Health Care Providers' Evaluations of Family Presence During Resuscitation

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Introduction: The benefits of family presence (FP) during resuscitation are well documented in the literature, and it is becoming an accepted practice in many hospitals. There is sufficient evidence about health care provider (HCP) and family attitudes and beliefs about FP and little about the actual outcomes after family witnessed resuscitation. The purpose of this study was to evaluate FP at resuscitations.

Methods: A descriptive design was used to collect data at an academic medical center in the western U.S. There were 106 resuscitations during the study period. Family presence was documented on 31 (29%) records. One hundred and seventy-four health care provider names were listed on the resuscitation records, and 40 names (23%) were illegible or incomplete. The convenience sample of 134 HCPs was invited to complete an electronic survey and 65 (49%) responded.

Results: Respondents indicated that family members were able to emotionally tolerate the situation (59%), did not interfere with the care being provided to the patient (88%). In addition, team communication was not negatively affected (88%). A family facilitator was present 70% of the time, and it was usually a registered nurse (41%). Twenty-one narrative comments were summarized to reflect the following themes: 1) family presence is beneficial; 2) family presence is emotional; 3) a family facilitator is necessary.

Discussion: These study findings demonstrate that having families present during resuscitations does not negatively impact patient care, is perceived to benefit family members and that a dedicated family facilitator is an integral part of the process.

Key words: Family presence during resuscitation; Family presence; Family-witnessed resuscitation; CPR; End of life; Outcomes; Family-centered care; Emergency nursing

Several national guidelines and professional organizations recommend that family members be offered the option of being present during patient resuscitation and certain invasive procedures.[1-5] Nevertheless, only 5% of US hospitals have written policies addressing this practice.[6] International studies show similarly low rates of family presence policies and recommend the development of intra-professional and international guidelines as a way of forming a more consistent approach to this sensitive clinical issue.[7,8] The paucity of established policies suggests that family presence during resuscitation remains a controversial practice.[9]

There is a growing body of evidence regarding health care providers' attitudes toward, and family members' beliefs about, the effects of family presence during resuscitation.[9-13] Perceived benefits include (1) enhanced family understanding of the patient's condition, (2) opportunities for family members to support the patient or obtain closure in the case of death, (3) family appreciation of resuscitation efforts, (4) staff attention to the "personhood" of the patient, (5) enhanced professional behavior among staff members, and (6) a more holistic approach to care.

There are also concerns and risks associated with the practice of family presence.[9,11,12,14-16] Frequently cited concerns include (1) potential emotional trauma to the family, (2) fear that family members will interfere with care, (3) provider performance anxiety associated with "being watched" by family members, (4) impaired team communication, and (5) family misinterpretation of resuscitation activities. These equivocal findings reflect the con-

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troversial nature of family presence in times of crisis. Most family presence research has focused on critical care and emergency practitioners. Studies show that nurses tend to have more favorable opinions of family presence than do physicians and that emergency nurses have the most positive attitudes about the practice.[13] We continue to discover more about health care professionals' attitudes and beliefs, yet little is known about the actual outcomes observed by health care providers after family-witnessed resuscitation.

A holistic framework, one that preserves the wholeness, dignity, and integrity of the family unit, guided this study. Incorporating a holistic family presence philosophy during resuscitation supports both patient and family.[17] Much of the nursing profession has strongly endorsed a holistic perspective. For example, the American Nurses Association's *Code of Ethics for Nurses* speaks to nurses' responsibility to recognize "the patient's place in the family or other networks of relationship."[18] A holistic framework is also consistent with a philosophy of patient- and family-centered care, which seeks to address patients' psychosocial, emotional, and spiritual needs, as well as their physical requirements.

Patient- and family-centered care is the philosophy of care at the University of Colorado Hospital (UCH). In keeping with this value, in December 2006 UCH implemented a guideline allowing the option of family presence during resuscitation and invasive procedures. The guideline was adapted from other family presence policies and ENA recommendations, as well as data from research conducted at our institution in 2005. The full guideline is included in Figure 1. Highlights from the guideline include the following:

- Health care providers should consider the option of family presence.
- Families will be assessed to determine whether they are suitable candidates for family presence.
- Patients will be asked whether they wish to have a family member present. When patients are unable to express their wishes, the preferences of family members will be honored.
- The decision to offer family presence or not should be arrived at by health care team consensus.
- Family presence should only be offered when a family facilitator is available.
- Family members may be asked to leave a patient care area if they become disruptive, emotionally distraught, or physically unstable or if the patient's condition intensifies or requires more aggressive procedures.

These guidelines were disseminated to UCH nurses, physicians, and resuscitation team members via informal educational sessions and hospital grand rounds.

Purpose

The purpose of this study was to evaluate family presence during patient resuscitation, from the perspective of involved health care providers, at one academic medical center in the Western United States. Specific aims of this study were (1) to determine the frequency with which family members are present during resuscitation and (2) to examine health care providers' experiences with family presence during resuscitation.

Methods

DESIGN

A descriptive study design was used to generate quantitative and narrative data. An electronic survey consisting of 7 questions (including 5 Likert scaled items) was developed by the research team. Response options ranged from strongly disagree to strongly agree. Open-ended questions and areas for comments were also included. Members of the hospital resuscitation committee reviewed the survey to establish content validity. The Cronbach α was 0.81 for the 5 scaled questions. To keep the survey brief and facilitate completion, no demographic data other than profession were requested. Figure 2 shows the questions asked in the survey. The study was reviewed by the Institutional Review Board and qualified for exempt status.

SETTING

UCH is a 407-bed tertiary care academic medical center with approximately 100 to 120 cardiac arrest events per year that result in resuscitation team activation (also called "codes"). The resuscitation team consists of 2 intensive care nurses, 1 anesthesiology attending physician or fellow, 1 pulmonary attending physician or fellow, 1 fourth-year medical resident, 1 fourth-year surgical resident, 1 respiratory therapist, and 1 clinical pharmacist. Resuscitation team activation occurs by digital pager.

PROCEDURE

Every emergency call that results in a resuscitation team response has a resuscitation record associated with the event. The Clinical Excellence and Patient Safety Department at UCH receives all resuscitation forms for quality review. The form contains an area for the event recorder to indicate whether family members were present. The names of health care team members responding to the resuscitation are also documented on the form. Resuscitation records were reviewed every 2 weeks by the primary researcher (K.S.O.) to determine whether family members were present and to identify health care providers involved in each resuscitation attempt. An E-mail was generated to any provider involved