is growing as healthcare professionals (HCPs) seek to make sound decisions for patients and families (Duran, Oman, Abel, Koziel, & Szymanski, 2007).

FPDR is becoming a more acceptable practice in the United States (U.S.), despite a lack of strong research evidence about the outcomes of FPDR and how to implement it effectively.
Professional organizations have started advocating for FPDR and offering guidelines for implementation that require further testing. Nurses are often the gatekeepers of the FPDR process. Nurses communicate with all stakeholders in the resuscitation event, negotiate the family invitation, provide support to the family during the resuscitation, and assist with debriefing and comforting after the resuscitation event. Research reveals that nurses often are ambivalent about FPDR, and nurses’ perceptions of risks and benefits have not been thoroughly explicated (Twibell et al., 2008). Further exploration of nurses’ perceptions of FPDR is essential in order to guide the practice of implementing FPDR in a culture of family-centered care.

**Background and Significance**

FPDR is not a new concept. In colonial times, death was an accepted part of life. Families were the caregivers of their loved ones, and homes were the hospitals. The family was present during all aspects of care from birth to death. Then, medicine advanced, and hospitals became the places where care was given and death often occurred. Families were no longer allowed to be present at their loved ones’ bedside whenever they desired. They were allocated to the role of a visitor, and during critical illness, families often were separated from their loved ones and sent to waiting rooms where they spent hours between brief visits to the bedside (McCullough, 2010).

Families first requested to be present at a resuscitation attempt in a hospital at Foote Hospital in Michigan in the U.S. in 1987. Families were permitted to be present in the room when emergency resuscitation procedures were in progress with their loved one. Research over the last 25 years has produced hundreds of studies on many aspects of FPDR. Studies have investigated the effects of FPDR on family members and patients (Duran et al., 2007). Initially, investigations of the attitudes of nurses, physicians, and other health care
providers about FPDR revealed that health care professionals (HCPs) perceived many risks and few benefits of FPDR. Support for FPDR has steadily gained momentum since 2000 when professional medical organizations began publishing guidelines for development of policies for family presence.

Several professional organizations of healthcare worldwide have demonstrated strong support of FPDR. Written recommendations were published, and national consensus guidelines were released from these organizations, starting in the year 2000. American Heart Association and International Liaison Committee released cardio-pulmonary resuscitation (CPR) guidelines in 2000 to encourage family presence during CPR (American Heart Association, 2005). Emergency Nurses Association (ENA) has supported FPDR since 1993. The ENA published a recommendation in 2005 that healthcare facilities create formal written policies on FPDR. The European Resuscitation Council posted a recommendation in their CPR guidelines that families be given the option of being present for CPR in 2005. The European Federation of Critical Care Nursing Association developed guidelines for FPDR in 2007 (McCullough, 2010). The American Association of Critical Care Nurses (AACN) (2010) published a Practice Alert on the subject to give guidance for FPDR.

Despite the written guidelines, published suggestions to develop policies and procedures regarding FPDR, and the research completed over the last 25 years, this topic continues to be discussed and debated throughout the medical world. Interestingly, there are fewer than 5% of the hospitals in the U.S. that have developed and approved a written FPDR guideline or policy (AACN, 2010).

Adoption of FPDR is even less accepted in other parts of the world than in the United States. Research studies have been completed in Germany, Canada, Malaysia, Israel, and Turkey with
nurses and other health care professionals related to the perceptions of risks and benefits of FPDR. The risks and benefits noted by Emergency Department and critical care nurses were closely related in theme to those identified by western nurses; non-western nurses perceived more risk than benefit. Global consensus about FPDR has not yet been attained (Duran et al., 2007; Fell, 2009).

Emergency departments (ED) and critical care units have been reported the most likely areas for resuscitation to take place (Madden & Condon, 2007). A review of the literature revealed most studies have been conducted with ED nurses and critical care nurses. The review indicated FPDR was an accepted practice in some hospitals and taboo in others. FPDR is a debated phenomenon across all types of medical units, not just ED and critical care units.

**Family Perceptions of FPDR**

Families began requesting to be present during resuscitation in the 1980s, and even families who did not want to stay at the bedside during a resuscitation at least wanted the option offered to them. Many family members asserted the “right” to be present during resuscitation was important and helpful to them. Families wanted to physically “be with” the patient, stay informed of their loved one’s condition, provide comfort to loved one, and be comforted and supported by the health care team (Madden & Condon, 2007). Additionally, family members indicated FPDR decreased fear, worry, and sense of helplessness; decreased guilt for leaving patient during a crisis; facilitated the grieving process; and provided greater ability to cope with loss. Family member participants of FPDR (a) stated they would attend another resuscitative event, (b) did not intrude into the resuscitative process, (c) kept their attention focused on their loved one, and (d) did not report any adverse effects from witnessing the resuscitation (Koberich, Kaltwasser, Rothaug, & Albarran, 2010).
Prior research studies did not show results of adverse psychological effects on family members who witnessed resuscitation, nor did the research show that resuscitation processes were interrupted by FPDR (Leske & Brasel, 2010). There have not been any legal action suits filed by family members who participated in FPDR noted in studies.

**Patients’ Perceptions on FPDR**

Patients identified their emotional and psychological needs were met by FPDR (Madden & Condon, 2007). Patients expressed FPDR comforted them and maintained a sense of patient-family connectedness (Oman & Duran, 2010). Patients reported that family members would benefit from FPDR and help them understand everything was done to save the life of the loved one (Koberich et al., 2010). Recently resuscitated patients and those who had never required resuscitation both supported FPDR (Feagan & Fisher, 2011). Belanger and Reed (1997) recorded a FPDR event in which a 60-year old man was interviewed after his resuscitation event. He had stated “he was very much aware of his wife’s presence, which was enough of an encouragement for him to continue his fight for survival” (p. 239).

**Medical Professionals’ Perceptions about FPDR**

Numerous concerns and benefits have been identified by health care professionals related to FPDR. Concerns most often cited in research studies have included: potential trauma the family member might experience when witnessing a resuscitation event; the family’s possible disruption or interference with the resuscitation team and its process; anxiety among the resuscitation team members due to family members being present or watching them; and medical-legal concerns (Twibell et al., 2008). Other issues brought out by staff perceptions were violation of patient’s confidentiality, difficulty protecting patient’s privacy, family members out of control, inadequate
staff to support family, and family misinterpretation of resuscitation events (Oman & Duran, 2010; Sheng, Lim, & Rashidi, 2010; Leske & Brasel, 2010).

Perceptions of benefits as viewed by nurses were listed as knowing everything possible was done to save their loved one, facilitation of the grieving process, family’s ability to see seriousness of condition and changes in condition as they occurred, closure on shared life, and enhanced professional conduct of resuscitation team (Itzhaki, Par-Tal, & Barnoy, 2011; Leske & Brasel, 2010). Additional positive benefits acknowledged were staff recognized the patient as part of family during resuscitation, family members were more likely to terminate resuscitation if present, and family felt their presence had supported patient during resuscitation (Koberich et al., 2010; Mian, Warchal, Whitney, Fitzmaurice, & Tancredi, 2007; Oman & Duran, 2010; Sheng et al., 2010).

