

FAMILY PRESENCE DURING RESUSCITATION

by Judy Boehm, RN, MSN



Traditionally, when a patient arrests in a hospital the family is guided away from their loved one into a waiting room while life-saving measures are initiated. As a nurse is able to break away from the resuscitation, she updates the family on the patient's status. But the scene is changing as families exercise their right to be present during resuscitation – in the same way they once did in the delivery room. Allowing family members to be present at the bedside during cardiopulmonary resuscitation (CPR) is a contentious issue in the United States and has stimulated widespread debate. In less than two decades however, the movement to allow family presence (FP) has steadily evolved because of support from professional organizations, attention from the media, and research on the topic.

This article on family presence during resuscitation (FPDR) will focus primarily on adult patients in the hospital setting, including the emergency department (ED). Surveys, research and review articles that will be mentioned originate primarily from the U.S. Much of literature includes FP during invasive procedures (IP), but this article will speak only to resuscitations - and it will not include trauma resuscitations.

Definitions

For the purpose of this article, the following definitions will be used.

Family presence (FP): The presence of family in the patient care area, in a location that affords visual or physical contact with the patient during resuscitation events.¹

Family member: A person older than 18 years who has an established relationship with the patient (includes patient's family, loved ones, and close friends).²

Family support person (FSP): A role assigned to a specific healthcare provider (HCP) who has no direct patient care responsibility during a resuscitation and is specifically assigned to initiate interventions, assist the family, provide emotional and psychosocial support, and be a shoulder to lean upon in FP situations.³

History of Family Presence during Resuscitation

FPDR can be traced back to 1982 at Foote Hospital in Jackson, MI, in which there were two separate incidents when family members *demand*ed to be present.⁴ One person, after riding in the ambulance during resuscitation, refused to leave the patient. Another begged to enter, if only for a few minutes, to be with her husband, a police officer who had been shot. A chaplain stayed with the family members who were allowed in. When these two situations were evaluated, positive feedback came from both families and staff. A survey was then conducted of family members of patients who had recently died in the hospital to determine whether they had felt a need to be present.⁵ Of the 18 surveyed, 13 (72%) responded that they wished they had been present during the resuscitation. A program of FPDR was instituted at Foote, with a follow-up survey in 1985 of 47 family members who had been present during resuscitation reporting that:⁴

- 76% felt that their adjustment to the death was made easier by their presence in the room.
- 64% felt that their presence was beneficial to the dying person.
- 94% believed that they would choose to be present again during CPR if given the opportunity.

During the mid to late 1990's research articles began being published that assessed families' perspectives and the psychological benefits of being present during resuscitation efforts. Concurrently, studies were being published that identified healthcare providers' beliefs about FP. In a bold move the Emergency Nurses Association (ENA) adopted a resolution in 1993 in support of FP during IPs and resuscitation, followed by their first position statement in 1994. An educational program entitled *Presenting the Option for Family Presence* was released in 1995 by the ENA, with its latest revision in 2007.¹

FPDR programs in hospitals are often started by grassroots efforts of nurses, usually in the ED. This practice remains highly controversial among HCPs but is gaining support in many institutions. MacLean reported in 2003 on the state of FP in hospitals, by publishing results of a 30-item survey mailed to 1500 members of the American Association of Critical Care Nurses (AACN) and 1500 members of the ENA.⁶ 984 surveys were returned showing:

- 5% of the respondents worked on units that had a written policy allowing the option of FPDR.
- 45% of the nurses responded that their institution didn't have policies related to FP, but their unit allowed FPDR.
- 29% reported that FPDR was prohibited on their unit but there was no written policy.
- 36% of the respondents had taken a family member to the bedside during a resuscitation a mean of 3 times during the past year.
- 31% said that a patient's family had asked whether they could be present during CPR a mean of 3 times during the past year.

