



Inviting family to be present during cardiopulmonary resuscitation: Impact of education



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ABSTRACT

Encouraging and permitting family members to stay together during cardiopulmonary resuscitation benefits the patient, family and staff. Health care professionals (HCP) attitudes and experiences are documented as barriers to initiating family presence during cardiopulmonary resuscitation (FPDR). The aim of this pilot study was to explore the influence of education on changing HCPs attitudes and intent to provide families with the option to be present at the next cardiac arrest. A purposive sample of 29 HCP from an acute care hospital participated in this quasi-experimental study. 18 of the original 29 HCP completed both the education package and the post-test questionnaire.

Results: The majority of participants in this study had previous experience with FPDR (62%) and supported FPDR (69%). While participants had slightly more positive attitudes towards FPDR post education, this change was not significant ($p = 0.79$). Similarly, participation in education did not change participants concerns about safety issues or increase participant's intention to invite a family member to be present at the next cardiac arrest. The majority of participants strongly supported the development of a dedicated family support person. Education has limited impact on change participant's attitudes or intentions to invite family to be present at the next cardiac arrest.

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Introduction

Family presence during resuscitation (FPDR) is “the attendance of one or more family members in a location that affords visual or physical contact with a patient during cardiopulmonary resuscitation (CPR)” (Eichhorn et al., 2001). Family, the general public and professional bodies all have favorable disposition towards the concept of family being present during resuscitation (Axelsson et al., 2010; Dwyer, 2015; Eichhorn et al., 2001; Emergency Nurses Association, 2001; Rittenmeyer and Huffman, 2012). From the perspectives of the family, the notion of being there or being connected, in what may be sometimes the last moments of their loved one's life, is important (Dwyer, 2015; Hung and Pang, 2011). Never the less, it is common to find that staff are not offering family the option to be present and remain reluctant to change this practice. This stance conflicts with a family-centered model of care which proposes that family should be afforded the choice to be present or not (Davidson et al., 2007).

Staff attitudes are a barrier to having families present as they are neither prepared nor educated to meet the needs of families who are present (Axelsson et al., 2010; Madden and Condon, 2007). However, providing education in itself may be insufficient. Where there is evidence that education makes attitudes more favorably disposed to having families present, any consideration of the impact of education on the intention to invite families to be present has been overlooked. This pilot study sought to compare staff attitudes and intent to invite family to be present before and after participating in a self-directed education session on FPDR. The primary outcome of interest was a change in the staff support for the concept of FPDR and a corresponding adjustment in their intent or motivation to do so.

Literature review

Family-centered care acknowledges the important role of the family in the health and wellbeing of the patient (McMahon-Pakes et al., 2009; Redley et al., 2004). The ongoing practice of separating patients and family during CPR has been challenged on the basis it is contrary to family-centered care (McClenathan et al., 2002; Meyers et al., 2000; Redley et al., 2004; Sacchetti et al., 2000)

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and public desire to be included (Dwyer, 2006; Hung and Pang, 2011; Mazer et al., 2006; Ong et al., 2007). Professional bodies recommend that (American Association of Critical Care Nurses, 2010; American Heart Association, 2005; Australian Resuscitation Council, 2006) where the adult patient has not raised a prior objection it is reasonable to give select family members the opportunity to be present (Australian Resuscitation Council, 2006).

Attitudes to FPDR

Despite support by professional bodies, staff attitudes continue to be a major obstacle to FPDR with staff support varying between 22 and 90% (Doyle et al., 1987; Grice et al., 2003; Holzhauser and Finucane, 2007, 2008; Holzhauser et al., 2006; Mian et al., 2007; Redley et al., 2004; Weslien and Nilstun, 2003). Nurses have higher levels of support than physicians (Chalk, 1995; Critchell, 2007; Duran et al., 2007; Fulbrook et al., 2007; Hallgrimsdottir, 2000; Helmer et al., 2000; McClenathan et al., 2002; Mian et al., 2007; Moreland and Manor, 2005; Redley et al., 2004; Walker, 2006). Staff opposed to family presence are more inclined toward the opinion that relatives may find the experience traumatic and their presence may influence staff performance and the potential of litigation (Fulbrook et al., 2005, 2007; McClenathan et al., 2002; Meyers et al., 2000; Ong et al., 2007). On the contrary, being present (Clarke and Carter, 2002; Doyle et al., 1987; Eichhorn et al., 2001; Hansen and Strawser, 1998; MacLean et al., 2003; Meyers et al., 2000; Oman and Duran, 2010; Robinson et al., 1998) offers family the opportunity to be there and begin the process of accepting the death (Maxton, 2008; McGahey-Oakland et al., 2007). Further, the public believe it is their right to be present (Dwyer, 2015) and getting in is a challenge (McMahon-Pakes et al., 2009). Staff knowledge and attitudes are cited as reasons for family not being invited to be present (Davidson, 2006; Duran et al., 2007; Feagan and Fisher, 2011).