Patients and families expect to be involved in their care in the healthcare environment, including making decisions during end of life events. Hospitals and health care providers continue to incorporate the patient and family processes that are shown to create satisfaction with healthcare. These processes need to be evidence-based and professionally supported so as to avoid litigation. Policies and programs need to be developed that support the healthcare provider in providing appropriate interventions and opportunities for families to participate in a loved one’s care. In particular, as the topic of FPDR continues to evolve, research will play a vital role in determining best practices and resolution of the debate surrounding FPDR. Perceptions of HCPs need further clarification and definition. Specifically, knowledge of nurses’ perceptions is needed as nurses are the key HCPs involved with all aspects of a resuscitation event, including inviting family to bedside, supporting family during resuscitation, and comforting of family following the resuscitation event.
Statement of the Problem

FPDR is a controversial issue worldwide. Patients and families have overwhelmingly voiced their desires regarding FPDR (Itzhaki et al., 2011; Leske & Brasel, 2010; Madden & Condon, 2007; Sheng et al., 2010). Families contend it is their right to be present with loved ones during resuscitation. Patients in general want families to be present, or at least have the option to be present. Health care team members see advantages and disadvantages. Nurses, who are key personnel in resuscitation efforts, report ambivalence regarding the risks and benefits of FPDR. More research is needed on nurses’ perceptions related to FPDR so that consensus can be reached in the health care community and best practices can be designed for optimal patient outcomes.

Purpose of the Study

The purpose of the study was to explore nurses’ perceptions of risks and benefits regarding families’ presence at the bedside during resuscitation.

Research Questions

The research questions that guided the study were:

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

2. What are nurses’ perceptions of risks and benefits related to the family presence during resuscitation and selected demographic variables?

Conceptual Framework

The conceptual framework that guided this study was McCubbin and McCubbin’s (1996) Resiliency Model of Family Stress, Adjustment and Adaptation. This family stress theory is based on Reuben Hill’s (1949) ABCX Framework. It is a combination of the ABCX Framework
and three additional family stress theories grounded in the ABCX framework. These theories have been developed over the last 40 years, and the Resiliency Model of Family Stress, Adjustment, and Adaptation (McCubbin & McCubbin, 1996) is the most current version of this work.

Hill’s (1949) original ABCX Model identified the following components: A is the stressor (change in a loved one’s medical condition); B is the resource (how does the family cope); C is the family’s definition of the stressor (change in family as a result of change in condition); and X is the crisis situation (resuscitation event). McCubbin and McCubbin (1996) developed this model further beginning in 1976. Their research indicated there were more factors involved in family recovery than in the original model. The current model includes family adjustment and adaptation as well as resiliency.

Definition of Terms

Family members.

*Conceptual Definition:* Family members included individuals, relatives or significant others with whom the patient shared an established relationship.

Family presence during resuscitation.

*Conceptual Definition:* FPDR means a family member(s) is present at the bedside of a loved one who is receiving active cardiopulmonary resuscitation.

*Operational Definition:* The actual location of a family member during a loved one’s resuscitation.

Resuscitation.

*Conceptual Definition:* Resuscitation is a sequence of events initiated to sustain life or prevent further deterioration of the patient’s condition in an acute health episode.
(Leske & Brasel, 2010).

Nurses’ Perceived Risks of FPDR.

*Conceptual Definition:* Perceived risks are the negative outcomes nurses are concerned might occur during or in relation to FPDR.

*Operational Definition:* Self-reported areas of possible perceived loss, based on nurses’ beliefs and attitudes in relation to FPDR.

Nurses’ Perceived Benefits of FPDR.

*Conceptual Definition:* Perceived benefits are the positive results nurses believed would occur during or in relation to FPDR.

*Operational Definition:* Benefits nurses identified as their own beliefs and attitudes in relation to FPDR.

Limitations

The study was limited by the participants’ reporting only of their perceptions of risks and benefits of FPDR. No questions were asked regarding prior experience with a resuscitation event or if the nurse had ever participated in a resuscitative event. Previous studies showed perceptions are changed with participation in resuscitation events (Koberich et al., 2010) and with experience in nursing (Twibell et al., 2008; Itzhaki et al., 2011). Generalizability of results of the study may be limited secondary to limited ethnicity of sample and the fact that the sample was all from a single mid-western hospital. Research studies have indicated culture and geographical region have an impact on FPDR (Sheng et al., 2010; Koberich et al., 2010).

Assumptions

The assumptions that grounded this study included:

1. All respondents answered questions honestly based on their own experience.
2. The sample was representative of the population studied.

Summary

FPDR has become a growing trend in the United States over the last 25 years. It has remained surrounded by controversy over that same time period. Families believe it is their right to be present and want to be given the option of FPDR. Patients generally want families to have the option and see advantages to having their family with them. Health care professionals express ambivalence, reporting both risks and benefits. Nurses are key personnel in the FPDR dilemma. More research is needed to clarify the perceptions of nurses related to FPDR. The purpose of this study was to expand what is known about nurses’ perceptions of risks and benefits regarding families being present at the bedside during resuscitation.
Chapter II

Literature Review

FPDR is a controversial issue worldwide. Families contend it is their right to be present with loved ones during resuscitation. Patients in general want families to be present, or at least have the option to be present. Health care team members see advantages and disadvantages. Nurses, who are key personnel in resuscitation efforts, report ambivalence regarding the risks and benefits of FPDR. More research is needed on nurses’ perceptions related to FPDR so that consensus can be reached in the health care community and best practices can be designed for optimal patient outcomes. The purpose of this study was to expand what is known about nurses’ perceptions of risks and benefits regarding families being present at the bedside during resuscitation. This is a partial replication of Twibell et al.’s (2008) research.

Organization of Literature

The literature is organized into three sections: (a) organizing framework; (b) nurses’ perceptions regarding FPDR; and (c) effects of FPDR on families and family members. Each section has analyses of studies conducted to explore concepts related to FPDR.

Organizing Framework

The conceptual framework that guided this study was McCubbin and McCubbin’s (1996) Resiliency Model of Family Stress, Adjustment and Adaptation. This family stress theory is based on Hill’s (1949) Family Stress Theory. It is a combination of the ABCX Framework and three additional family stress theories grounded in the ABCX framework. These theories have
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The Resiliency Model (McCubbin & McCubbin, 1996) describes a set of relationships among family strengths and outcomes. Family strengths are identified as resources, coping, and problem-solving communication. Outcomes are the result of the family adapting to the stress of a critical situation and the strengths of the family to manage it (Leske & Brasel, 2010).

This model presents a means to assess family functioning and the coping mechanisms used to attain adjustment and adaptation to a medically stressful hospitalization or diagnosis. This middle range theory helps nurses to understand stages of illness and family’s response. The Resiliency Model (McCubbin & McCubbin, 1996) guides nursing practice to recognize a family’s needs beyond a precipitating event, such as resuscitation. The three main areas assessed include stressors, family coping, and how did the precipitating event affect family functioning. This model also includes the components of adaptation and resiliency. Both of these focus on family strengths and response to health stressors in relation to how well the family recovers from the event. The Resiliency Model has been used extensively in nursing research as well as social
science disciplines to validate family theories of adjustment, adaptation and resiliency, especially in chronic and life-threatening illnesses.