The respondents wrote that "the policy would provide equal access to all we serve" and that it was important to "have a policy in place to think and decide ahead of time how to handle requests."⁶

Framework for Family Presence during Cardiopulmonary Resuscitation

FPDR is a natural outgrowth of family-centered care, which regards the family as the primary source of strength and support. The family-centered approach moves toward care that is driven by the needs of the patient and his family rather than controlled by HCPs. Family needs during medical crises focus on maintaining the relationship with their loved one and being with him or her at the time of death. Hampe identified several family needs at end of life:⁷

- To be kept informed of the patient's condition
- To be aware of the patient's impending death in order to anticipate the loss
- To be with the dying person

In the healthcare environment today, families expect to be involved with their own care and care of family members and to be actively involved in care decisions. FP policies parallel other

trends giving patients and families control over end-of-life care, e.g. advance directives and hospice care.

Position Statements in Support of Family Presence

The ENA's position statement on *Family Presence at the Bedside during Invasive Procedures and Cardiopulmonary Resuscitation* was most recently updated in 2005. It can be found at: <http://www.ena.org/about/position/PDFs/5F118F5052C2479C848012F5BCF87F7C.PDF>.

The AACN followed with a *Practice Alert on Family Presence during CPR and Invasive Procedures*, declaring:

- Family members of all patients undergoing CPR and IPs should be given the option of being present at the bedside.
- All patient care units should have an approved written practice document for presenting the option of FP during CPR and bedside IPs.

It was updated in November, 2004 and can be found at:

[http://www.aacn.org/AACN/practiceAlert.nsf/0/11f60b2d58551570882573e2005a10db/\\$FILE/Family%20Presence%20During%20CPR%2011-2004.pdf](http://www.aacn.org/AACN/practiceAlert.nsf/0/11f60b2d58551570882573e2005a10db/$FILE/Family%20Presence%20During%20CPR%2011-2004.pdf).

The American Heart Association (AHA) first addressed FP in its 2000 *Guidelines*.⁸ In support of the 2005 *International Consensus on Cardiopulmonary Resuscitation and Emergency Cardiovascular Care Science and Treatment Recommendations*,⁹ the AHA states in their 2005 *Guidelines*:¹⁰

“In the absence of data documenting harm and in light of data suggesting that it may be helpful, offering select family members the opportunity to be present during a resuscitation seems reasonable and desirable (assuming that the patient, if an adult, has not raised a prior objection).”

Others who have developed position statements on FP include:

- European Federation of Critical Care Nursing Associations, European Society of Paediatric and Neonatal Intensive Care, and European Society of Cardiology Council on Cardiovascular Nursing and Allied Professions¹¹
- National Association of Social Workers³
- American College of Critical Care Medicine¹²
- American College of Emergency Physicians (FP related to care of children)¹³
- American Academy of Pediatrics (the option of family-member presence for “all aspects of ED care”)¹⁴

In 2003 representatives from 18 national organizations were convened for a conference to develop consensus recommendations regarding FP during pediatric procedures and CPR.² Their eight recommendations have been endorsed by the Ambulatory Pediatrics Association and by the American Academy of Pediatrics; see the reference for specifics.

Public Opinion of Family Presence during Resuscitation

Public opinion polls conducted by NBC Dateline in 1999 and USA Today in 2000 have shown a strong majority (approximately 70%) sentiment in favor of staying with a loved one.¹⁵ In a later telephone survey by Mazer in 2006, 408 persons responded with the following results that show the public being more divided:¹⁶

- 49.3% “strongly agree” or “agree” that s/he would want to be present in the room with a loved one during CPR.
- 46.8% “strongly agree” or “agree” that a family member or friends have the right to be in the room while a loved one is undergoing CPR.
- Respondents who desire CPR themselves were generally more likely to have positive feelings about witnessed resuscitation.

Perspectives of Family toward Family Presence during Resuscitation

In 1998 Meyers at Parkland Hospital in Dallas, TX, conducted a retrospective telephone survey of family members of patients who died in the emergency department (ED) in the previous year.¹⁷ 95% of the patient deaths were caused by traumatic injury, and all occurred within an average of one hour after admission. Of the 25 family members, 80% said that had they been given the opportunity to be in the room during CPR, it would have been helpful to them and the patient.

If a person has lived with a family member through birth and significant life events, why should they be removed at the end of life?

