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Australian Emergency Department health professionals' reasons to invite or not invite Family Witnessed Resuscitation: A qualitative perspective

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ABSTRACT

Background: Debate continues regarding the effectiveness of Family Witnessed Resuscitation and little is known about the reasons why staff invite family presence.
Aim: Explore why health professionals invite or not invite Family Witnessed Resuscitation.
Design: Descriptive qualitative study.
Method: Three open-ended questions enabled 114 clinicians to describe why they would or would not invite family presence. Data were analysed using qualitative data analysis.
Results: Four themes representing factors that influenced staff decision to invite or not invite Family Witnessed Resuscitation were identified: *motivating factors*, *personal choice*, *staff judgment*, and *organisational factors*. Motivating factors described reasons to invite family presence, and staff and organisational factors were reasons to not invite family presence.
Conclusion: Family presence can be beneficial for staff and family and is likely to be motivated by family-specific factors where this choice is appropriate for all stakeholders. Participants described factors that can impact on the appropriateness of inviting family presence and these need to be considered before an invitation is extended.
Relevance to practice: To support all parties throughout the process it is imperative that a skilled support person be available to the family and that written policies and guidelines be available for staff.

Introduction and background

This paper is one of a series investigating the perceptions of clinicians working in an Australian Emergency Department (ED) toward Family Witnessed Resuscitation (FWR) (Chapman et al., 2012, 2013). To investigate staff perceptions of FWR in breadth and in-depth this series of studies utilised both a quantitative and qualitative design. The previous papers reported the quantitative survey findings and provided a brief summary of the qualitative survey responses. This paper presents an in-depth account of the qualitative findings of the study. Quantitative designs provide the opportunity to investigate FWR broadly within the parameters of the specific variables assessed, whereas qualitative approaches allow a more in-depth focus (Borbasi et al., 2004; Schneider et al., 2007).

Family Witnessed Resuscitation is the practice of enabling patients' family members to be present during resuscitation. This practice has been conducted in health care settings nationally and internationally since the 1980s (Hanson and Strawser, 1992; Chapman et al., 2013). Prior to this time family members were usually prevented from being present during the resuscitation and were asked to sit in a separate room (Doyle et al., 1987). We have provided an overview of the literature in our previous papers, however, although a great deal of research has investigated the perspectives of patients' relatives and staff regarding FWR, there appears to be limited consensus as to the effectiveness of this practice (Halm, 2005; Chapman et al., 2012, 2013). There is also a lack

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of clear understanding about the reasons why staff would invite or not invite FWR (Chapman et al., 2012, 2013). Several factors have been identified that can influence whether a family member may be present during resuscitation and these include it being beneficial for the team, the impact of family behaviour, and assisting with the grieving process, (Madden and Condon, 2007; Walker, 2007; Holzhauser and Finucane, 2008; Chapman et al., 2012). Further factors that may influence staff invitation of FWR include the lack of effective policies and guidelines or the availability of a support person (Maclean et al., 2003).

In many health care settings the practice of FWR is utilised on an informal basis depending on the self-confidence of the healthcare provider, and commonly without specific FWR policy and guidelines (Chapman et al., 2012). This impromptu practice may increase staff anxieties related to FWR and as a result they may view the practice negatively (Fulbrook et al., 2005; Knott and Kee, 2005). Furthermore, it remains unclear what factors, in addition to staff confidence, influence clinicians reasoning to invite or not invite FWR. Therefore, in order to provide both the staff and the family with adequate support and reduce the negative impact during these events, it is important to understand the reasons why health providers invite or do not invite FWR. This information may provide health services, managers and clinicians with information to provide consistent, reliable and supportive practice.