The first of family strengths, resources, involve each individual family member, the entire family as a whole, and the community the family is involved in. Resources are the capabilities the family has to manage a critical situation. The critical situation in this study is the resuscitation of a loved one. Personal, social, and economical resources are the important supports most families require in order to maintain their family as a functioning unit after a resuscitation event (Leske & Jiricka, 1998).

The next identified resource is coping. Family coping involves maintaining or strengthening the family, maintaining emotional stability and well-being of family members, use of family and community resources to manage the stressor, and beginning to resolve the hardships caused by the stressor. Individual coping responses in family members often play a role in how the family responds as a unit and, in some studies, have been found to have a significant relationship to how the loved one recovers from the precipitating event (Leske & Jiricka, 1998).

Problem-solving communication is often the piece of family resources that becomes more supportive or becomes an additional stressor and escalates family conflict. It reflects the family’s ability to break down a stressor into manageable pieces, decide alternative courses of action, and cultivate the best communication needed to deal with the resuscitation or the resuscitation outcome. Understanding the loved one’s medical condition and having information about the progress or changes in a loved one’s condition are components necessary for family to problem solve adequately (Leske & Jiricka, 1998; Leske & Brasel, 2010).

Coping and problem-solving communication together promote reduction or elimination of a stressor, and help the family generate additional personal and community resources, as well as
promote family adaptation (Leske & Brasel, 2010). It is dependent upon a family’s response to a stressful event, the family’s available resources, and coping strategies. Adaptation is a continuum ranging from maladaptation to bonadaptation (negative to positive adaptation) and is an ongoing, dynamic process. Family adaptation is the outcome of the family using its resources to balance the stress of a resuscitation event and possible loss of a loved one and the strengths of family resources to manage the illness or loss of the loved one.

**Nurses’ Perceptions regarding FPDR**

Duran and colleagues (2007) conducted a study to explore perceptions of various stakeholders regarding family presence during resuscitation. FPDR has been defined as “the attendance of patients’ family members during resuscitation attempts and/or invasive procedures” (p. 271). Duran et al. noted that some healthcare providers are reluctant to include family members in resuscitation procedures for various reasons, including (a) viewing the resuscitation event may offend some family members, (b) family members might be disruptive or unable to deal with the event itself, (c) staff could feel additional stress, and (d) family presence might interfere with the resuscitation event. The purpose of this particular study was “to describe and compare attitudes and beliefs about FPDR of healthcare providers, patients’ family members, and patients” (p. 273).

This descriptive study took place in a 300-bed academic hospital in the western United States. Units included Emergency Department, three different types of adult intensive care units, and the neonatal intensive care unit (NICU). Surveys (n = 1,093) were mailed to health care providers from the aforementioned units. Providers (n = 202) responded with a response rate of 18% [15% physicians (n = 98), 27 % nurses (n = 98), and 15 % respiratory therapists (n = 6)]. Patients’ family response rate was 99 % (n = 72), and patient response rate was 95 % (n = 62).
Patients and family members were approached at the bedside and invited to participate, which could explain the high response rate. Exclusions from study were: less than 18 years of age, did not speak English, confused, delirious, emotionally distraught, unstable hemo-dynamically, or incapable of making decisions as assessed by the bedside nurse. For NICU surveys, only family members participated. No prior experience with FPDR was needed to participate in the study (Duran et al., 2007).

Surveys were adapted from a prior FPDR study completed at Parkland Health and Hospital System in Dallas, Texas in 2000. The original survey targeted participants’ attitudes toward and beliefs about FPDR, whether or not prior experience with FPDR existed. The healthcare provider survey had 74 items; the survey for patients’ families had 58 items; and the patients’ survey had 52 items. Healthcare provider surveys included definitions for resuscitation events and invasive procedures. Validation of surveys occurred by expert review from nursing school faculty, one nurse research scientist, pastoral care team member, emergency department doctors, and adult and neonatal ICU nurses. Pilot testing of the survey was completed by healthcare providers and people from the general public. Cronbach alphas were .97 for healthcare provider surveys, .93 for family member survey, and .89 for patient surveys (Duran et al., 2007).

Mean scores for scales on each survey were converted to an overall mean family presence attitude score (M-FPAS). Higher M-FPAS scores indicated more positive attitudes regarding FPDR. The possible range of mean scores on the instruments was 1 to 4 with 1 being strongly disagree and 4 being strongly agree. Higher values indicated participants were more favorable towards FPDR (Duran et al., 2007).

Demographic data of healthcare providers indicated 88% were white, two-thirds were female, the mean age was 40 years (SD = 11.22); and the mean of years in practice was 13 (SD =
66% of the health care professional respondents had prior experience with FPDR, and 86% had prior experience with family presence in an invasive procedure.

Results for healthcare providers reflected an overall positive attitude regarding FPDR ($M_{FPAS} = 2.59$, $SD = 0.48$). Respiratory therapists scored highest for positive attitude ($M_{FPAS} = 2.87$, $SD = 0.75$). Significant differences were noted between attitudes of healthcare providers who had prior experience with FPDR and those health care providers who did not have prior experience ($p < .001$). Likewise, attitudes differed between respondents who did and did not have experience with family presence during an invasive procedure ($p < .001$). Health care providers who had experience were more positive about FPDR (Duran et al., 2007).

Duran et al.’s (2007) study indicated significant differences in mean attitude scores between nurses and physicians (nurses’ $M_{FPAS} = 2.79$ and physicians’ $M_{FPAS} = 2.37$, $p < .011$). Interestingly, non-attending physicians, including interns, residents, and fellows, had more positive attitudes about FPDR than did the attending physicians ($p < .02$). For healthcare providers, the majority had positive attitudes for supporting FPDR (54%) as well as family presence during invasive procedures (69%).

Duran et al. (2007) addressed policy development for family presence in their study as well. Nurses liked the idea of a written policy better than physicians (86% and 46%, respectively). 66% of the healthcare providers ($n = 123$) supported development of a written policy for FPDR.

Four themes were recognized by Duran et al. (2007) from the analysis of the healthcare providers’ qualitative data. Themes included concerns for patient and family safety, concerns about the emotional responses of the family members, performance anxiety of health care professionals, and the need to individualize FPDR experience.
Family members involved in the study were generally white, married females with a mean age of 44 years (SD = 16.13). 24% (n = 16) had graduated from college. 31% (n = 20) had prior experience of being present when a loved one had an invasive procedure or had been resuscitated. Family M-FPAS was 2.9 (SD = 0.41). Survey results indicated family members believed “it was their right to witness their loved one’s resuscitation and/or invasive procedure” (p. 276). Family members wanted staff to offer them the chance to be present if they so desired. Families reported that being present would enhance the family’s understanding of the patient’s condition. Ninety-five percent (n = 18) of those with prior family presence experience indicated they would repeat the experience. Results indicated family members could control emotions and actions while witnessing the scene of their loved one being resuscitated (Duran et al., 2007). Most qualitative questions were not answered by the family members, so analysis was not completed on these questions.