The reality of the resuscitation room is far less horrifying than the fantasy of it.¹⁸

Two years later, after Parkland Hospital had implemented the ENA FP guidelines, Meyers interviewed 39 family members who were present for 14 cases of resuscitation and 25 cases of IPs.¹⁹ 95% of the families indicated that the experience of being present helped them realize the seriousness of their loved one’s condition and the

treatment provided. In addition, 95% of the family members felt they helped the patient with their presence. 97% of family members who had participated in FPDR stated that they would do so again.

Multiple studies have found perceived benefits of FP from the family’s perspective. These are described in Table 1.^{19, 20, 21, 22, 23}

**Table 1 Perceived Benefits of Family Presence During Resuscitation
from the Perspective of the Family Member**

- Helps the family realize the seriousness of the patient's condition.
- Fosters appreciation for the efforts of the CPR team to ensure that "everything possible" was done to save the patient.
- Helps the family realize the seriousness of the patient's condition.
- Dispels wondering and dread of the unknown if they were not present at the bedside.
- Enhances feeling of usefulness by offering pertinent information to the CPR team and actively supporting the patient (e.g. through prayer, touch, speaking).
- Gives opportunity for the patient's values to be expressed to the staff.
- Facilitates the need to physically be with their loved one.
- Provides comfort to their loved one and let's the patient know his/her family is present.
- Strengthens a patient's will to live.
- Sustains patient-family connectedness and bonding.
- Promotes a strong spiritual connection between patients and their loved ones during resuscitation.
- Reduces guilt about leaving the patient in crisis.
- Allows closure on a life shared together, facilitating the grief process; offers the chance to say goodbye.
- Allows the family to touch their loved one while s/he is still warm (warm is alive to the general public).

Concern has been expressed that family members may experience negative emotional and psychological consequences as a result of FP. Osuagwu argues that "witnessing resuscitation is non-therapeutic and traumatic enough to haunt surviving family members for the rest of their lives."²⁴ Robinson evaluated the psychological effects of witnessing resuscitation of a loved one in a randomized study where 13 family members in the intervention group were offered FPDR and 12 family members in the control group were not.²⁵ In 22 cases of death, 18 family members were interviewed and completed five psychological tests at 1 and 6 months after resuscitation. Findings were reported as:

- Those who remained in the resuscitation room with a support person were no more distressed than those who did not witness resuscitation.
- None of those who witnessed resuscitation reported being frightened by the process or needing to leave the room.
- Most thought that their grief was eased by sharing last moments with their loved one.
- All were content with their decision to be present.
- Scores on the psychological tests indicated lower levels of intrusive imagery and post traumatic avoidance behavior for those in the FP group.
- Scores on the psychological tests indicated lower grief scores for those in the FP group.

The authors concluded that there was little evidence to support excluding family members who wished to be present during the resuscitation. Providing the families the choice to be present (with a staff member accompanying them) and supporting their decision in an unbiased manner was recommended by the authors. This study was designed to continue for 18 months, but it was discontinued early when the research team became convinced of the benefits of FP.

An emergency physician in Vancouver stated: "To watch a team of strangers frantically shove tubes down the throat of a relative, pierce each arm with large-gauge needles or, in extreme situations, crack open the chest, would not only be traumatic to observe but could also leave the relative with a horrifying final memory."²⁶

Perspectives of Healthcare Providers toward Family Presence During Resuscitation

HCPs' opinions regarding FPDR vary according to one's profession, specialty and level of experience. Several surveys have indicated that between 86% and 96% of nurses endorse FPDR, compared with 50% to 79% of physicians.²⁷ A survey by Meyers found that less experienced physicians exhibited lower enthusiasm, with only 19% of residents supporting FPDR.¹⁹ McClenathan surveyed 554 health professionals (all had at least attended one resuscitation) at an international meeting of the American College of Chest Physicians in 2000 and reported that only 43% of surveyed nurses (n=28) and 20% of physicians (n=394) favored FPDR in adult patients.²⁸ Their group encouraged rigorous scientific study of FPDR before its widespread implementation.