Method

Quantitative and qualitative data were collected using an anonymous self-administered validated questionnaire. The survey was mailed to all ($n = 221$) doctors and nurses working within the ED of a large metropolitan hospital to explore their perceptions of FWR. The clinical setting, content, factor structure, and performance of the quantitative assessment scales are described elsewhere (Chapman et al., 2012, 2013). The survey included two open-ended questions that asked participants to provide information about why they would or would not invite family members into a resuscitation. A third question invited staff to provide any other thoughts, feelings or perceptions they had regarding FWR. Ethics approval was gained from the human research ethics committees of the university and hospital. Consent was implied on return of the questionnaire.

Data analysis

Data from the open-ended questions were transcribed verbatim. Transcriptions were reflected on and coded line-by-line and analysed following the standards of qualitative data analysis procedures i.e., categorising and clustering (Speziale-Streubert and Carpenter, 2003) and significant words and phrases were identified. The key words or phrases were underlined, and significant meanings listed, aggregated and categorised. All transcribed data were compared with each other for patterns and recurring themes as they emerged from the data. Following this procedure the major thrust or intent of the transcripts were conceptualised (Berg, 2009).

Trustworthiness was achieved by addressing credibility and transferability of the data (Lincoln and Guba, 1985). Credibility was ensured by giving a sample of the transcripts to two experts in qualitative data analysis, who coded and categorised the data individually, with overall agreement and consistency between the experts' analysis. Transferability was established by developing rich descriptions and maintaining an audit trail to allow comparison of our study with those conducted in similar contexts (Lincoln and Guba, 1985; Denzin, 1989).

Results

The sociodemographic characteristics of the 114 (52%) respondents have been presented elsewhere (Chapman et al., 2012, 2013). In summary, the respondents were mainly female, nurses, aged between 25 and 55 years, and Caucasian. The respondent's qualifications ranged from hospital based to post-graduate university qualifications. Less than half held a specialty certificate, and most held professional organisation membership.

Three open-ended questions elicited the participant's reasons for inviting or not inviting family members to be present during resuscitation. Respondents identified several factors that influenced their decisions to decide to invite or not FWR and these included *motivating factors*, *personal choice*, *staff judgment*, and *organisational factors*. Each theme had a number of sub-themes (or finer level processes) that emerged from, and which afford a better understanding of, the data. Table 1 presents a summary of the themes and sub-themes and examples.

The following section focuses on the evidence for each of these themes in turn. Our description begins with the theme and sub-themes most commonly associated with reasons for inviting family presence, and ends with the themes and sub-themes most commonly associated with reasons for not inviting family presence.

Motivating factors

Motivating factors were considered to be the instrumental function of FWR and are linked to benefits of FWR for family members and, to a lesser extent, for staff. Sub-themes that emerged included 'assists with the grieving process', 'see all efforts have been made', 'family member as a historian' and 'help with decision making'.

Participants considered that an important reason to invite FWR was to aid with the grieving process. This outcome was especially significant if the resuscitation was not successful. Many respondents identified that FWR enabled the person witnessing the event to start the grieving process and to come to terms with the death of their relative. As one participant stated "*[FWR] Allows family to say goodbye – Also helps in grieving process…*".

Another reason for inviting FWR was to enable the family to see that all efforts had been made and the medical team had done everything in their power to save their relative. Participants noted that by observing the resuscitation family members would be more accepting of the outcome. As one respondent wrote:

> "*…. After one family witnessing a resuscitation they then realised that their family member could not be saved thus ending a long exhausting team effort in resuscitation of this person; Everything that could be done was done…*"

Some participants viewed that the family members could be of assistance by acting as a historian during the resuscitation. As one participant noted "*to assist medical & nursing staff in gathering information regarding the event and the lead up to it* [the resuscitation]". Another way that family could help during the resuscitation was in helping the team decide if the resuscitation should be continued, with FWR enabling the family to "*become involved in decision making at times*".

Personal choice

Participants reported that the decision to invite FWR was dependent on what the staff, family and patient chose to do, especially if it was "*specifically requested by patient*". Family member choice was also a reason given by many participants to invite or not FWR, particularly if "*they* [family member] *do not wish to be there*". Some participants stated that the family had a right to be