Patient demographics indicated most were white (72%, n = 44), female (52%, n = 32), with a mean age of 43 years (SD = 15.45). Some had post high school education (36%, n = 32) and 48% (n = 29) were married. Sixteen patients (29%) had prior experience with having a family member present either during resuscitation or an invasive procedure. Patient M-FPAS was 2.65 (SD = 0.45). Patients’ results indicated they would feel comforted with a family member with them. As in family member analysis, no analysis of qualitative data was completed secondary to many questions left unanswered (Duran et al., 2007).

The results of Duran et al.’s (2007) study were consistent with many other studies completed on FPDR. One exception was that non-attending physicians were more positive than attending physicians. The healthcare provider participants indicated a need for a policy on family presence
for consistent practice. One of the limitations noted by the authors was the need for a more diverse sample.

In a similar study that focused on the perceptions of only nurses, Twibell et al. (2008) examined nurses’ perceptions of self-confidence related to family presence during a resuscitation event, as well as perceived risks and benefits of family presence during a resuscitation event. Four research questions framed the study:

1. What are the psychometric properties of two new instruments used to measure nurses’ perceptions related to family presence?
2. What are the relationships between nurses’ perceptions of risks, benefits, and self-confidence related to family presence during resuscitation?
3. What are the relationships among demographic variables and nurses’ perceptions of family presence during resuscitation?
4. What are the differences in perceptions of nurses who have and have not invited patients’ families to be present during resuscitation? (Twibell et al., 2008, p. 102).

Three gaps in knowledge were addressed in this study. First, most of the research on FPDR has been done through opinion surveys or interviews. These types of studies are difficult to replicate. If survey questions differ, the findings cannot be compared. Secondly, previous research studies on FPDR have not had a conceptual framework for the basis of the study. Thirdly, samples from earlier research have not included nurses who worked in non-critical care units. Most sample numbers were less than 100 with low response rate. In addition, demographics were not consistently measured in previous studies (Twibell et al., 2008).

This study used an exploratory design. The convenience sample came from a 348-bed Midwestern teaching hospital. Nurses had to be 18 years or older, able to read English, and hold
a nursing license in Indiana in order to participate. RNs and LPNs (n = 375) responded for a response rate of 64%. Nurses worked in critical care areas (36%, n = 136), noncritical care areas (44%, n = 165), emergency department (6%, n = 22), and outpatient setting (7%, n = 26). The majority of respondents were women who were white with at least 6 years nursing experience (Twibell et al., 2008)

Variables explored in this study were perceived risks, perceived benefits, and self-confidence related to FPDR. Twibell et al. (2008) developed two new instruments to measure these variables. The Family Presence Risk-Benefit Scale (FPR-BS) was used to measure nurses’ perceptions of the risks and benefits of family presence to the family, patient, and the resuscitation team. The Family Presence Self-Confidence Scale (FPS-CS) was used to measure nurses’ self-confidence related to managing resuscitation with patients’ families present. Validity of the two new tools was supported by factor analysis and criterion-related validity. Cronbach alpha reliability of the FPS-CS was 0.95 and reliability for the FPR-BS was 0.96. Both instruments used 5-point Likert scales, that ranged from (1) strongly disagree to (5) strongly agree.

Analysis of survey answers yielded a mean total score for the FPR-BS of 3.15 and for the FPS-CS, 3.65, with a range of 1 to 5. When nurses scored high on the FPR-BS, it indicated perceptions of more benefits and fewer risks; scoring lower indicated perceptions of more risks and less benefits. Twibell et al. (2008) reported significant correlations (r = 0.56, p < .001) between nurses’ perceptions of risks and benefits and self-confidence with family presence during resuscitation (FPDR). Nurses who believed FPDR contained fewer risks and more benefits were more self-confident in managing family presence (p = .008).
Perceptions between critical care nurses and non-critical care nurses were not significantly different. Membership or non-membership in a professional nursing organization resulted in significant differences in scores on the FPB-RS ($p < .001$). This same significance was noted between nurses who had a specialty certification and those who did not ($p < .001$). The exact same level of significance ($p < .001$) was noted on the FPS-CS between the same correlations of these two groups. Nurses with specialty certifications and membership in professional organizations believed there were fewer risks and more benefits and had more self-confidence than those not certified or not members of professional nursing organizations.

Emergency department nurses comprised just under 6% of the sample, yet, their perceptions were significantly different from rest of sample. They noted lower risks and more benefits ($p < .001$) and greater self-confidence ($p < .001$) than the rest of nurses in the study. Perceptions related to FPDR did not vary significantly among participants across varying education levels, ages, and years of nursing experience. Twibell et al. (2008) concluded that “the more times nurses invited family presence, the more benefits they perceived and the greater was their self-confidence” (p. 107).

Twibell et al. (2008) stated, “Initial tests of the FPR-BS and FPS-CS indicate that the scales provided reliable and valid measures of nurses’ perceptions of risks, benefits, and self-confidence related to family presence” (p. 110). Additional testing of the new tools is indicated. More research on nurses’ confidence and perceptions related to family presence is needed.

In another study of nurses’ perceptions of FPDR, Madden and Condon (2007) conducted the first comprehensive study in Ireland on emergency nurses and FPDR. Emergency departments, by nature of their environment, are the most likely areas for resuscitation events to occur. The purpose of this study was “to examine emergency nurses’ current practices and understanding of
family presence during cardiopulmonary resuscitation with a view to developing policies and guidelines” (p. 434). Four specific objectives were targeted in the study:

1. What are the demographic characteristics of the nurses in the sample?
2. What did nurses know about policies and procedures that addressed family at the bedside during resuscitation?
3. Did emergency room nurses want a policy written to address family presence during resuscitation?
4. What are the barriers and facilitators in allowing family presence during resuscitation (Madden & Condon, 2007)?

The sample (n = 90) was drawn from a population of registered nurses who worked in a Level 1 trauma center ED in Ireland. Inclusion criteria were that the nurses needed 6 months' worth of nursing experience in their department, had worked in the resuscitation room, and had participated in resuscitation efforts (Madden & Condon, 2007).

A survey questionnaire consisting of 15 questions that was developed by the Emergency Nurses Association (ENA) was used for this study. Items on the questionnaire addressed the four purposes of the study. Content validity of the questionnaire had previously been established by the ENA using a panel of experts, and reliability was established with a pilot testing conducted by the ENA (Madden & Condon, 2007).

Of the 100 questionnaires distributed, 90 were returned for a response rate of 90%. Data analysis of the demographics revealed most participants were female (83.3%) in the 30 to 39 year age group who worked as staff nurses (80%). 51.1% of the nurses had four to ten years’ nursing experience with greater than one-third working full time (Madden & Condon, 2007).
Knowledge with respect to policies and procedures regarding FPDR data provided an interesting result. 65% of the ED nurses correctly identified the fact that no written policy on FPDR existed. This meant 35% of the nurses did not know if a policy existed or not. Madden and Condon (2007) indicated that, when no written policy existed, a lack of information prevailed and new staff nurses were not oriented consistently on FPDR.

