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Family support liaison in the witnessed resuscitation: A phenomenology study

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ABSTRACT

Background: Family-witnessed resuscitation remains controversial among clinicians from implementation to practice and there are a number of countries, such as Iran, where that is considered a low priority.
Objective: To explore the lived experience of resuscitation team members with the presence of the patient's family during resuscitation.
Design: The hermeneutic phenomenology.
Settings: The emergency departments and critical care units of 6 tertiary hospitals in Tabriz, Iran.
Participants: There were potentially 380 nurses and physicians working in the emergency departments and acute care settings of 6 tertiary hospitals in Tabriz. A purposive sample of these nurses and physicians was used to recruit participants who had at least 2 years of experience, had experienced an actual family witnessed resuscitation event, and wanted to participate. The sample size was determined according to data saturation. Data collection ended when the data were considered rich and varied enough to illuminate the phenomenon, and no new themes emerged following the interview of 12 nurses and 8 physicians.
Methods: Semi-structured, face- to- face interviews were held with the participants over a period of 6 months (April 2015 to September 2015), and Van Manen's method of data analysis was adopted.
Results: Three main themes emerged from the data analysis, including 'Futile resuscitation', 'Family support liaison', and 'Influence on team's performance'. A further 9 sub-themes emerged under the 3 main themes, which included 'futile resuscitation in end-stage cancer patients', 'when a patient dies', 'young patients', 'care of the elderly', 'accountable person', 'family supporter', 'no influence', 'positive influence', and 'negative influence'.
Conclusions: Participants noted both positive and negative experiences of having family members present during cardiopulmonary resuscitation. Welltrained and expert resuscitation team members are less likely to be stressed in the presence of family. A family support liaison would act to decrease family anxiety levels and to de-escalate any potentially aggressive person during the resuscitation. It is recommended that an experienced health care professional be designated to be responsible for explaining the process of resuscitation to the patient's family.

What is already known about the topic?

- Family members often remain in a waiting area as the resuscitation attempt takes place.
- Family are often absent from the bedside when the patient dies reducing opportunities to say goodbye.
- Although there is growing support for FWR in literature, controversies continue among clinicians around implementation to practice.

What this paper adds

- Resuscitation events tend to be prolonged when family members are allowed to be present.
- Well trained and expert CPR team members are better equipped to support family presence and are unaffected by the potential stresses related to have family in the resuscitation room.
- A family support liaison helps to decrease family anxiety and to de-escalate any potentially confrontations between staff and family members.

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1. Introduction

A new paradigm has emerged in nursing and medicine; a shift has occurred from the paternalistic model to team work and patient/family-centred care. As a result, a holistic view has been developed in which a person is seen as part of a large and complex whole in the context of the family unit (Mitchell et al., 2009; Nethercott, 1993). In family-centred care, which focuses on the important role of family during a disease process, the needs of a patient's family members are identified and considered (Frampton et al., 2003; McCormack and McCance, 2011).

Family-witnessed resuscitation (FWR) is defined as family members having the right and ability to make eye or physical contact with a patient during cardiopulmonary resuscitation (CPR) (Emergency Nurses Association, 2007). FWR has been discussed and reported in the literature since the mid-1980s (Doyle et al., 1987). In the event of the patient dying, family members who were not permitted to be present at the bedside may experience the grieving process more traumatically (Sak-Dankosky et al., 2014). Family members now have expectations of health care providers to enable FWR and other invasive procedures (Cepero, 2012; Mccabe, 2014; Ward, 2011; Westley et al., 2014) and are increasingly seeking permission to be present (Cepero, 2012; Hassankhani et al., 2017).

There is renewed debate among health professionals about FWR, as they seek to understand the advantages and disadvantages of allowing family to be present (Sak-Dankosky et al., 2014). FWR can influence the quality of the communication between team members; it has also been known to enhance the dignity of the patient and increases the professional atmosphere in the resuscitation room (Tudor et al., 2014). When family members are permitted to be present, they become aware of the effort that the resuscitation team is providing, which can assist with the grieving process and provide assurances that everything possible was done for the patient (Porter et al., 2014; Tudor et al., 2014; Hassankhani et al., 2017).

Engaging the patient's family in routine care can increase patient and family satisfaction as well as enhancing therapeutic relationships between staff, patients and family members (Tudor et al., 2014). However, during life threatening events, the presence of family may become a contentious issue among members of the health care team (Mccabe, 2014). According to the Emergency Nurses Association, the presence of family members during CPR should be permitted with a formal policy in health care centres (Tudor et al., 2014). Although the literature states that there is growing support for FWR, there remain perceived barriers to implementation (Giles et al., 2016; Harteveldt, 2005; Mccabe, 2014; Taraghi and Ilail, 2013; Tudor et al., 2014).

