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Facilitated family presence at resuscitation: Effectiveness of a nursing student toolkit

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SUMMARY

Background: Facilitated family presence at resuscitation is endorsed by multiple nursing and specialty practice organizations. Implementation of this practice is not universal so there is a need to increase familiarity and competence with facilitated family presence at resuscitation during this significant life event. One strategy to promote this practice is to use a nursing student toolkit for pre-licensure and graduate nursing students. The toolkit includes short video simulations of facilitated family presence at resuscitation, a PowerPoint presentation of evidence-based practice, and questions to facilitate guided discussion.
Methods: This study tested the effectiveness of this toolkit in increasing nursing students' knowledge, perceptions, and confidence in facilitated family presence at resuscitation. Nursing students from five universities in the United States completed the Family Presence Risk–Benefit Scale, Family Presence Self-Confidence Scale, and a knowledge test before and after the intervention.
Results: Implementing the facilitated family presence at resuscitation toolkit significantly increased nursing students' knowledge, perceptions, and confidence related to facilitated family presence at resuscitation ($p<.001$). The effect size was large for knowledge ($d=.90$) and perceptions ($d=1.04$) and moderate for confidence ($d=.51$).
Conclusions: The facilitated family presence at resuscitation toolkit used in this study had a positive impact on students' knowledge, perception of benefits and risks, and self-confidence in facilitated family presence at resuscitation. The toolkit provides students a structured opportunity to consider the presence of family members at resuscitation prior to encountering this situation in clinical practice.

Introduction

Since the early1990s, the Emergency Nurses Association (ENA), the American Association of Critical-Care Nurses (AACN), and the Society for Critical Care Medicine (SCCM) have promoted family presence at resuscitation with published position statements in support of the practice (American Association of Critical-Care Nurses, 2010; Davidson et al., 2007; Emergency Nurses Association, 2010). Despite widespread endorsement of this practice, known as facilitated family presence during resuscitation (FFPR), it has yet to gain widespread support by healthcare providers, including registered nurses (Dingeman et al., 2007; Tomlinson et al., 2010). In a national survey of members of the American Association of Critical-Care Nurses and the Emergency Nurses Association, only 5% of critical care units in the United States had developed written policies allowing family presence during resuscitation and invasive procedures (MacLean et al., 2003). Similarly, in Canada only 8% of critical care units had written guidelines or policies (Fallis, et al., 2008). The reasons for the relatively low acceptance of FFPR are complex (Critchell and Marik, 2007; Twibell et al., 2008), but lack of education and experience likely contribute to some nurses' reluctance to endorse this well-described, evidence-based practice (Tomlinson et al., 2010). Furthermore, nurses may not be prepared to handle the emotional impact of FFPR on the family and themselves (Davidson et al., 2011).

Background

Admission to the ED or ICU often happens unexpectedly and as a result of a life-threatening illness or injury. If conscious, the patient is likely to be in an unfamiliar environment, concerned and anxious about survival, and surrounded by unfamiliar healthcare workers, interventions, and support equipment. Under these circumstances patients may desire their family members to be present (Mcmahon-Parkes et al., 2009). At the same time, family members typically experience increased stress and anxiety related to the uncertainty of their loved one's condition (Auerbach et al., 2005), often requiring frequent information

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about patient status and asking to be close to the patient (Eggenberger and Nelms, 2007; Wagner, 2004). One intervention that may occur during emergency or intensive care is cardiopulmonary resuscitation (CPR). When CPR is necessary, family members may be especially anxious and upset (Weslien et al., 2005), and may desire to be with the patient (Duran et al., 2007).

When FFPR is offered as an option and family members can be present at the bedside of their ill or injured loved one, anxiety may be reduced, family coping may be increased, and family integrity can be preserved (Meyers et al., 2000; Robinson et al., 1998). FFPR allows the family to support and comfort the patient both emotionally and physically during interventions. It increases the trust and the quality of the nurse–family relationship by decreasing doubt, fear, and anxiety about the patient's condition, and by witnessing that everything possible is being done for the patient (Eichhorn et al., 1996; Meyers et al., 2000; Robinson et al., 1998). Family presence also allows a sense of closure and facilitates the grief process, should death be the result (American Association of Critical-Care Nurses, 2010; Robinson et al., 1998).