Do nurses want a written policy for FPDR? Madden and Condon’s (2007) study showed that 74% of the nurses preferred a written policy for FPDR. About 66% of ED nurses had already initiated FPDR. 20% preferred no written policy but wanted the option of FPDR. 2.2% of the nurses did not want FPDR at all. Respondents indicated 58.9% had invited FPDR in the last 12 months. 17.8% of respondents had not had the opportunity to experience FPDR; however, they believed if given the chance to take family in, they would do so. These actions pointed toward the positive attitude of nurses for FPDR (Madden & Condon, 2007).

Barriers and facilitators for FPDR were addressed by Madden and Condon (2007). The number one barrier identified by 58% of participants was that physicians objected to family presence. 50% of nurses identified negative effects on code teams: “being watched” and “making errors” (p. 437) were two of the effects listed. Legal repercussions were noted by 39%. Family disruption of resuscitation event was the barrier cited by the least amount of nurses (29%).

One facilitator of FPDR cited by 96.6% of nurses was recognizing how important family presence was for family and patient. 94% thought resuscitation teams in agreement made FPDR more acceptable. Overall, 88% of respondents said a written policy would help FPDR (Madden & Condon, 2007).
Two main limitations of the study were noted by Madden and Condon (2007). First, “the quantitative design did not allow for nurses’ perceptions to be explored in depth” (p. 437). The second limitation was the instrument itself. The authors thought further development of the instrument would be beneficial.

The results of this study agreed with many of the findings from previous research studies completed. Nurses had a positive attitude toward FPDR. These nurses cited a need for a written policy in EDs. Madden and Condon’s (2007) study revealed nurses’ number one concern was conflict among the resuscitation team. This concern is significant secondary to study results in the literature that indicate physicians are less likely to agree with FPDR than nurses. The authors reported the greatest facilitator was that ED nurses learned more about FPDR and better understood why FPDR was so important to nursing. Continuing education and a written policy for FPDR were needs identified by the study.

Since so little is known about the perceptions of nurses outside of the United States of America regarding FPDR, Koberich, Kaltwasser, Rothaug, and Albarran (2010) conducted a study of intensive care German nurses. The authors noted that family presence during resuscitation, also known as family witnessed resuscitation, is not an accepted practice worldwide. Koberich and colleagues aimed to answer the following research questions:

1. What are the experiences of German intensive care nurses regarding FPDR?

2. What are the attitudes of German intensive care nurses towards FPDR?

The sample for the study consisted of 394 intensive care nurses attending the Intensive Care Nursing Congress in southern Germany in September 2008. A questionnaire and explanation letter were given to each delegate. The questionnaire had been developed and used in a prior study (Fulbrook, Albarran, & Latour, 2005). Four areas were assessed: biographical data,
dichotomous questions regarding experience with FPDR, questions regarding attitudes toward FPDR, and an area where participants could write in comments regarding issues related to the study’s aim/purpose. Section three had 30 items and was divided into 3 sub-sections: decision-making, processes, and outcomes of FPDR. Delegates rated each statement on a 1(strongly agree) to 5 (strongly disagree) point Likert scale. A written response area was included to gain qualitative data. Data analysis was completed using the SPSS, version 11.5.1 (Koberich et al., 2010).

Nurses (n = 166) responded to the questionnaire for a response rate of 42.1%. Close to 59% of the nurses were from three of the southern federal states of Germany. Biographical data showed 66.1% (n = 113) were women with a mean age of 37 years (SD = 8.9). The median work experience was 16 years (Koberich et al., 2010).

Of the nurses who completed the questionnaire, 42.2% (n = 70) had prior experience with FPDR. 65.7% of those with experience (n = 46) indicated their experience with FPDR was negative. Families had verbalized their desire to go to the bedside for a loved one’s resuscitation to 10.2% of the participants (n = 17). Only one nurse reported having invited a family member to the bedside (Koberich et al., 2010).

Attitudes of German intensive care nurses appeared to be very different from most western world nurses. 67.5% (n = 112) nurses in this study did not support FPDR. 54.9% (n = 91) did not want families in resuscitation events at all. 66.9% (n = 111) felt nurses and medical staff should make the decision to allow FPDR together. Barriers expressed by the German nurses for FPDR were similar to those reported in other studies done throughout the world (Leske & Brasel, 2010; Lowry, 2012; Itzhaki et al., 2011). These barriers included possible breaches of confidentiality (69.9%, n = 116), a fear that family members might question the resuscitation...
team and its actions (62.7%, n = 104), and a belief that family members did not need to witness resuscitation in order to make decisions about loved ones (66.3%, n = 110). Yet, 34.3% (n = 57) indicated if FPDR occurred, family members would stop CPR sooner. One of the largest barriers for FPDR, as indicated by 79.5% (n = 132), was the fear that family members might interfere with resuscitation procedures. Family members’ distress related to witnessing the resuscitation of a loved one was cited as a barrier by 63.2% (n = 105) of participants. Rooms too crowded was cited as another barrier by 54.9% (n = 91) of participants. Attitudes toward family presence did not appear to be positive in this study. In addition, 74.7% (n = 104) did not want FPDR as a standard procedure (Koberich et al., 2010).

A strong majority of participants (73.5%, n = 122) indicated there should be a family support person to deal exclusively with the family when FPDR occurred. Conversely, 43.3% (n = 72) indicated FPDR was not important to family members; yet 60.8% (n = 101) noted that when families witnessed resuscitation, they realized the team did everything possible to help their loved one (Koberich et al., 2010).

Thematic analysis of the qualitative responses resulted in recognition of four themes. Individualized decision-making, supporting family members, physical and violent threats, and involvement of families were identified as areas of concern by the participants. Various comments from the participants included in Koberich et al.’s (2010) study presented a positive attitude for a family support person; indicated both positive and negative outcomes with involvement of families; pointed to primarily negative attitudes regarding physical and violent threats by family members; and generated a semi-positive attitude for individualized decision-making by a family member on whether or not to be present during resuscitation.

Percentages of nurses in resuscitation events with FPDR (42%) were comparable to other
European studies. 20% of nurses identified the FPDR event as positive. Authors Koberich et al. (2010) concluded, “German intensive care nurses have a guarded attitude towards the concept of FPDR” (p. 248).

While FPDR has been progressively more accepted over the last two decades in the western world, especially in the United States, it has not gained popularity all over the world. Countries from the Far East have not been involved in research studies with this particular focus except in very limited areas. The purpose of a study by Sheng et al. (2010) was “to determine the general attitude of health care professionals (HCP) in Malaysia towards family presence (FP) to witness ongoing medical procedures during resuscitation” (p. 288).

This descriptive study was conducted in Malaysia over a 6-month time period. The sample was drawn from care givers at four sites: the largest hospital in Malaysia, which was also one of the largest in Asia (2,302 beds); the second largest hospital in Malaysia (1,090 beds); and two teaching hospitals with 723 beds and 900 beds, respectively. The sample consisted of 300 personnel in the 4 emergency room departments that delivered direct patient care in their department. These personnel included physicians, medical officers, staff nurses, medical assistants, and unspecified care givers (Sheng et al., 2010).

