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Family presence during resuscitation: A descriptive study with Iranian nurses and patients' family members

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ABSTRACT

Background: Family presence during resuscitation (FPDR) has advantages for the patients' family member to be present at the bedside. However, FPDR is not regularly practiced by nurses, especially in low to middle income countries. The purpose of this study was to determine Iranian nurses' and family members' attitudes towards FPDR.
Method: In a descriptive study, data was collected from the random sample of 178 nurses and 136 family members in four hospitals located in Iran. A 27-item questionnaire was used to collect data on attitudes towards FPDR, and descriptive and correlational analyses were conducted.
Results: Of family members, particularly the women, 57.2% (n = 78) felt it is their right to experience FPDR and that it has many advantages for the family; including the ability to see that everything was done and worry less. However, 62.5% (n = 111) of the nurses disagreed with an adult implementation of FPDR. Nurses perceived FPDR to have many disadvantages. Family members becoming distressed and interfering with the patient which may prolong the resuscitation effort. Nurses with prior education on FPDR were more willing to implement it.
Conclusion: FPDR was desired by the majority of family members. To meet their needs, it is important to improve Iranian nurses' views about the advantages of the implementation of FPDR. Education on FPDR is recommended to improve Iranian nurses' views about the advantages of the implementation of FPDR.
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1. Background

According to work by Florence Nightingale and the Theory of Integral Nursing, nurses are facilitators of healing for patients and families. As such, nurses do not perform the actual healing but instead assist patients and families to determine and access their own healing potentials. This involves listening to and respecting patient and family wishes and this should occur in all healthcare settings across the globe [1]. Traditionally, resuscitation has not been implemented in a family-centered manner and patients and families have been separated [2]. In Iran, this practice of separating the patient and family during resuscitation continues [3,4]. Family presence during resuscitation (FPDR) provides family-centered care by allowing family members to have visual and/or physical contact with the patient during cardiopulmonary resuscitation (CPR) if they choose [5,6]. Research has shown family members support FPDR as an option and that it can benefit the family [7]. As a result, FPDR is supported by multiple professional organizations such as the American heart association, society of critical care medicine, emergency nurses association, European federation of nursing associations, and European resuscitation council [8–12].

1.1. Benefits and concerns related to FPDR

Family members are the primary source of support for their loved ones during vulnerable times such as life-threatening events [13], and they prefer to be present at the bedside with their loved ones during the last days of their life [14]. When a patient is experiencing a health-related crisis, family members have certain needs that must be met. These needs include having honest, consistent, and thorough communication with healthcare providers, being

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physically and emotionally close to the patient, feeling that healthcare providers care about the patient, seeing the patient frequently, and knowing exactly what has been done to the patient [15]. In addition, family members feel guilty when their loved ones die alone and they are not able to say goodbye [16]. These needs underscore the importance of maintaining patient and family connectedness during health-related crises.

FPDR maintains connectedness of the patient and family during life-threatening events that require CPR. It fulfills family member needs for proximity to the patient and allows them to provide support and comfort [6]. FPDR also lets the family see that the healthcare team has taken all efforts possible to save their loved one [6,14,17,18]. Family member understanding about the patient's condition and status is improved through explanations from the accompanying healthcare provider [6,18,21] and this can lead to better healthcare decisions, such as stopping futile CPR [19]. When CPR is not successful, FPDR provides family members the opportunity to say goodbye to their loved one and this can improve the families grieving process [13,18,19]. FPDR has been shown to result in significantly less symptoms of post-traumatic stress disorder, anxiety, depression, and complicated grief for those family members given the option for FPDR [20,21]. Due to these advantages, the majority of family members who have experienced FPDR would choose to experience it again [15].

FPDR as a double-edged sword for the family and resuscitation team is influenced by the cultural context and despite strong evidence about the advantages of FPDR, nurses do not regularly implement it [14,22–25]. Studies have repeatedly shown nurses have negative attitudes towards FPDR, which result from the disadvantages they perceive it to have. Nurses expressed concerns about FPDR include the potential for disruption or interference with patient care, increased stress and performance anxiety for the healthcare team, fear of litigation, resultant trauma for the family, negative impact on CPR performance, and lack of space in the patient care area [14,18,26–31]. Research has not supported these expressed concerns, and resuscitation outcomes are similar whether FPDR is implemented or not [32].

