Family Presence During Trauma Activations and Medical Resuscitations in a Pediatric Emergency Department: An Evidence-based Practice Project

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CE Earn Up to 8.5 CE Hours. See page 188.

Introduction: The existing family presence literature indicates that implementation of a family presence policy can result in positive outcomes. The purpose of our evidence-based practice project was to evaluate a family presence intervention using the 6 A's of the evidence cycle (ask, acquire, appraise, apply, analyze, and adopt/adapt). For step 1 (ask), we propose the following question: Is it feasible to implement a family presence intervention during trauma team activations and medical resuscitations in a pediatric emergency department using national guidelines to ensure appropriate family member behavior and uninterrupted patient care?

Methods: Regarding steps 2 through 4 (acquire, appraise, and apply), our demonstration project was conducted in a pediatric emergency department during the implementation of a new family presence policy. Our family presence intervention incorporated current appraisal of literature and national guidelines including family screening, family preparation, and use of family presence facilitators. We evaluated whether it was feasible to implement the steps of our intervention and whether the intervention was safe in ensuring uninterrupted patient care.

Results: With regard to step 5 (analyze), family presence was evaluated in 106 events, in which 96 families were deemed appropriate and chose to be present. Nearly all families (96%) were screened before entering the room, and all were deemed appropriate candidates. Facilitators guided the family during all events. One family presence event was terminated. In all cases patient care was not interrupted.

Discussion: Regarding step 6 (adopt/adapt), our findings document the feasibility of implementing a family presence intervention in a pediatric emergency department while ensuring uninterrupted patient care. We have adopted family presence as a standard practice. This project can serve as the prototype for others.

Key words: Evidence-based family presence program; Family presence during CPR; Family-witnessed CPR; Trauma stats, medical alerts, codes; Pediatric emergency nursing; Pediatric emergency medicine

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Standard practice in most emergency departments precludes family presence during emergency procedures. It is estimated that only 5% of emergency departments have written family presence policies.[1] One of the most compelling arguments against family presence is the fear that families might lose emotional control and interrupt patient care.[2] Interruption of care may negatively affect patient safety and therefore should be avoided particularly during critical procedures. Ensuring patient safety through uninterrupted patient care is crucial for the successful practice of family presence.

Before the introduction of a family presence policy in our emergency department, family presence was practiced sporadically and without formal guidelines. Our goal was to establish a standardized protocol that would ensure all families were presented with the option of family presence and protect the safety of patients, families, and staff. We believed that the policy should be based on best evidence, represent consensus opinion of involved staff and leadership, and define the steps for implementing family presence without interruption of patient care.

An organized roadmap is important to successful implementation and enculturation of new practice.[2] The updated ENA guidelines for family presence, *Presenting the Option for Family Presence*,[2] recommend that the process for establishing a family presence program be guided by models of evidence-based practice (EBP) to promote quality patient care.[3-5] The purpose of this article is to describe the development, implementation, and evaluation of a family presence program using the steps of an EBP model. We combined the steps outlined in ENA's guidelines for developing a family presence program[2] with the steps of the evidence cycle,[6] which includes the 5 A's (ask, acquire, appraise, apply, and analyze),[7] and added a sixth A: adapt/adopt (Figure).

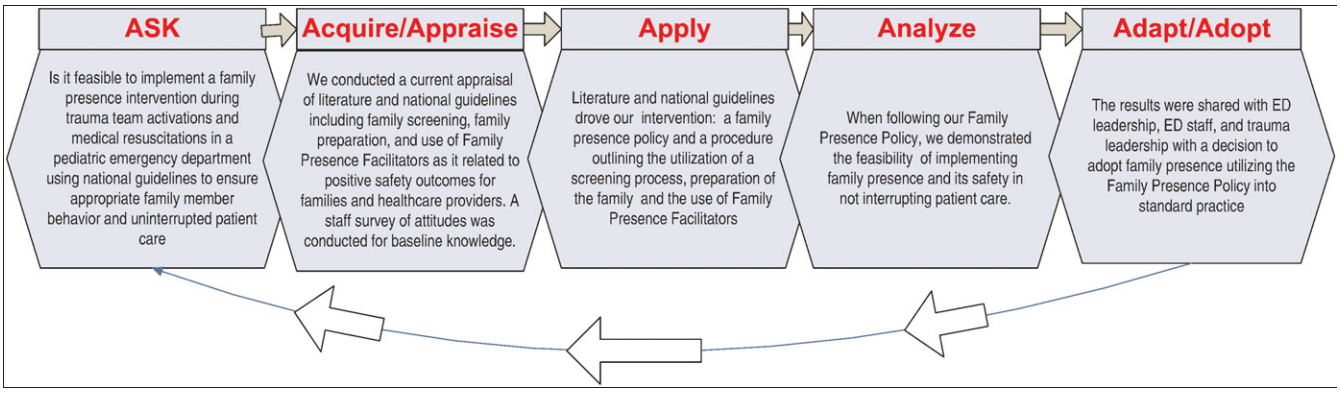
Aims

STEP 1: ASK CLINICAL QUESTION

The development of our ED family presence program began with emergency nurses and physicians who strongly advocated that families be present with their children during every level of ED care. An interdisciplinary team consisting of the emergency clinical nurse specialist, pediatric emergency medicine physicians, an ED social worker, staff nurses, and a nursing research mentor with expertise in family presence was formed. We also elicited the support of ED nursing and medical leadership. The team established the aims of our EBP project: to determine the feasibility of implementing a family presence policy and procedure during trauma team activations (trauma stats) and medical resuscitations (medical alerts) based on national guidelines and determine the ability of this practice to ensure appropriate family member behavior and uninterrupted patient care. To achieve this aim, we evaluated the following research questions: (1) Is it feasible to implement a family presence policy and procedure for patients during trauma stats and medical alerts in a pediatric emergency department (process evaluation)? (2) Is the implementation of a family presence policy and procedure during trauma stats and medical alerts effective in ensuring safe and appropriate family member behavior while at the bedside that results in uninterrupted patient care (outcome evaluation)?

STEP 2 AND STEP 3: ACQUIRE AND APPRAISE EVIDENCE ON FAMILY PRESENCE

Evidence was acquired by review of relevant published studies, guidelines, position statements, and recommendations from professional organizations. We also conducted a sur-



FIGURE

Implementing and evaluating a family presence intervention using the 6 A's of the evidence cycle.