Bi-lingual (English and Malay) questionnaires were handed out in envelopes with a respondent rate of 90% (270 out of 300). The respondents were given 2 days to complete the questions. It was divided into 3 sections: demographic data, attitudes of staff towards allowing family presence and actual experience of staff with family requests to be allowed to witness the resuscitation. The instruments were not identified by name in the study. About 50% of the sample was males and 50% females, with an average age of 31 years. Ethnicity was diverse
including Malay (78.9%), Indian and Chinese. Different religions were represented through Muslim, Hindu, Buddhist, and Christian (Sheng et al., 2010).

The survey used in this study to measure attitudes of health care providers (HCPs) towards FPDR consisted of 12 questions, some yes or no items and some situational questions. Forty percent of HCPs would more readily allow family presence during simple invasive medical procedures that usually resulted in successful outcomes such as blood draws and intravenous starts. They were not as likely to allow family presence during an invasive procedure with an uncertain outcome or one which involved exposure of a patient’s genitalia (6.7% for central venous line insertion and 4.1% for foley catheter insertion). Yet, 17.8% were agreeable to FPDR. Authors Sheng et al. (2010) reported 63% of HCPs recognized FPDR enabled families to give loved ones last rites before death, a significant cultural and religious event. Results also indicated that physicians and paramedics were statistically significantly different in perceptions related to FPDR. Doctors were 2.8 times more likely to agree to FPDR than paramedics (p = 0.002).

HCPs of Malaysia cited several of the same reasons to not allow FPDR as previous research studies: traumatic experience for the family, medical / legal issues, privacy, families might interfere with resuscitation process, overcrowding, and stress to staff. Benefits of FPDR acknowledged in the survey also reflected areas noted in previous research studies: everything was done for the patient, aids in grieving, and strengthens bond between families and the resuscitation team. One additional interesting finding was 60.7% of HCPs were more likely to agree to FPDR if the family members were medical staff (Sheng et al., 2010).

Slightly more than 71% of the HCPs had previous experience with families requesting to be present during resuscitation. Over 75% reported zero to five requests for family presence in last
6 months prior to survey. Almost half reported their first reaction to be a sense of dilemma when family presence was requested. About a fourth reported their first reaction as anxiety. HCPs cited shock and acceptance as most relatives’ reactions to resuscitation (Sheng et al., 2010).

The idea of FPDR was not well accepted in Malaysian emergency medical practice. Although FPDR has been well accepted and practiced in western countries, it is rare in Malaysian society (Sheng et al., 2010). The results of this study indicated Asian HCPs may be more resistant to FPDR than HCPs of the Western medical world.

Lowry (2012) conducted a study of emergency room nurses who had a written well-established protocol for FPDR. Lowry wrote that the Emergency Nurses Association (ENA) “has supported family presence at the bedside during resuscitation of a loved one since 1993” (p. 329). FPDR has been recommended by professional health care organizations, such as American Heart Association, American Association of Critical Care Nurses, and the ENA, as an integral part of family centered care. However, only a small percentage of healthcare institutions have FPDR protocols in place and actively in use. The aim of the study was to determine the benefits and harm of FPDR as perceived by the nurses. An additional purpose for the study was to define the family presence experience through these same nurses’ perceptions.

The research design was a descriptive study using qualitative methodology. It took place in a Level II trauma ED in a Midwestern community hospital. The hospital “has had a written protocol allowing the presence of a family member at the bedside during resuscitation since 1992” (Lowry, 2012, p. 330). The written protocol from this hospital had 6 key elements: invitation, pastoral care, wait until, family escort, explanation of what to expect, and removal of family member if needed.
Population for the study from which the sample was drawn consisted of 76 registered nurses (RNs) “who had at any time participated in the resuscitation of a patient during which a family member was present at the bedside in the emergency department” (Lowry, 2012, p. 330). RNs were invited to participate if able to be reached by phone. Actual sample consisted of 14 RNs who responded and agreed to participate.

Demographics of the sample (n = 14) were that the participants were white (92.9%, n = 13), female (92.9%, n = 13) with an average age of 39 years. Associate degrees were earned by 57.1% (n = 8) of sample nurses and 64.4% (n = 9) had more than 10 years of nursing experience (Lowry, 2012).

Each nurse was interviewed one-on-one by the researcher. Interviews were audio taped, transcribed verbatim, and data analysis included the identification of categories and trends. The analysis was confirmed by a second analyst at an 80% level of agreement (Lowry, 2012).

Nurses were able to easily identify positive FPDR events. Six categories of nurse perceptions emerged from the data: watching for family, family member choices, family member behavior, supporting the family, family comforting, and staff composure. Lowry (2012) stated, “Every nurse described FPDR as an expected part of any resuscitation when family members are present” (p. 331)

Lowry (2012) identified three areas of benefit of FPDR. These included: (a) family as team member, (b) family sees evolving events, and (c) family sees everything was done. Family as a team member was illustrated when the family provided information about the event that precipitated the resuscitation. Family sees evolving events described how the family member can see the loved one’s condition changing throughout the resuscitation event. Family member
seeing everything was done emerged from the perception the family member took away from the resuscitation event regarding the effort the team had made to save their loved one.

The researcher reported only one nurse recalled a negative FPDR event. The nurse related the negativity to the number of family members arriving for that patient. “None of the nurses described seeing actual harm by a family member that was directly attributable to family presence” (Lowry, 2012, p. 332).

Lowry (2012) reported, “The nurses in this study describe a degree of comfort with FPDR not previously represented in the literature” (p. 333). Nurses were not able to voice exact follow-through of the FPDR protocol and how a decision was made regarding whom to assign to a family member. However, the nurses modeled the protocol for all new employees in the ED.

Results from Lowry’s (2012) study supported previous research findings in family member behavior, FPDR support by ED staff, and FPDR comforts loved ones. New findings cited included nurses’ anticipation of FPDR, ability of family members to make choices regarding FPDR, nurse acceptance of different family behaviors, FPDR gives families a chance to see loved ones’ condition change over time, and “nurses’ feeling that their efforts were validated by the presence of family members” (p. 333). Future research needs identified were: determining proper time to invite FPDR to bedside and new ED nurses’ acceptance of FPDR with well-established protocol (Lowry, 2012).

Effects of FPDR on Family Members

Leske and Brasel (2010) decided to explore the effects of FPDR events that occurred before hospitalization. The purpose of the study was “to examine the effects of FPDR in patients experiencing trauma from motor-vehicle crashes (MVC) and gunshot wounds (GSW) prior to hospitalization” (p. 11). Specifically, the authors wanted to compare the effects of FPDR on
three identified family strengths (resources, coping, and problem-solving communication) with outcomes (well-being) and then compare the results of the strengths and outcomes to families who witnessed and families who did not witness resuscitation before hospitalization. The conceptual framework of the Resiliency Model of Family Stress, Adjustment, and Adaptation (McCubbin & McCubbin, 1996) was chosen to ground the study and choose the study variables.

