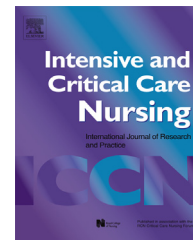




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ORIGINAL ARTICLE

Care, compassion and competence in critical care: A qualitative exploration of nurses' experience of family witnessed resuscitation



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Summary This exploratory study was grounded in a local initiative promoting family witnessed resuscitation in the critical care units of a regional cardio-thoracic centre in the United Kingdom (UK). Research in this field has focussed on the perceived benefits, or otherwise, of family involvement, but little is known about the impact this has on critical care nurses or their practice. This study aimed to gain insights into nurses' experience of family witnessed resuscitation and identify any implications for critical care practices.

The study employed a phenomenological approach and interviewed six nurses who had been involved in family witnessed resuscitation. Data from the transcribed interviews were analysed thematically and organised into descriptive categories which reflected the nursing experience of these resuscitation events.

The three thematic categories generated by data analysis illustrate the challenges nurses faced in seeking to balance compassionate care and technical competence in emergency situations on critical care units. They also showed how nurses sought to reconcile unsettling emotions with their professional practice and responsibilities.

The findings of this study are consistent with what is already known about the challenges of critical care nursing, but suggest that more research is needed to understand the practical and emotional complexities of family witnessed resuscitation.

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Implications for Clinical Practice

- Whilst the concept of FWR is a laudable objective in patient centred care, the practice is fraught with emotional and technical challenges.
- The practice of FWR requires nurses to balance compassion and humanism with a high level of technical competence.
- FWR situations inspire nurses to reflect on their own professional values and actions.
- In order to support the practice of FWR with the best evidence more research is need to understand the multidisciplinary and family perspectives.

Introduction

The practice of family witnessed resuscitation (FWR) during cardiopulmonary resuscitation (CPR) is believed to meet the emotional needs of both family and patient (Leung and Chow, 2012); however, FWR divides professional opinion (Fulbrook et al., 2004). Although it may not be appropriate during every resuscitative event, acknowledgement of the feelings of both staff and family are instrumental in decision making around the inclusion of family members in CPR (Royal College of Nursing, 2002). Despite being recognised as important by various professional bodies (Emergency Nurses Association, 2005; Resuscitation Council, 1996; Royal College of Nursing, 2002), for various reasons FWR is not always implemented within critical care environments.

The practice of FWR has been contentious since the 1980s (Doyle et al., 1987), and implementation in the United Kingdom (UK) is largely driven by current national health policy which emphasises individualised, high quality care (DH, 2008, 2013a). This ethos can be extended to FWR. Resuscitation Council guidelines (1996), recommend that family members should be given the choice to be present during resuscitative attempts and need appropriate support throughout the experience. The ubiquity of the internet, and the growth of information and communication technology in recent years, means that the general population has become more aware of both the practice and complexities of CPR. Cardiac arrests in the public arena can be witnessed by onlookers, often as a result of circumstance, thereby increasing exposure to the resuscitation process (Mitchell and Lynch, 1997). Widespread coverage of invasive and surgical procedures, as well as graphic images of human carnage has desensitised the general public to traumatic images (Fulbrook et al., 2004) and high profile, celebrity driven, national educational campaigns have encouraged public involvement in CPR in the UK (British Heart Foundation, 2012). The shift in public attitudes and expectations, and the promotion of FWR by healthcare providers, may also be associated with the wider expansion of palliative care (Fulbrook et al., 2004), which has encouraged a more open and inclusive approach to the management of death and dying. Nonetheless, a cardiac arrest is still most likely to be an unexpected medical emergency. In which case it is arguable that in a resuscitation event the need for technical nursing competence and compassionate care is even greater than that required in an expected or managed death.

Caring has always been the central tenet of nursing practice and in the UK health service the concept of nursing

care is currently at the forefront of professional and political debate. The recent publication of the Francis Report (DH, 2013a), the Keogh report (DH, 2013b) and the articulation of nursing '6Cs' (caring, compassion, competence, communication, courage and commitment) by the office of the Chief Nurse (DH, 2012), have re-emphasised the centrality of compassionate care in nursing practice. In the critical care environment it has long been recognised that the context in which nursing is practiced challenges the very fundamentals of caring (Ashworth, 1990; Wilkin and Slevin, 2004). The need to provide a humanistic, empathetic environment, for both patients and family members, is compounded by the complexity of the patients' conditions, the range of sophisticated equipment employed, and the need for critical care nurses to have a high degree of technical knowledge and competence alongside their caring skills.

Within the critical care environment there is also considerable potential for tensions to arise in nurses who are obliged to balance the 'art' of caring together with the 'science' of care technology. Nowhere is this need for balance more evident than during FWR, as complex resuscitative procedures have to be completed alongside intense psychological support of family members. To deliver compassionate care during FWR requires an innate sensitivity to both the physical and practical complexities of the critical care environment, as well as an understanding of the multi-faceted dimensions of emotional care giving. It has been suggested that the nurse is able to influence the family's response to an illness, by giving guidance and meaning to the event (McKivergin and Daubenmire, 1994; Watson, 2008). This is especially relevant during cardiac arrest situations. Efforts to provide compassionate and humane care in crisis situations are often inspired by a sense of professional mission and the emotional reaction of the nurse to the suffering of the patient or their family (Schapira, 2013). It could be argued that the ability to deliver this type of nursing care effectively requires prior experience of FWR, but it appears that the practice of FWR is sporadic and subject to widespread variation of staff opinion and practice (Walker, 2008). In this context it is reasonable to assume that there will be considerable differences in the experiences of critical care nurses and it may be the case that many are unprepared for dealing with the complexities of FWR. However, there is little in the published literature which facilitates our wider understanding of the effect of FWR on critical care nurses or their practice and it was in this context that the study was designed.

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