Differences between physicians and nurses on this issue remain when evaluating the responses of those who have actually witnessed FPDR. McClenathan reported that of those physicians who had participated in FP only 39% would endorse FPDR again, compared with 53% of nurses.²⁸ However, findings from additional studies suggest that staff attitudes toward FPDR can evolve positively over time. MacLean found that nurses who had experience escorting families to the bedside were significantly more likely to support policies allowing family presence than nurses who had not.⁶ In a survey of 41 CPR team members at a rural community hospital, most physicians who were initially resistant had become strong proponents of FPDR.²⁹

Twibell recently reported on a study at Ball Memorial Hospital in Indiana, an institution without a policy on FPDR, yet some units did practice FP while others did not.³⁰ They developed two instruments, the Family Presence Self-confidence Scale and the Family Presence Risk-Benefit Scale. It was found that nurses who invited FPDR were significantly more self confident in managing it and perceived more benefits and fewer risks ($P<0.001$). Perceptions of more benefits and fewer risks were associated with membership in professional organizations, professional certification, and working in an ED compared to those working in critical care units and general units ($P<0.001$).

Perceived problems with FPDR from the perspective of the HCP are outlined in Table 2.^{19, 23, 31, 32}

**Table 2 Perceived Problems with Family Presence During Resuscitation
from the Perspective of the Healthcare Provider**

- Fear that staff might be distracted from providing needed patient care by distraught family members.
- Concern that staff members would experience more emotional stress that would inhibit their performance.
- Fear that the CPR team will have difficulty controlling their own emotional response with the family present.
- Fear that family members who witness errors or misunderstand what they see or hear may be more likely to sue, especially if the patient dies.
- Concern that codes might be prolonged in futile situations because of the requests of the family.
- Anxiety about the loss of control of the environment and the possibility of disruptive behavior by the patient's family members.
- Anxiety that an overwrought family member might hurt himself. If the family member faints, resources could be diverted away from resuscitating the patient. There could also be accidental exposure to blood and body fluids.
- There is not enough space in the room to accommodate the family.
- There are not enough staff to provide a designated family support person at the bedside.
- Concern that the patient's confidentiality and right to privacy are compromised.
- Limitations may be imposed in training of residents.

Most of these fears and concerns have not been borne out in the literature. Hanson reported from discussions with nurses at Foote Hospital that families were rarely disruptive.⁴ They seemed awed by the activity in the room, and frequently had to be led to the bedside and encouraged to touch and speak to their loved one. Nurses did find that FP made it more difficult to remain distant and unemotional during the code. Identification with family members brought emotions closer to the surface, at times making the incident more difficult to deal with later. But clinical tasks remained a priority and staff members found that they remained able to function professionally. In their nine years of experience, not one instance of actual interference with resuscitation activities had occurred. In a few instances family members were overcome with grief and felt faint or hysterical. The support person was able to escort them quietly from the room until they could compose themselves.

For three months after implementation of a FP protocol in the ED at Children's Medical Center of Dallas, Mangurten reports that a "Family Presence Policy Evaluation Form" was completed by the family facilitator in 54 cases.³³ She writes: "None of the families present during IPs and resuscitations was disruptive, and none had to be escorted out of the room; two family members left on their own accord. In 100% of the family presence cases, patient care was not interrupted."

Staff stress does occur during resuscitation efforts. In one of the few research-based studies on FP, Boyd showed that 22% of emergency staff study participants (25 of 114 questionnaires) showed two or more symptoms that could be classified as an acute stress reaction 24 hours after a non traumatic code.³⁴ However, the staff symptoms did not differ between the resuscitations with and without FP.

The American Academy of Pediatrics states that the “risk management literature indicates that patients and families are significantly less likely to initiate lawsuits, even when mistakes are made, if there is open and effective communication and trusting relationships between the practitioner and the patient and family.”³⁵ Strengthening the bond between staff and family through FPDR actually decreases the likelihood of legal action.