The setting for the study was a major Level 1 trauma center in the Midwest. The trauma victims were 18 years of age or older and required resuscitation before admission to hospital. The sample consisted of family members of the victims. The family members were defined as “a group of individuals bonded by biological, legal, or social relationships” (Leske & Brasel, 2010, p. 14). Only one family member per victim could participate in study. The participant must have been at least 18 years of age; have visited victim in the critical care unit; spoke and understood English, and had only one victim in the family hospitalized. Exclusions included family members less than 18 years of age and those members whose loved one had cardiac, burns, suicidal, and brain injuries. A total of 33 family members participated in the study (MVC = 57%, n = 19, and GSW = 43%, n = 14).

Three family strengths were explored, specifically resources, coping, and communication. The variables were measured by the responses of family members who completed self-report instruments selected for easy administration, psychometric properties, reading level below eighth grade, and ability to be used for many different types of family units (Leske & Brasel, 2010; McCubbin, Thompson, & McCubbin, 1996).

Three subcategories of family resources were measured by the Family Inventory of Resource for Management subscale II (McCubbin, McCubbin, & Thompson, 1996). A total of 30 items measured personal resources, family systems resources, and physical and emotional
health resources. Reliability for this instrument was 0.93 in the study (Leske & Brasel, 2010). Higher scores reflected more resources.

Coping strategies were measured by the Family Crisis-Oriented Personal Evaluation Scale (McCubbin, Olson, & Larsen, 1996). Family members responded on a 5-point Likert scale to rate agreement or disagreement. Reliability for this instrument measured 0.82 for the study. Higher scores reflected more coping strategies (Leske & Brasel, 2010).

Communication was measured by the Family Problem-Solving Communication Index (McCubbin, McCubbin, & Thompson, 1996). This scale assessed “the specific communication style that families use to manage and solve problems and conflicts in various types of stressful situations” (p. 15). Scale is 0 (false) to 3 (true). Internal reliability for this scale measured at 0.82. Greater scores reflect more supportive communication style (Leske & Brasel, 2010).

Well-being was measured by the Family Member Well-Being Index (McCubbin & Patterson, 1996). The index “measured the degree to which a family member is adapted in terms of concerns about health, tension, energy, fear, anger, and general needs” (p. 15). The response scale was 1 (not concerned at all) to 10 (very concerned). Internal reliability for this scale measured at 0.72. Lower scores reflected positive outcomes (Leske & Brasel, 2010).

Participating family members were asked to participate within 48 hours of a victim’s hospitalization. Family members completed the four instruments in private in a conference room at hospital. Respondents who witnessed resuscitation were matched to respondents who did not witness resuscitation based on age, gender, and admitting diagnosis of trauma patient (Leske & Brasel, 2010).

Demographic data revealed patients were predominantly male (70%, n = 23); ethnicity ranged from African American (46%, n = 15), white (42%, n = 14) to Hispanic (12%, n = 4).
Mean age of patients was 32 years old. Demographic data for family members revealed that the sample was mostly female (73%, n = 24), African American (58%, n = 19) and white (42%, n = 14) race with a mean age of 35 years. Relationship to patient was listed as sibling, parent, child, spouse, and other with sibling as the most prevalent. A large majority of the sample (79%) reported having had a family member in critical care in the past (Leske & Brasel, 2010).

Per the study design, almost half of the sample (49%) had experienced FPDR while 51% had not. Lekse and Brasel (2010) reported “scores for family resources, coping, problem-solving communication, and well-being were no different in families who witness resuscitation compared to those who did not witness resuscitation prior to hospitalization” (p. 15).

One aspect of FPDR that has not received thorough study is benefit and or harm consequences for the family member who witnesses a loved one’s resuscitation. Compton et al. (2011) designed a study to “compare bereavement-related depression and post-traumatic stress disorder (PTSD) symptoms among cardiopulmonary resuscitation (CPR) patients’ family members who remain in the waiting room of an urban emergency department with those who are invited to witness CPR” (p. 715). The authors noted the following two facts regarding their study:

1. The study provided the largest and most detailed study of the impact of FPDR on bereavement outcomes to the date
2. For the first time, data results were obtained from a predominately African-American sample in an urban setting (Compton et al., 2011).

The study was completed at two urban, Midwestern teaching hospitals. It was a quasi-experimental, comparison group study conducted over a 2-year period. The sample consisted of 65 family members all of whom were 18 years of age or more, spoke English, and had a loved
one who received CPR for non-traumatic reasons. In the sample, 24 people witnessed CPR, and
41 did not witness CPR. One reason cited for the size difference between the witness / non-
witness groups was the fact some family members did not arrive in the ED in time to be invited
into the resuscitation room. Demographic characteristics for this sample included African-
American (75.4%, n = 49), women (67.7%, n = 44), with a mean age of 55.7 years. 43.5% (n = 27) were with the loved one at the time of their cardiac arrest (Compton et al., 2011).

Interviews were conducted at 30 and 60 days after the resuscitation event had occurred. The
instruments used in gathering data included the Posttraumatic-Stress-Disorder (PTSD) Symptom
Scale (Foa, Riggs, Dancu & Rothbaum, 1993) and the Center for Epidemiological Studies-
Depression Scale (CES-D) (Radloff, 1977). CES-D is a nationally validated tool for use in the
African-American population. Both scales have reliability and validity as reported by Compton
et al. (2011). The intervals of 30 days and 60 days were chosen due to this is earliest frame
where PTSD symptoms can begin to be diagnosed. Grief has a natural course, and it affects
everyone differently; symptoms still present after 30 days can be significant. The latter time
frame was to evaluate participants for any delayed symptoms of grief and depression.

The participants all had high levels of depression and demonstrated PTSD symptoms during
their periods of grieving. Results did not show a statistical difference between those who had
witnessed CPR and those who did not at 30 days or 60 days (Compton et al., 2011).

Compton et al. (2011) compared the participants’ CES-D symptoms scores for acceleration
or reduction between 30 days and 60 days. This comparison indicated a significant reduction in
symptoms for those who had witnessed CPR. Scores for the PSS-SR were not significantly
different. Assessment of the impact for FPDR was done by regrouping participants ad hoc into
groups of those non-witnessing participants and those who witnessed CPR pre-hospital or in the
ED. No significant differences were noted at 30 or 60 days in the CES-D or PTSD scores.

Compton et al. (2011) concluded, “Bereavement-related depression and PTSD symptoms are commonly seen in family members of cardiac arrest victims; however, the magnitude of the effect is not substantively impacted by witnessing or not witnessing CPR in the emergency department” (p. 715).

Summary

FPDR has continued to stir controversy in clinical settings world-wide, despite gaining momentum from health care providers’ professional organizations and from families. Many health care providers, especially nurses, remain ambivalent about the practice of FPDR.

Risks and benefits of FPDR for patients, patients’ family members and staff participants were cited in all of the studies reviewed in this chapter. Differences of opinion continue to revolve around perceived risks and perceived benefits of nurses and other health care providers.

The perceived risk most often cited was psychological trauma to the family members present during a resuscitation event. Other perceived risks cited by nurses in the majority of studies included family members would disrupt/interfere with resuscitation event, staff participants would have additional stress, patient confidentiality, and legal issues (Duran et al., 2007; Koberich et al., 2010). Madden and Condon’s (2007) study indicated that nurses were very conscious of conflict among the resuscitation team members, particularly among physicians, and how this would negatively affect family members if present during a resuscitation event.