In Iran, the patient's family is traditionally escorted away from the bedside when cardiac arrest occurs, and usually a nurse informs them about the patient condition [4]. In Iran due to the low CPR survival rate of 4.8% and low rate of hospital discharge following CPR of less than 2.6% [33], opportunities for the family to present and say goodbye to their loved one are often lost when they are separated during resuscitation. Studies have shown attitude towards FPDR varies by geographic location. In some Western countries attitudes towards FPDR are more positive, while FPDR is commonly viewed as unacceptable in non-Western countries [2]. In Iran, there is a lack of knowledge about nurses' and family members' attitudes towards FPDR. This study aimed to describe and compare Iranian nurses' and family members' attitudes towards FPDR. An additional aim was to assess for relationships between demographic information and FPDR attitudes.

2. Methods

2.1. Setting and participants

Iranian nurses and the family members of patients who experienced adult CPR within an intensive care unit (ICU), internal medicine, surgical, and emergency wards were sampled from the four Tabriz teaching hospitals using a random cluster sampling method. One family member per family / patient was recruited. None of the hospitals had a formal FPDR policy. The study was explained to nurses and family members, and informed consent was obtained from all participants following approval from the research council and ethics committee of the Tabriz University of Medical Sciences. Participation was voluntary and inclusion criteria for nurses were an academic degree in nursing and the experience of caring for a patient who underwent CPR. Family members of patients who had CPR were also invited to participate and were required to be age 18 years and older. Approaching family occurred within 6 months period post resuscitation event when they were stable. Adjustment after bereavement has been empirically shown to occur through a sequence of stages within approximately 6 months of loss [34]. The family members of deceased patients were contacted by telephone after 6 month from the time of death. An individual interview was requested with explanation of its purpose and made an appointment in hospital where appropriate specialists were informed and their support requested.

2.2. Instrument

A questionnaire to measure the nurses' and family members' attitude towards FPDR was adapted for use in this study which was developed by Tsang (2012) based on the comprehensive review of related literature and studies conducted in Western and non-Western countries [35].

The questionnaire consisted of two parts; items to collect demographic information and 27 items to collect data on participants' attitudes towards FPDR. The 27 items to measure attitudes towards FPDR were divided into four areas; attitudes towards patient and family member rights for FPDR (range of scores: 3–15), potential advantages of FPDR (range of scores: 8–45), potential disadvantages of FPDR (range of scores: 12–60), and opinions about supportive requirements for the implementation of FPDR (range of scores: 4–20). All items to measure attitudes towards FPDR used a 5-point Likert scale and responses ranged from strongly disagree (1) to strongly agree (5) for the first 23 items and from very unimportant (1) to very important (5) for last 4 items. Validity of the questionnaire was confirmed by 10 nursing faculty members of the Tabriz University of Medical Science, and reliability was assessed (Cronbach's alpha) of 0.767 demonstrating a high level of internal consistency. The questionnaire was pilot-tested on randomly-selected nurses (15) and family members (10) and minor modifications (confusing wording) were made based on their feedback about the content, sentence structure and clinical relevance.

2.3. Data collection and analysis

From September 2015 to March 2016, the questionnaire was completed by nurses and patient's family members following an experience with CPR. It was administered by two trained interviewers for six of the family members (4.4%, n = 6) who were illiterate and unable to fill in the questionnaire independently. The interviewers were trained to read the questions during the interview and mark the illiterate family members' response to questionnaire items without providing any input. Data on the demographic information and attitudes towards FPDR were analyzed using descriptive statistics (percentage, mean, and standard deviation). To determine differences in attitude between nurses and family members, inferential statistics were used including independent *t*-tests for parametric variables and the Mann-Whitney test for nonparametric data. Spearman correlation coefficients were used to assess for relationships between demographic data and attitudes towards FPDR.

3. Results

A total of 316 out of 350 distributed questionnaires were completed for a 90.28% response rate. Study participants consisted of

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