Occasionally, family members at the bedside have lead physicians to prolong a code, with Meyers citing that 15% of providers prolonged CPR attempts because of family presence.¹⁹ Some see a benefit of FPDR is that the violence of a code can serve as a “wake-up call” to families who continue to insist on doing everything possible in a futile resuscitation. More often, families have asked to stop a code, sometimes prematurely.

Healthcare providers perceive several benefits of FPDR. They are listed in Table 3.^{19, 23}

Table 3 Perceived Benefits of Family Presence During Resuscitation from the Perspective of the Healthcare Provider

- Reminds staff that patient is a person and a member of a family.
- Helps staff provide more holistic care to the patient during the crisis situation.
- Encourages more professional behavior among staff during the resuscitation.
- Allows a patient’s family members to recognize the staff’s efforts to save the patient.
- Reaffirms the role of the HCP as an advocate for patients.
- Focuses staff’s attention on the patient’s privacy and dignity.
- Affords the HCP a chance to educate the family on the condition of the patient.
- Modifies staff conversations at the bedside and promotes a more careful choice of words with less black humor.

The Patient’s Viewpoint toward Family Presence During Resuscitation

There is very little literature available on the patient’s viewpoint about the effect of FP on them. In 1997-1998 Eichhorn conducted a qualitative research study at Parkland Hospital to examine this variable.³⁶ Forty-three patients had a family member present during an invasive procedure or CPR. Nine patients, 8 who had undergone an IP and one who had CPR, were surveyed approximately two months after the event. Seven themes emerged from the subjective reports. Patients felt:

- Comforted (i.e. loved, supported, and less alone).
- That they received help by families acting as advocates for them, relaying their needs to the health care team.
- Their family’s presence reminded caregivers of their “personhood”.

- That family presence enhanced the patient-family connection.
- Families had a right to be present.
- That the experience had a beneficial effect as well as taking a toll on family members.
- That family presence can affect the health care environment.

Belanger writes about a situation at Wooster Community Hospital in Ohio involving a 60-year-old man who arrived with symptoms of a massive myocardial infarction and had a cardiac arrest in the ED:²⁹

"The wife was present during the defibrillation. After several shocks, he regained consciousness long enough to speak with his wife momentarily until he again went into ventricular fibrillation. The code continued with his wife at his bedside whispering words of encouragement. Within minutes, he again regained consciousness. Anticoagulation was initiated and he was transferred to the critical care unit. A few days later he was interviewed by an emergency nurse and stated he was very much aware of his wife's presence, which was enough of an encouragement for him to continue his fight for survival."

In Robinson's study of relatives who were present during resuscitation, it is also reported that all three patients who survived were content that a relative had remained with them during resuscitation and felt supported by their presence.²⁵ None of the patients believed their confidentiality or dignity had been compromised.

In the largest study to date, Benjamin interviewed 200 ED patients and after describing the nature of a resuscitation, found that 72% would want family members present if a cardiac arrest were to occur.³⁷ However, 56% of these positive responders only wanted certain family members there. Traditionally, a patient's permission is required before medical information is disclosed to outside parties. Benjamin writes: "Are we breaching patient confidentiality, and are we in conflict with the relatively new Health Insurance Portability and Accountability Act? The answers to some of these questions involve unique personal values and ethics and do not offer themselves easily to future research." It would be ideal if patients could have the ability to determine if they desire FP, and who should be present. Osuagwu asks if FPDR could be considered for inclusion in the advance directives document.³⁸

Strategies for Developing a Family Presence during Resuscitation Program

The ENA has outlined a process for establishing FPDR in an institution, so why not use it as the basis for developing your own rather than "reinventing the wheel"? The ENA manual is titled *Presenting the Option for Family Presence*, and was updated in 2001.¹ They suggest that the plan for developing a process for FPDR should include the following:

- Identify the champions.
- Establish a task force or project team.
- Assess the institution and departments.
- Develop an implementation plan to support the process of FPDR.
- Evaluate the success of the FPDR plan with HCPs, families, and patients.

It is important to identify the project champions from the outset and seek out champions from a variety of disciplines and within the organization's management structure. Champions should take advantage of opportunities to discuss the topic with their colleagues, increase awareness, role model family support interventions, and gain support for providing the option for FP.