The family's desire to be present at resuscitation was first described in the 1980s (Doyle et al., 1987). Initially, family presence research and practice were limited to pediatric settings. After the American Heart Association issued a recommendation to allow family presence during resuscitation (American Heart Association, 2000), family presence has also been investigated in adult patients (Meyers et al., 2000; MacLean et al., 2003; McClenathan et al., 2002). There is increasing evidence supporting benefits of family presence in adult and pediatric care settings (Benjamin et al., 2004; Duran et al., 2007; Mazer et al., 2006). In a review of the literature, Howlett et al. (2010) found that while provider commitment to FFPR was necessary at all levels, nurses were in the best position to facilitate incorporating family presence into practice. Perceptions, attitudes, and beliefs of nurses and the health care team regarding family presence influenced the decision to offer the option of family presence. Some of the beliefs that contributed to limitations on family presence imposed by nurses and/or healthcare providers included the belief that family presence inhibits caregiver access to patients, causes disruption in care, may cause emotional and psychological trauma to family members, and may increase malpractice litigation (Davidson et al., 2011; Tomlinson, et al., 2010; Anzoletti et al., 2008; McClenathan et al., 2002). These findings demonstrate the need for improving educational experiences for nurses and other health professionals about the benefits of supporting family presence at resuscitation. Feagan and Fisher (2011) demonstrated the benefits of an educational intervention for practicing clinicians using a PowerPoint presentation and discussion format to improve knowledge and attitudes toward family presence.

Simulation is increasingly used in nursing education to develop skills and nursing knowledge while socializing students into the roles of the professional nurse (Walton et al., 2011). Video simulation has been utilized as one such strategy to contextualize nursing care in the lives of patients (Cardoso et al., 2012). Videos are widely available through the internet and may be delivered to varying class sizes. Implementing video simulation in nursing education is an untested strategy for promoting the incorporation of FFPR into clinical practice. To this end, we developed a video simulation-based nursing education toolkit (FFPR Toolkit) which includes three video scenarios, instructor teaching guides and presentations, and student packets (Table 1).

Theoretical Framework

Two theoretical frameworks were used to guide the development of the FFPR Toolkit and the study evaluating its effectiveness: nursing education simulation framework (Jeffries and Rogers, 2007) and social learning theory (Bandura, 1977). The nursing education simulation framework includes five components: teacher, student, educational practices, design characteristics and simulation, and outcomes. While the design of the scenarios for this study incorporated all of these components, there was a particular focus on educational practices. The video scenarios and associated guided discussions served as a platform for two educational practices: collaborative learning and faculty student interactions. Bandura's social learning theory postulates that people learn through observation and exposure. The video simulations provided students an opportunity to observe a modeling of facilitated family presence that they were unlikely to have encountered in their clinical placements.

The primary aim of this study was to evaluate the effects of the FFPR Toolkit on the development of nursing students' knowledge, attitude, and confidence with facilitated family presence at resuscitation. Our hypothesis was that the use of the FFPR Toolkit would increase nursing students' knowledge of FFPR, acceptance of family presence as a desirable standard of care, and confidence in their ability to facilitate family presence.

Table 1
Video scenarios of facilitated family presence during resuscitation and education toolkit available online.

Videos	
Postpartum	http://vimeo.com/14864959
Pediatric	http://vimeo.com/14864545
Adult trauma	http://vimeo.com/14865388
Supplemental questions	http://vimeo.com/15205609
Instructor packet	
http://nursing.wsu.edu/research/FFPR/Family_Presence_Instructor_Packet.pdf	
Training presentation	
http://nursing.wsu.edu/research/FFPR/Facilitated_FPDR_Instructor_Guide_self-knowledge_assessment.pptx	
Clinical practitioner packet	
http://nursing.wsu.edu/research/FFPR/Family_Presence_Clinician-Baccalaureate_Completion-Graduate_Student_Packet.pdf	
Student packet	
http://nursing.wsu.edu/research/FFPR/Family_Presence_Nursing_Student_Packet.pdf	

Methods

The FFPR Toolkit was developed collaboratively by PhD students and the faculty of a college of nursing, and nurses and staff of an acute care hospital. The project was initiated as part of an effort to implement the hospital's new policy for FFPR. The FFPR Toolkit was subsequently used to train experienced healthcare providers, including physicians, nurses, social workers, chaplains, and respiratory therapists, in different settings within the hospital. In order to broaden the application of this program, the FFPR Toolkit was standardized and adapted for use in classroom settings, small group settings such as clinical conferences, and online for asynchronous learning or self-study. The learning objectives of the FFPR Toolkit are listed in Table 2. A description of the FFPR Toolkit and the methods used to evaluate its effects follows.

FFPR Toolkit

The FFPR Toolkit includes three video simulations of family presence, an instructor guide, discussion questions, and a literature-based PowerPoint presentation (Table 1). Implementation of the Toolkit takes approximately one hour and begins with students watching one of the video simulations. The videos involve three realistic family presence scenarios across the lifespan: a) a mother who collapses suddenly in the recovery room after cesarean delivery; b) a child in deteriorating condition in the intensive care unit; and c) a middle-aged man in the

Table 2
Facilitated family presence at resuscitation (FFPR) Toolkit learning objectives.

Students will be able
1. To explain the practice of FFPR
2. To analyze and comment on a simulation of FFPR
3. To develop a personal plan for integrating FFPR into their practice