All in the Family Presence

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Fifteen years ago, my husband underwent open heart surgery. Within 2 hours of arriving in the intensive care unit (ICU), he had a cardiac arrest. The ICU nurses were gently trying to remove me from the room. I calmly stated, "My husband looks like he is going to die; I would prefer he dies holding my hand, not yours," and stayed in the room. Believe it or not, despite the highly skilled and clinically adept emergency nurse that I am (ok, so maybe that is my personal assessment!), I was not paying any attention to the orders, the monitor, the commotion, or the team. My focus was solely on my husband—and I was totally silent (yes, for those of you who know me, that in itself is a miracle!). The code lasted about 10 minutes, and thankfully, the resuscitation measures were successful. Afterward, one of the nurses came to apologize to me and said that she never thought of a code in the manner I described. She said she was forever changed and would look at family being present in the room differently. This month's column will focus on family presence from a few different perspectives. Emergency nurses and the Emergency Nurses Association were the pioneers of family presence, but it never hurts to revisit it from time to time!—*AnnMarie*

From the Outside Looking In

When a patient codes, lives are changed forever. Whether the patient lives or dies, the patient, the family, and the caregivers are transformed by the event itself. Strategies for resuscitation have been developed and are successful some of the time. Novice nurses may experience their first time actually performing CPR. They may question their ability, competence, and knowledge in an emergency setting. A physician or nurse practitioner may have to convey news to a family for the first or the 100th time in his or her career. No matter what the outcome, lessons are learned and lives are affected.

When a patient codes, the nurse must take the knowledge she or he has of the patient, from diagnosis to assessment to findings, translate it into what is "need-to-know" information for the health care team to piece together the possible reasons for the arrest, and come up with strategies to save the patient. The most important factor leading to survival after sudden cardiac arrest is the presence of a trained rescuer who is ready, willing, able, and equipped to act.[1] Nurses remain on the unit caring for the patients after the code, whereas the health care team completes their responsibilities during the code and returns to their previous location. The other patients, quieted by the rush of the emergency, have needs to tend to, medications to receive, and undoubtedly, questions to ask about what happened.

Prompt activation of resuscitation mechanisms and less delay in the initiation of resuscitation protocols may be associated with high survival-to-discharge rates.[1] I have been a nurse for 31 years, with half that time spent in the ICU, where codes were not uncommon because of the high acuity of the patients. Several years were spent supervising ICUs, which meant I carried the code pager and responded to all codes in the entire hospital, now called rapid response teams (RRTs). Although some codes are more traumatic and heart wrenching, as in the case of a young bicyclist hit by a drunk driver, the rituals of the resuscitation process are the same.

Personal life experiences affect nurses in the work they do. My husband, who is a respiratory therapist, was a patient in the hospital when we heard a code called in the next room. When a patient codes, dilemmas arise regarding what to do with family members who are present. The situation is uncomfortable and tense already. Having family there intensifies this and causes added stress to all involved. However, in recent years, research has suggested that families are less likely to take legal action when present and feel more satisfied when they see what is done to their loved one.[2] The helplessness of being behind that door and the strangeness of hearing all the familiar commands and not being able to chime in or help were gut wrenching. Never before had I even thought about what other patients and families nearby may be hearing, feeling, or experiencing. Most people would not understand the jargon or the process of resuscitation, although television attempts to emulate reality. More information on family presence is available at: https://www.ena.org/publications/ena/Pages/FamilyPresence.aspx.

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The announcement of vital signs and the glorious sound of the monitor signifying a returning heartbeat were heard, followed by applause and shouts from family and staff. I began to cry, knowing that the patient was alive and being transferred to the ICU. I knew that there would be many struggles ahead for this patient and family after the code and also realized the transformation that just took place. We would never be the same. Neither one of us would ever approach a code in the same way again. The silence in our room was deafening. No words could describe the range of emotions and feelings in those moments.

Afterward, my husband and I noted how professional, attentive, and respectful the staff was throughout the entire process. This is not always the case. In the heat of the moment, tempers may flare and inappropriate comments are sometimes made. It is essential for staff to maintain a professional demeanor and perspective on the surroundings. Other people are listening and may hear staff comments and conversations. Maintaining a level of compassion and seriousness demonstrates a level of professionalism that is crucial to credibility.

When the staff rounded later in the night, we let them know how well things were handled from our standpoint. We applauded them for the success of the resuscitation and complimented them on their communications. They were appreciative of the feedback.

The events of that night affected me as a person, a family member, and most of all, a nurse. It changed my approach to the code environment. The responsibilities nurses have are great; they must constantly be prepared for the unexpected. It is imperative that nurses recognize and are sensitive to nearby patients and families while caring for a patient.—*Beth Cusatis Phillips, MSN, RN, CNE, Assistant Professor, Duke University, Durham, NC; E-mail:* Beth.phillips@duke.edu

Early Beginnings of Family Presence

I began working in the emergency department as a graduate nurse in 1987. Back then, it was perfectly acceptable to keep an anxious family in the waiting area wondering what was happening to their loved one. It really did not matter what the circumstances were: resuscitative efforts, procedures such as laceration repair or dislocation reduction, and so on. If the provider believed that the family might interfere with the care being provided, they were asked to step out and were given an occasional update when someone was able to break away. The emergency nurses that I worked with had no issues with this, and it was not until I was on the family side of the situation that I began to wonder if this was really the best way to care for our patients and their families. I remember reading studies about family presence in the emergency department in the early to mid 1990s, but it was not until the late 1990s that I experienced my first code with a family member outside the room watching everything we did. It made me nervous, but I realized we were more available to talk with the family and let them know what was going on. Nobody had to tell them it was a serious situation. Nobody had to tell them that the outcome might be bad. They saw how hard we worked to save the life of someone they loved, and even if the efforts were not successful, they walked away grateful for all we had done. Family presence allows families to see that although they may feel helpless, their loved ones are being provided with the best care they can receive at that moment and their best chance for survival.—*Kimberly C. Mikula, RN, BSN, CEN, Nurse Educator, Doylestown Hospital, Doylestown, PA; E-mail:* kmikula@dh.org

Spiritual Approach

"Get them out of here!," the medical team barked, tersely directing the chaplain to remove the family from the room or trauma bay door where the patient was coding or being treated. This was standard practice for too many years. Within the past 10 years, there has been a shift away from this practice. Now, the chaplain is standing with the family in the room (if there is room), in the hallway (with the door open), or at the trauma bay doorway.

The chaplain's role in these times spans being present with the family so they are not alone but also serving as a clinical team member. I am often comforting as well as explaining "what's next will be" and "that means . . ." to help the family understand what looks like chaos to them.

In the event that the patient does not survive, the chaplain will already have developed a relationship of support with the family as the medical team breaks that news. Staff has that sense as they work to save the patient. In the case of a code blue, there have been many times the family will say, "He/she wouldn't have wanted this," as they watch. Otherwise, the code may have continued much longer.

I have seen better outcomes regarding the emotional needs of the family and staff because the family was present during these times. The staff appreciates knowing the chaplain is caring for the family as the staff cares for the patient. This is a symbiotic approach for best outcomes for us all.—*Sharon Hindle, Chaplain, Robert Wood Johnson University Hospital, New Brunswick, NJ*