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Research paper

Family presence during management of acute deterioration: Clinician attitudes, beliefs and perceptions of current practices

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ABSTRACT

Background: The nature of acute clinical deterioration has changed over the last three decades with a decrease in in-hospital cardiac arrests and an increase in acute clinical deterioration. Despite this change, research related to family presence continues to focus on care during resuscitation rather than during acute deterioration.
Aim: To explore healthcare clinician attitudes, beliefs and perceptions of current practices surrounding family presence during episodes of acute deterioration in adult Emergency Department patients.
Methods: Clinicians ($n = 156$) from a single study site in Melbourne, Australia completed a 17-item survey.
Results: Participants disagreed that family members would interrupt (59.0%) or interfere (61.5%) with patient care if present during episodes of patient deterioration. Most (77.6%) participants stated that they included family during episodes of patient deterioration. Females, nurses and Australians/New Zealanders had a more positive attitude towards including family during episodes of patient deterioration when compared to males, doctors and clinicians of other ethnicities. Nurses with post-graduate qualifications and those with more years of experience had a more positive attitude towards including family during episodes of patient deterioration than nurses without post-graduation qualification and with less years of experience.
Conclusions: Clinicians had predominantly positive attitudes towards including family during episodes of patient deterioration and perceived it to be a common day-to-day practice. Gender, profession, country of birth, education level and years of experience all impacted on clinician attitudes, beliefs and perceptions of family presence during acute deterioration.

What is known

- The nature of acute clinical deterioration has changed over the last three decades with an increase in clinical deterioration and a decrease in in-hospital cardiac arrest.
- Family presence during resuscitation is a well researched and supported practice within current healthcare.
- Family presence during acute deterioration has not been studied.

What this paper adds?

- Emergency Department clinicians have a predominantly positive attitude towards family presence during episodes of patient deterioration.
- Emergency Department clinicians perceive family presence during episodes of patient deterioration to be a common day-to-day practice.
- Gender, profession, ethnicity, education level and years of experience all impact on clinician attitudes, beliefs and perceptions of family presence during acute deterioration.

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Introduction

Family presence during resuscitation is defined as the presence of one or two family members in the room while their relative is undergoing cardiopulmonary resuscitation [1–4]. Family presence during resuscitation was first introduced at the Foote Hospital, United States, in the 1980s [1,5,6]. Research evidence to date shows there are multiple benefits for families, patients and clinicians when families are present during resuscitation [1,4,5,7,8]. Benefits for families include improved grieving processes, decreased anxiety and increased understanding of the event [1,4–8]. Patients report an increased sense of comfort and support [2,9–11] and clinicians are more likely to improve their professional manner when families are present during resuscitation [4,12].

The evidence base supporting family presence during resuscitation has resulted in best-practice guidelines and position statements, from major international, national and local organisations [13–16]. Despite the significant support for family presence during resuscitation, clinicians have varying attitudes and beliefs towards the presence of families during resuscitation [2,4,10,17,18]. Key themes in the literature are that clinicians often have concern for the emotional wellbeing of families who are present during resuscitation [2,4,10,17,18] and that having family present during resuscitation may negatively impact patient care [2,4,10,17,18]. Further, some clinicians have concern that having family present during resuscitation may negatively impact team performance, with clinicians experiencing increased feelings of stress and performance anxiety [2,10,17].

The epidemiology of in-hospital acute deterioration and cardiac arrest has changed over the past three decades. Poor survival rates following in-hospital cardiac arrest [19–22] and evidence of deterioration prior to cardiac arrest [23–25] have been the catalyst for a change in focus from management of cardiac arrest to early recognition and response to deterioration. Widespread introduction of Rapid Response Teams (RRTs) has been associated with a decrease in in-hospital cardiac arrests [26–29]. Further, the national importance of early recognition and response to deteriorating patients is evident in Standard Nine: Recognising and Responding to Clinical Deterioration in Acute Care of the National Safety and Quality Health Service Standards (NSQHSS) [30].

The NSQHSS recognises the importance of early recognition of clinical deterioration and the importance of family involvement and engagement in care, including during deterioration and resuscitation [30]. Despite the national push for inclusion of families during a patient's episode of deterioration [30], the changing epidemiology of deterioration [26–29] and evidence supporting family presence during resuscitation [1,4,5,7,8], research related to family presence during management of the deteriorating patient is absent from published literature. Published evidence is required to understand current practices and determine best-practice in caring for families during management of the deteriorating patient.

Aim

The aim of this study was to explore clinician attitudes, beliefs and perceptions of current practices surrounding family presence during episodes of acute deterioration in adult Emergency Department (ED) patients.

For the purposes of this study an episode of deterioration was defined as any episode resulting in activation of the ED rapid response system [31] or when an urgent emergency physician review was requested.

Table 1
Clinical instability criteria [31].

Parameter	Criteria
Airway	Stridor, upper airway obstruction, threatened airway
Respiratory rate	<10 or >30 breaths/min
SpO_2	<90% with O_2 flow rate 10 l/min via Hudson Mask
Arterial blood gas	pH < 7.20
Systolic blood pressure	<90 mmHg or >200 mmHg
Heart rate	<50 or >120 beats/min
Urine output	<20 ml/h or <100 ml/6 h
Conscious state	Sudden decrease in the level of consciousness (fall in GCS >2)
Seizure	Repeated or prolonged
Nurse worried about patient	Present

SpO_2, peripheral capillary oxygen saturation; O_2, oxygen; GCS, Glasgow Coma Scale.

Method

This study had ethical approval from the associated university Human Research and Ethics Committee and the study site Human Research and Ethics Committee.

Design

A descriptive exploratory approach was used to undertake this study and data were collected by surveying ED clinicians.

Setting

The study was conducted in the ED of a major urban hospital in Melbourne, Australia. The ED has 50 treatment spaces and cares for approximately 1500 patients per week [32]. Patient population include both adult and paediatric patients [32]. Common presentations include acute myocardial infarction, respiratory failure and asthma, pain for investigation, industrial accidents and trauma [32]. Previous studies at this ED have shown that there are an average of 76 ED RRT activations per month [31]. The RRT criteria used by the clinicians within the studied ED is shown in Table 1. The hospital's resuscitation policy has content regarding family presence during resuscitation. There is no policy regarding family presence during management of acute deterioration.

Data collection tool

Data were collected using the Emergency Department Family Presence (EDFP) survey [33] and four additional questions. The EDFP tool is a 13-item validated survey for measuring ED clinician attitudes towards family presence during acute deterioration in adult patients [33]. In order to meet the aim of this study, four additional items were added to the EDFP survey:

(i) Family presence during a patient's episode of deterioration occurs within my practice.
(ii) Families are encouraged to be present during a patient's episode of deterioration within my practice.
(iii) If family are not present when a patient deteriorates I make an effort to find the family in order to offer them the option of being present.
(iv) I feel comfortable providing psycho-social-spiritual support to family members during a patient's episode of deterioration.

The EDFP had five factors: Factor One – effects on patient care; Factor Two – effects on the patient; Factor Three – effects on the family; Factor Four – effects on the individual healthcare provider; and Factor Five – personal beliefs of current practices. Cronbach's