The project team should include members from the roles of nurses, physicians, respiratory care practitioners, pre hospital care providers, social service workers, pastoral care staff, risk management personnel, and security agents. Support from upper management is essential, especially if financial resources are needed or opposition is anticipated from HCPs. Family member and patient representation on the team may present some logistical challenges but should be incorporated. From the outset there should be a clear delineation of reporting procedures, responsibilities, and authority of the project team.

The ENA suggests that an assessment be performed of the following factors which could impact the development and implementation of a process to support FPDR:

- Organizational structure and authority
- Mission and vision of the organization
- Human and fiscal resources
- Risk management concerns
- Staff beliefs and attitudes
- Current practices
- Physical plant limitations
- Family follow-up services
- Staff follow-up services

In the ENA manual you will find questions to pose under each of the factors. A helpful Staff Assessment Tool can be found in the appendices.

A clear philosophy statement related to FP and family-centered care provides a conduit for the development of the guidelines for FP. The guidelines should reflect the basic elements of providing the option, family support resources, and roles and responsibilities of the HCPs. A sample guideline can be found within the ENA's appendices. Why is a formal FPDR policy/guideline needed for the institution or department? Foremost, it solidifies the institution's commitment to FP. Cathie Guzzetta, who has been in the forefront of this movement to accept FP during IPs and resuscitation states:³⁹

"Policies affirm that a structured plan is in place to legally protect staff before crises occur, and they confer equal consideration for all patients and their families. Formal policies specify who does what, what should and should not be done, and under what circumstances to achieve uninterrupted patient care. Moreover, policies support educational programs for staff and a plan for ongoing research, evaluation, and quality improvement of the practice."

The ENA manual outlines clearly the roles of the persons trained to be family support persons (FSPs). The American College of Critical Care Medicine recommends that the FSP be a recognized member of the CPR team.¹² It is expected that the FSP remain with the family at all times while in the resuscitation room. In the European Joint Position Statement, it is written that "Whilst it is conceded that on some occasions it may not be possible to provide a health care professional whose sole responsibility is to care for the family member, this should not mean the exclusion of the family member from the resuscitation. Rather, an experienced member of the resuscitation team, who is not undertaking a lead role, should be designated primary responsibility for the continued care of the family member."¹¹

Even though FP is offered at the time of cardiac arrest, not all family will desire to be present at the bedside. A social service worker or chaplain can provide support to the family in the waiting room, keeping them updated about the status of the patient during the resuscitation. FPDR guidelines should outline criteria that would be used to exclude family members from the bedside. Individuals who should not be asked if they desire FP at the bedside are those who:⁴⁰

- Have an altered mental status, and/or are under the influence of drugs or alcohol
- Are suspected of being involved in abuse of the patient
- Are the suspected perpetrator of a violent crime
- Are physically aggressive, combative
- Are behaving in a threatening, argumentative manner
- Are extremely unstable emotionally, hysterical, loud and cannot be redirected or calmed

At the National Teaching Institute of the AACN on May 7, 2008, Cathie Guzzetta, Angela Clark, and Margo Halm gave a presentation on *2008 Updates from ENA and AACN on Family Presence during CPR*. I'd like to pass on some of their practical hints for success of a program on FPDR in Table 4.

Table 4 Practical Hints for Success of a Hospital Program on Family Presence during Resuscitation

- An institution should decide how to proceed if the FSP assessing the family member(s) for being present at the patient's bedside identifies serious disagreements among family members.
- Remove non-essential equipment and personnel from the resuscitation room in order to make space for family members.
- Think about infection control practices. Should the family members be asked to don gloves, gown and eye protection in order to prevent exposure to blood and body fluids?
- Plan for the use of interpreters to partner with the FSP when language will be a problem when supporting family members.
- After the resuscitation is concluded, facilitate the family's viewing of the body, offering them time alone. Help them with funeral arrangements and make sure to give them patient valuables.
- Plan for a bereavement follow-up process for families that involves periodic contact with them. Perhaps a chaplain could call the family in one month. Give the family the opportunity to ask questions of the medical staff at a later time.
- Plan for a staff critical incident stress management program with defusing during the first 12 hours and a debriefing session for those involved in the resuscitation in 24 to 72 hours.

