Using Systematic Reviews to Guide Decision Making About Family-Witnessed Resuscitation

Susan W. Salmond, EdD, RN, ANEF, FAAN,
Lisa M. Paplanus, DNP, RN-C, ACNP-BC, ANP-BC, CCRN,
Amita Avadhani, DNP, DCC, ACNP, ANP, CCRN

Family-witnessed resuscitation (FWR) allows family members to be present while emergency cardiac life support measures are applied. This article describes the use of systematic reviews to inform best clinical policy on FWR. The authors searched Medline and CINAHL for relevant systematic reviews and retrieved four. The reviews were then tested for rigor and validity using the open source Critical Appraisal Skills Programme from the Institute of Health Science, University of Oxford. The reviews were assessed to be of acceptable quality and therefore good sources of evidence to guide practice and policy development. Two reviews examined FWR of adult patients, one examined FWR of children and adults, and one examined FWR of children. Together, the four reviews covered 83 studies that describe the perspectives of more than 15,000 health care providers; 2,000 family members; and 2,000 patients. The systematic reviews provide clear evidence that both patients and family members want the option to be present during FWR. In contrast, there is significant variability among health care providers, with those in favor ranging from 7% to 96%. This wide range is related to (worldwide) geography and to provider status (eg, Registered Nurse and Medical Doctor). Generally, patients, family, and providers agreed on the benefits of FWR. Barriers to FWR include perceptions of possible performance anxiety and family interruption of care. The authors conclude that institutional settings need to develop a rational policy on FWR, have family support personnel present during FWR, and develop training programs for students and staff on family presence.

Keywords: *Systematic review, family witnessed resuscitation, evidence-based practice.*

Susan W. Salmond, EdD, RN, ANEF, FAAN, is a Professor and Executive Vice Dean, Rutgers School of Nursing, Newark, NJ; Lisa M. Paplanus, DNP, RN-C, ACNP-BC, ANP-BC, CCRN, NP/PA, is the Coordinator—Vascular/General/Bariatric Surgery, New York University Hospital, New York, NY; and Amita Avadhani, DNP, DCC, ACNP, ANP, CCRN, is an Assistant Professor, Rutgers School of Nursing, Newark, NJ.

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Address correspondence to Susan W. Salmond, Rutgers School of Nursing, 65 Bergen Street, Suite 1141, Newark, NJ 07107; e-mail address: salmonsu@sn.rutgers.edu.

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Case Study

Scenario 1

JAMES P., AGED 70 YEARS, was admitted for video-assisted thoracic surgery (VATS) for a recently diagnosed advanced adenocarcinoma of the lung. His past history is significant for severe chronic obstructive pulmonary disease (COPD) requiring home oxygen that now limits his functional abilities. He has a 40-year smoking history of one pack a day, but he has not smoked since admission to the hospital for surgery. He had an increased work of breathing from COPD exacerbation on admission; there, he was placed on high-flow oxygen and required steroids as well as antibiotics.

James expressed to his nurse that he did not want to undergo this extensive surgery, which will likely require him to be on a ventilator postoperatively. His pulmonary physician and his registered nurse (RN) had a discussion with James's wife regarding his goals of care as his underlying comorbidities could render him ventilator dependent given the additional extensive stress of surgery. His wife insisted that he undergo the surgery as this was his only chance for an extended life. On being told that her husband wished to decline the surgery, his wife said to him, "Don't you want to do this for me? You know I love you." So, James consented to the surgery.

The planned VATS approach had to be converted to an open thoracotomy as the tumor could not be accessed using VATS. He was in the operating room (OR) for 8 hours for this extensive resection of his left lower lobe and partial resection of the left upper lobe of the lung. Despite the rough intraoperative course, he remained hemodynamically stable, was extubated in the postanesthesia care unit (PACU), and transferred to the surgical intensive care unit (ICU). Approximately 8 hours after admission to the ICU, he developed dyspnea and hypoxemia and his work of breathing increased progressively, requiring reintubation.

Two days after being on the ventilator, James was on a very high concentration of oxygen (100%), requiring high doses of intravenous continuous sedation as he was often restless, agitated, and in pain as per the nonverbal pain assessment. One evening, during a period of agitation, James tried to sit up and remove his endotracheal tube. His heart rate dropped and he went into asystole. His nurse called a Code Blue. James's wife was very anxious: "What's wrong…what's wrong…is he all right?"

What should the nurse do with James' wife as the code team arrives and continues the resuscitative efforts? The hospital has no policy regarding family remaining during resuscitative efforts. Your choices are:

A. Ask Mrs. James to leave the room and provide ongoing information on her husband's status.
B. Encourage Mrs. James to stay while resuscitative efforts continue.
C. Escort Mrs. James outside of the room and offer to bring her back to witness the resuscitation after explaining to her what happened and after assessment of her emotional status.

Scenario 2

Peter S. is a 79-year-old Caucasian man with a history of hypertension, COPD, and non–small-cell lung cancer for which he underwent a right lower lobe resection and pleurectomy for malignant pleural effusions. His postoperative course was unremarkable and he was discharged home 2 days after surgery. He returned to work and was compliant with his treatment. A few weeks ago, Peter experienced new, progressively worsening shortness of breath. His oncologist suspected metastasis to the left lung as well as to other distant organs; this was confirmed on computed tomography scan.

Peter was scheduled for a bronchoscopic evaluation and a biopsy of his left lung lesion. He presented to the preanesthesia care unit accompanied by his eldest son Jack and his daughter Jill. Jack, who has power of attorney for his father's care, was asked to complete the preanesthesia unit form, which included a section on the patient's advance directive/goals of care/practitioner orders for life-sustaining treatment. Jack tells you that he does not want to complete these forms. He explains that he realizes that his dad is very sick, but their religion does not allow them to cease care for a