Impact of education

As evidence supporting the benefits of FPDR becomes increasingly apparent, health professionals are being educated to address the commonly cited barriers that impede the practice (Davidson, 2006; Duran et al., 2007; Feagan and Fisher, 2011). Education sessions have however, had varied impact on changing attitudes (Ellison, 2003; Holzhauser and Finucane, 2007; Mian et al., 2007). Pre- and post-test studies report that opinion-based beliefs regarding FPDR can be changed following attendance at education sessions (Bassler, 1999; Feagan and Fisher, 2011). In contrast, the attitudes of Australian nurses to FPDR did not alter ($p = 0.29$) prior to ($n = 63$) or following ($n = 36$) participation in targeted FPDR education (Holzhauser and Finucane, 2007). While education does have variable impact on staff attitudes it is not known if these translate to a change in clinical practice or individual behavior. Measuring actual behavioral change in this context is difficult given the infrequent occurrence of cardiac arrests. According to the Theory of Planned Behavior (TPB) (Ajzen and Fishbein, 1980) any change in an individual's behavior will be immediately preceded by a positive intent (motivation) to modify or change the specific behavior. Hence, understanding the influence of education on changing staff attitudes and intent to provide families with the option to be present may be the key to improving FPDR practice in the acute care setting. The aim of this study was to examine the influence of targeted education on an individual's attitudes and intent to change their behavior and afford family the invitation to be present.

Method

Design

This pilot study was planned as a single group pre-test, post-test quasi-experimental design where the intervention was a self-directed learning education package. The study consisted of two dependent samples with two data collection points (baseline and two months post intervention). The primary outcome measures were attitudes and intent to invite family to be present.

Setting and sample

The study was set in a regional Australian tertiary teaching hospital all nurses and doctors employed in a clinical capacity ($n = 200$) were invited to participate. The site had an established medical emergency team (MET) but no established FPDR policy nor a dedicated FPDR support person. The University and Hospital Human Research Ethics Committees (HREC) approved the study conducted in accordance with national standards (National Health & Medical Research Council, 2007).

Instrument

The developed survey was used in an earlier study of 100 registered nurses (Dwyer, 2007) and consisted of closed and open ended items. There were four sections: socio-demographic (6 items), FPDR experience (13 items) and attitudes to FPDR (17 items). Consistent with previous use of the developed survey (Dwyer, 2007) attitudinal questions were grouped into four priori attitudinal items that were called: Staff safety concerns, Family support, Staff decision making and Patient rights. Attitudinal items used a five point Likert type scale format ranging from 1 = strongly disagree to 5 = strongly agree. Individual attitudes were elicited using two open-ended questions;

1. Please comment on your experiences of having family present.
2. What would you like to see changed?

Intervention

A purposively developed evidence-based, self-directed on-line learning package consisting of journal articles, web links and summaries of commonly cited facilitators and barriers to FPDR. This mode of delivery was chosen to increase staff engagement and accessibility as previous studies on FPDR education sessions have noted few staff actually attended (Mian et al., 2007). Further, studies comparing various methods, including self-directed packages, for resuscitation education have concluded that there is no significant difference between face-to-face and self-directed methods (de Vries and Handley, 2007; Jones et al., 2007).

Data analysis

Data analysis was performed using the computer software SPSS for Windows version 19. Frequencies, means and standard deviations were computed to obtain a profile of the participants' demographic characteristics ($n = 29$) and the perceived importance of each statement. Pre- and post-test data were compared using paired t-test with Bonferroni correction and Wilcoxon signed rank as appropriate. The internal consistency of the priori attitudinal groupings (Table 2) was considered adequate with Cronbach alpha coefficients of over 0.7 (Tabachnick and Fidell, 2001). Qualitative responses were analysed using inductive content analysis (Braun

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