Education can be an effective tool in changing nurse and other staff attitudes toward FPDR. Bassler used a quasi experimental design and showed that 25 of 46 (56%) of critical care and ED nurses at a large urban teaching hospital were in favor of FP before an education intervention, compared to 40 of 46 (89%) afterwards.⁴¹ The percentage of nurses who planned to offer FP increased from 11% to 79% with the education. Consider making attendance at the education mandatory for all staff who would be involved in FPDR. Consensus-building strategies should be incorporated into the implementation plan, realizing that there will be objections from physicians.

Included in the ENA manual is a staff education needs assessment and a slide program with accompanying dialogue. Mian writes about an innovative education program at Massachusetts Memorial Hospital that was designed by a psychiatric clinical nurse specialist and an attending physician for their ED.⁴² The one hour education session included descriptions of current research findings to support evidence-based practice. Then a video highlighting a family describing their personal experience as well as differing opinions from HCPs was shown to stimulate discussion. Findings from their initial staff survey also helped guide discussions related to their concerns, fears, and other issues. Next their FP guidelines were presented. A family script was included to guide staff in offering the FP option to families and to help them structure their visits; topics such as time frames and appropriate behavior were included. Posters were designed as newspaper headlines and included either the results of their initial survey or research about FP. Ethics conferences in the unit also included cases involving FP. FP became part of nurses' orientation to the unit, and new residents received training in FP.

As part of the evaluation process, keep track of the frequency with which FPDR occurs. Space could be provided on the paper CPR form for this information, and any problems could be mentioned in the quality record for the code. Could this tracking of FP be included in the data collected by the National Registry of CPR so that we can get a wider view of this practice and obtain information related to defined benefits and problems?

Conclusion

Systematic reviews of the literature related to FP with adult patients can be found in the following references:

- Boudreaux, E.D., Francis, J.L., & Loyacano, T. Family presence during invasive procedures and resuscitations in the emergency department: A critical review and suggestions for future research. *Annals of Emergency Medicine* 2002;40:193-205.
- Halm, M.A. Family presence during resuscitation: a critical review of the literature. *American Journal of Critical Care* 2005;14:494-512.
- Critchell, C.D., & Marik, P.E. Should family members be present during cardiopulmonary resuscitation? A review of the literature. *American Journal of Palliative Care* 2007;24:311-317.
- Walker, W. Accident and emergency staff opinion on the effects of family presence during adult resuscitation: critical literature review. *Journal of Advanced Nursing* 2008;61:348-362.

Most of the studies found in a review of the literature on FP are survey or observational in nature. Sample sizes are small, demographics of the sample are often not provided, and there are methodological flaws that make interpretation difficult and prevent comparison of results. Few authors addressed survey development, content validity and pilot testing of their instruments.

Research of an experimental design is needed to study the short- and long-term effects of FP on HCPs, families and patients in both general acute care and intensive care settings. We need to identify best practices, legal issues, and helpful educational approaches, in addition to assessing additional costs that FP incurs. Halm has excellent detailed recommendations for future studies.

In conclusion, we know that 49-97% of family members surveyed desire to be present during resuscitation of a loved one. HCPs are still quite uncertain about the helpfulness of FPDR. No research has shown that FP is harmful, and evidence is growing that FP is beneficial. Resources are available to assist with developing a FPDR program from the ENA, and hospitals that already have a program in existence can help to discuss education approaches and how to deal with resistance from HCPs.

I would like to end with words in an article by Carolyn Rosenczweig, a third-year medical student at the University of British Columbia:²⁶

"Relatives must not be viewed as an added complication but as a direct extension and reflection of the patient's life. The need to say good-bye before it is too late should be regarded as an innate response to the death of a family member.

Resuscitation teams seem to take for granted that they are often the last people to be in the presence of a dying person. Being present during these final moments is a privilege, not a side effect of an arrest protocol. Sharing this privilege may be the greatest comfort the medical profession can offer a grieving relative."

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