Survival rates following resuscitation remain low worldwide, ranging from 9.5% to 23.9% in the United States of America compared to only 7.2% in Iran (American Heart Association, 2013; Salari et al., 2010); therefore, for family members, the resuscitation event may be the last time the patient is seen alive.

Although FWR is supported and implemented around the world, for example, Victorian emergency personnel endorse and practice FWR (Porter et al., 2015), in Iran it is not generally accepted and remains a low priority during resuscitation events (Kianmehr et al., 2010; Soleimanpour et al., 2013; Taraghi and Ilail, 2013). In health care centres in Iran, a patient presenting with a cardiac arrest will have CPR commenced and all family members will be escorted to the waiting room outside the resuscitation room and will be informed of the patient's status only periodically by a nurse (Soleimanpour et al., 2013). When the patient's family remain in the waiting room and the patient dies, they can experience feelings of guilt that the patient has died alone without an opportunity to say goodbye (Demir, 2008). Walker (2008) suggests that differences can be affected by cultural variations that influence healthcare systems. These variations determine a perception of life and dying, as well as in attitudes towards resuscitation and other interventions. Cultural background was found to influence nurses' and physicians' opinions on FWR, and resuscitation team members' experiences and attitudes vary in different cultural and educational contexts (Sa-Dankosky et al., 2014).

Asian society and eastern medical culture tends to be paternalistic in nature by limiting visiting hours and not respecting family-centred care, which can explain opposing FWR (Ganz and Yoffe, 2012; Sheng et al., 2010). Cultural and social backgrounds could influence both the relationship between families and the resuscitation team and a family's responses to death (Demir, 2008; Kianmehr et al., 2010; McClement et al., 2009). For example, in Iran, people often become overwhelmed and agitated when given bad news about their families, expressing themselves with great sadness, and crying in a loud manner (Heidari et al., 2011).

The charter of patients' rights in Iran, states that dying patients have the right to be with their family during the last moments of their lives, however it is not adopted and practiced routinely to patients undergoing CPR (Parsapoor et al., 2010) and there are no FWR policy statements and clinical guidelines, and CPR is generally performed without the presence of family members in the most hospitals of Iran (Kianmehr et al., 2010). To the knowledge of the authors, no study has yet investigated the lived experience of medical and nursing staff regarding FWR in Iran. In view of the increasing evidence from international studies about the value of family witnessed resuscitation and the rapid changes taking place in Iran health care system due to globalization it is important to delineate FWR experiences of CPR team members.

This study aims to explore the lived experience of medical and nursing staff in Iranian high acuity clinical settings related to attitudes towards the presence of family during resuscitation.

2. Methods

The hermeneutic phenomenology developed by Heidegger (1889–1976) was used to explore the Iranian resuscitation team members' experiences of FWR.

Tabriz is the most populated and biggest metropolitan area in Northwest Iran (population 1,549,453 people) (Statistical Centre of Iran, 2011). There are 26 hospitals in Tabriz; a total of 3 public and 3 private hospitals with more than one resuscitation event per day were chosen for this study. One of the chosen public hospitals is the heart referral centre of Tabriz, and 2 of the 3 public hospitals had the highest admission rates in northwest Iran.

There were approximately 380 nurses and physicians working in the emergency departments and acute care settings from 6 tertiary hospitals in Tabriz. A purposive sample of 12 nurses and 8 physicians with at least 2 years' experience, having experienced an actual FWR event, and with the desire to participate were recruited for this study. The sample size was determined according to data saturation. Participants were contacted via phone to arrange a date and time for the interviews.

Semi-structured, face- to- face interviews were held with participants over a period of 6 months (April 2015 to September 2015). Open-ended interview questions were asked, such as 'tell me your experiences regarding family witnessed resuscitation', and 'how did having family present during resuscitation influence your performance'. The interview process began with the participant's experience in CPR and proceeded to elucidate their beliefs regarding family presence. They were asked to relay their experience of a resuscitation during which family members were present, to discuss family behaviour at the bedside, and to assess the impact of FWR on their individual and team performance. At the end of interview, participants were asked if they would like to add any thoughts. Interviews were done in Tabriz Turkish language. The translation has been kept as literal as possible by collaboration of lead researcher and two translators proficient in English whose native language was Turkish. Participants' use of language lost minimized by writing thematic sentences (Sandelowski and Leeman, 2012), and engaging in collaborative peer review of Iranian and native English speaker researcher who contributed in this study.