Perceived benefits of nurses noted in the majority of studies included family would see that everything was done for their loved one and FPDR facilitated the grieving process (Sheng et al., 2010; Leske & Brasel, 2010). Additional benefits included family understanding of the
seriousness of loved one’s condition, families can obtain closure if death occurs, and a holistic approach to care (Oman et al., 2010).

Overall, western nurses were supportive of FPDR. Health care professionals who had prior experience with FPDR were more positive toward FPDR than those who had no prior experience with this phenomenon. In hospitals where FPDR was practiced, the nurses were more apt to invite family presence than physician colleagues. Nurses have identified promotion of FPDR without written facility guidelines simply because the perception was it was the right thing to do (Lowry, 2012; Twibell et al., 2008).

Studies completed in other countries included Germany, Ireland and Malaysia. Nurses in Ireland were more positive about FPDR than negative. However, the nurses would prefer to have a written policy to guide facilitation of FPDR (Madden & Condon, 2007). German nurses reported negative experiences with FPDR (Koberich et al., 2010), and Malaysian nurses reported that FPDR depended on situation, expected outcome and physician approval (Sheng et al., 2010). Continued investigation and research of nurses’ perceptions of FPDR will provide the evidence based knowledge for implementation of this practice at the bedside.

A third-year medical student from the University of British Columbia, Carolyn Rosenczweig, was quoted in an article by Boehm (2008)

Relatives must not be viewed as an added complication but as a direct extension and reflection of the patient’s life. The need to say good-bye before it is too late should be regarded as an innate response to the death of a family member. Resuscitation teams seem to take for granted that they are often the last people to be in the presence of a dying person. Being present during these final moments is a privilege, not a side effect of an arrest protocol. Sharing this privilege may be the greatest comfort the medical profession can offer a grieving relative.
Chapter III

Methodology

Family presence during resuscitation remains a controversial topic in healthcare after more than two decades of discussion and inquiry. Research studies have evaluated many different aspects of FPDR, including support by physicians, nurses, and other health care team members. FPDR has been studied before hospitalization and during hospitalization; among several different cultures; with pediatric, adult, and geriatric families; and with a look at potential harm versus benefit to the patient and the family members.

This study was conducted to add to what is known about nurses’ perceptions of risks and benefits regarding families being present during resuscitation. It is a partial replication of the study done by Twibell et al. (2008).

Research Questions

The research questions for this study were

1. What are nurses’ perceptions of risks and benefits related to family presence during resuscitation?
2. What is the relationship between nurses’ perceptions of risks and benefits related to family presence during resuscitation and selected demographic variables?

Population, Sample, and Setting

This was an exploratory descriptive study that took place in one large teaching hospital in Indiana. The population of nurses (n = 600) consisted of registered nurses who worked in various units throughout the hospital. The convenience sample was 300 registered nurses. Optimal sample size was determined by a power analysis to be 280. Criteria for inclusion
consisted of: 18 years of age or older, able to read English, hold a license as a registered nurse in the state of Indiana, and be an employee of the hospital where study took place. Participants were not excluded by the number of hours worked per week or their specific nursing role or job description.

**Protection of Human Rights**

Approval was obtained from the Institutional Review Board of the hospital where data were collected. Investigators involved in the research study were required to complete an on-line training module to document competency in protection of human subjects during research.

Participants were informed that no one would see their responses other than the members of the research team. Anonymity was protected by no coding of the surveys in any way by research investigators. Furthermore, nurses were instructed not to identify themselves on the survey in any way, and nurses were informed they could withdraw from study at any time. There was a small risk of participant identification through completion of the demographic variables. The demographic data included gender, level of education in nursing, years of nursing experience, number of times invited family presence, age, and race. Given the large pool of potential participants, the chance of a participant being identified by demographic variables was minimal. No attempt was made to find out who participated in the study.

There were no benefits to the participants other than to contribute to professional knowledge for the discipline. The importance of the study was cited in the cover letter and included gaining knowledge about nurses’ perceptions of FPDR. No one can provide these perceptual data except staff nurses. The risk : benefit ratio was considered acceptable.

All completed surveys were kept by the principal investigator in a locked file in a locked, private office, and surveys were destroyed at end of study.
**Procedure**

An explanation of and an invitation to participate in the study were delivered to nurses who met the study criteria via intranet e-mail system. Packets containing information about the study were placed on all nursing units within the hospital. The information packet included a cover letter which explained the purpose of the study, a description of the nurses’ rights as a participant, the survey, and date the survey needed to be returned. Those nurses interested in participating in the survey took a packet, completed the survey instrument, placed it in a sealed envelope, and returned it to the locked survey boxes placed on their units by the research investigators. Consent for participation was indicated by the nurse returning the survey. No signed informed consent form was required. Nurses were reminded of the invitation to participate by posted flyers, e-mail reminders once per week for four weeks, and through verbal announcements in staff meetings.

**Instrument and Methods of Measurement**

The instrumentation for the study was the Family Presence Risk-Benefit Scale (FPR-BS) (Twibell et al., 2008). The FPR-BS measured nurses’ perceptions of the risks and benefits of family presence to the family, patient, and the resuscitation team. The FPR-BS contained 22 items originally; only 19 were used in this study, based on results from a previous test of the instrument. The scale had a 5-point Likert response option (1 = strongly disagree and 5 = strongly agree). Internal consistency reliability of the tool was supported in a previous study of 300 RNs, in which the Cronbach alpha was 0.96. Validity was supported by an initial review by experts and verification of the content validity and through an examination of construct validity in a previous study of RNs (Twibell et al.).
Participants completed a demographic tool that assessed gender, age, race, level of nursing education, years of nursing experience, and number of times invited family presence. In addition, a single item asked participants how often they had participated in FPDR by inviting a family member to be present during resuscitation. The response scale was 1 = never, 2 = fewer than five times, and 3 = five times or more (Twibell et al., 2008).

**Data Analysis**

Data were entered into an SPSS file for Windows, version 14.02. Selected items were reverse scored. First, the psychometrics of the FPR-BS were examined. Construct validity of the FPR-BS was verified through exploratory factor analysis with varimax rotation. Internal consistency was measured by Cronbach alpha reliability. Relationships between perceived risks and perceived benefits were computed using Pearson $r$ correlations among the scores. Relationships among demographic variables were analyzed descriptively. Pearson $r$ correlations, $t$ tests, and analysis of variance were used to determine relationships and differences between perceived risk and benefit and demographic variables. Analysis of variance was used to examine differences in risk and benefit scores on the basis of how often nurses had invited patients’ family members to be present during resuscitation. Level of significance was set at .05.

**Summary**

This chapter outlined the methodology used to complete this study. The target population was 600 registered nurses who worked in various units throughout the hospital. The convenience sample was 300 registered nurses. The instrument used in study was reliable and valid in a previous study (Twibell et al., 2008). Data were collected by the completion and return of the study by the convenience sample. Data were analyzed by descriptive and inferential statistics. This descriptive correlational study was conducted as a partial replication of Twibell et al.’s
(2008) study to add to the knowledge base of nurses’ perceptions of risks and benefits related to FPDR. The findings of this study may lead to changes in practice to accommodate family presence during resuscitation.
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