Review of Evidence About Family Presence During Resuscitation

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KEYWORDS

• Family presence during resuscitation • Family-witnessed resuscitation
• Family-centered care • Patient-centered care • Resuscitation

KEY POINTS

- Despite research documenting family presence during resuscitation (FPDR) is unlikely to cause psychological distress to families and may be helpful to them, the practice remains controversial in many settings.
- Being present during a loved one's resuscitation should be offered as an option to family, ideally in alignment with the patient's wishes, and with a designated family support person.
- Health care providers (HCPs) generally are less supportive of FPDR than patients and families, and levels of support vary by geographic region and culture.
- Variations in practice regarding FPDR may lead to inequitable patient care. Patients, families, and HCPs deserve to receive and give evidence-based care related to FPDR.
- HCP education about FPDR, policies or guidelines, and experience with FPDR tend to increase HCP support for the practice.

INTRODUCTION

A desirable attribute of nursing practice is to provide patient care based on evidence. Sometimes personal attitudes, opinions, traditions, and beliefs also influence nursing decisions and actions, as does the context of the practice environment. Care of the dying patient and his or her family is a complex, emotionally charged situation susceptible to personal attitudes of nurses and other health care providers (HCPs). Patients nearing the end of life require skilled nursing care at all times, but perhaps more so when death is unexpected and resuscitation is attempted.

Disclosure Statement: The authors have no significant relationships to disclose.
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Crit Care Nurs Clin N Am 26 (2014) 533–550
http://dx.doi.org/10.1016/j.ccell.2014.08.010 **ccnursing.theclinics.com**
0899-5885/14/$ – see front matter

To guide nurses and interdisciplinary colleagues, medical aspects of care during resuscitation are outlined in evidence-based basic and advanced cardiac life support (ACLS) guidelines.[1,2] Resuscitation guidelines facilitate shared expectations and collaborative workflow among members of health care teams. Technical aspects of resuscitation such as cardiopulmonary resuscitation (CPR), advanced airway management, electrical therapies, and medication administration have been widely adopted and generally agreed upon. Resuscitation activities may also involve ethical considerations, including whether to allow family presence (FP) at resuscitation, an issue about which resuscitation team members may disagree. Although several organizations[3–7] support offering the option of family presence during resuscitation (FPDR), implementation remains controversial. The problem is controversy leads to practice variation, so some families are offered this option while others are not. Inconsistent practice opens the door for inequitable patient care, and also poses a risk to the health care team as inconsistencies may lead to confusion, tension, or overt conflict between HCPs. Given the potential consequences, nurses and others may benefit from examining what is known about FPDR, including factors that hinder and help effective implementation, so as to best care for patients, families, and one another. This article presents relevant research on attitudes about FPDR, interventions to help change practice, and the authors' experience with a project to implement FPDR in a medical intensive care unit (MICU). This knowledge can be used to empower nurses to transfer evidence into practice.

BACKGROUND

FPDR remains a popular topic in contemporary health care literature. FPDR means family members are offered the option to witness any portion of resuscitation efforts on their loved one. Presence may range from allowing family members to touch or speak to the patient to having them passively observe without patient interaction. Offering FPDR as an option means the choice is offered devoid of coercive behavior intended to promote or discourage a specific decision. The optional aspect is important because FPDR may not be desirable for everyone. The term family, historically defined as one's legal relatives, has expanded. Besides legal relatives, the Joint Commission's definition includes friends or others who provide support to the patient as family.[8] Similarly, the American Association of Critical Care Nurses (AACN) defines family as including relatives and significant others who have an established relationship with the patient.[4] Clarifying who is considered family should be part of dialogue about FPDR to minimize misunderstandings.

The first article addressing FPDR was published more than 25 years ago, when researchers found most families wished to be present during resuscitation, and most staff surveyed endorsed FPDR.[9] Although there was a paucity of research over the following decade, interest in FPDR later resurfaced. Today there is a substantial body of literature surrounding the practice.

REVIEW OF EVIDENCE ABOUT FAMILY PRESENCE DURING RESUSCITATION

Available evidence can add objectivity to the creation of well-informed practice recommendations. The literature contains reports about HCP, patient, and public attitudes about and experiences with FPDR, offering viewpoints from key stakeholder groups. In addition, effects of various interventions used to change practice have been explored. Research findings about attitudes and experiences can guide planning and implementation of FPDR, and help to promote buy-in of interprofessional staff and organizational leaders.