Family Presence During Pediatric Resuscitation: A Focus on Staff

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The 8-year-old girl who was recovering from a near drowning 3 days earlier had had a relatively stable day. It was 2 AM. Suddenly, her oxygenation and hemodynamic stability deteriorated. Within seconds, her bedside was surrounded by members of the healthcare team participating in her resuscitation.

When the attending physician arrived 15 minutes into the resuscitative efforts, she immediately requested that the girl's parents be brought to the bedside to participate in the event by observing the team's efforts. Some staff members grumbled under their breath. Others, on the basis of previous experiences when this attending physician brought a patient's family to the bedside, commented in defense of the potential benefit to the girl's family. The child's parents arrived and stood unaccompanied at the door of the room. After almost an hour of aggressive interventions, there were no signs of improvement. The parents pleaded for the team to terminate efforts to save their little girl. The resuscitation attempt ended. The family began stroking the child's cold body. The staff walked away, unsettled by the family's presence during the resuscitation.

Fear is an emotion that is encountered at some time by every human being. It penetrates to the deepest part of human existence. Fear has been inextricably woven into the controversial issues associated with family presence during resuscitation attempts. Fear of what the family may encounter collides with the fear and insecurity of healthcare providers about the efficacy of including patients' family members in the resuscitation. As indicated in the opening example, these concerns often produce confusion and inconsistency among staff members in their approach to including patients' families during resuscitation efforts. This article summarizes the findings of current research on staff members' perceptions of including patients' families during resuscitation efforts and suggests implications for practice unique to pediatrics.

Recent information in both professional and consumer literature has stimulated discussion about the controversial topic of including a patient's family members during resuscitation.
attempts. “Family presence” is a buzz word in many institutions. What does this term mean? The protocol developed by researchers at Parkland Memorial Hospital in Dallas, Tex, defines family presence as “the attendance of the family member(s) in a location that afforded visual or physical contact with the patient during invasive procedures or CPR."

BACKGROUND

One of the first formalized attempts to develop an initiative to incorporate the presence of patients’ family members during resuscitation efforts was in 1982 at Foote Hospital in Jackson, Mich. Personnel at Foote Hospital were prompted to examine their policy of excluding patients’ family members during cardiopulmonary resuscitation when family members demanded to be present on 2 separate occasions. After these demands, surveys were sent out to families of recently deceased patients to determine the families’ desire to be present during resuscitation efforts if they had been given the opportunity.

Staff members at Foote Hospital initially resisted the implementation of a formal initiative for family presence. However, in 1985, after completing the initial program, 21 staff members (71%) indicated their support of the practice despite some additional stress experienced.

Since the initiative at Foote Hospital, other institutions have studied and implemented formal protocols. In 1994, the Emergency Nurses Association developed an educational booklet to facilitate implementation of family presence programs. In 1995, the association produced an official statement of the national guidelines for family presence during invasive procedures and cardiopulmonary resuscitation. The association revised and updated the position statement on family presence in July 2001, with continued support of the option for families to be present during resuscitation and invasive procedures. Finally, the 2002 update of the Pediatric Advanced Life Support manual supports the option of family presence during resuscitation as one of the evidence-based changes in the revised guidelines. The evolution of these events suggests the importance and relevance of these issues to any healthcare professional who may participate in a resuscitation effort.

A PEDIATRIC PERSPECTIVE

The focus of most research has been the implications for family members present during resuscitation of adults. As indicated, the goals of this article are a more specific focus on implications for healthcare staff and identification of issues unique to children. Healthcare professionals must clearly recognize that the emotionally charged issues of fear, grief, and tragedy associated with family presence universally exist across all age groups of patients.

Although many adult patients have parents and other family members who are actively involved in the patients’ care, children’s vulnerability and inability to care for themselves are unique. Anyone who provides care for children quickly realizes that most children come as a package, an extension of their parents or caregivers.

In a recent study, parents were surveyed about their desire to be present during invasive procedures performed on their children in the emergency department. A total of 400 parents who were in the emergency department for nonemergent treatment completed the survey. Five scenarios of various degrees of invasiveness, with a major resuscitation as the ultimate invasive procedure, were presented. The results indicated that parents desire to be with their children during a resuscitation; 83.4% of the respondents wished to be present if their child were likely to die. Interestingly, parents were adamant about not wanting physicians to decide if the parents stayed during a resuscitation or not. Only 6.5% indicated a willingness for the physician to make the decision. The findings of this large survey should prompt pediatric healthcare providers to recognize the significance of parental desires and to incorporate those desires in practice.

Perceptions of pediatric physicians are also changing, with a heightened awareness and acceptance of family presence. In a poll reported in 1997 of 27 physicians in the United Kingdom who were involved in resuscitations of children witnessed by the children’s parents, only 3 physicians viewed the experience as negative. The negative aspects included the lack of a support person for the family in 2 cases and the perception that the resuscitation had been prolonged unnecessarily in 1 case.

A review of the recent literature revealed 3 studies, 2 done in the United Kingdom, with specific implications for pediatric healthcare personnel. In a study reported in 1994, Back and Rooke developed a questionnaire to...
examine the perceptions of medical and nursing staff in 2 accident and emergency departments. Of the 13 staff members who responded, 7 had positive feelings about the presence of patients’ family members. The respondents who did not exclusively care for children had increased acceptance of including patients’ relatives in the resuscitation of children. Generalization of the findings of this study is difficult because of the small sample size.

In a study in the United States reported in 2000, Sacchetti et al evaluated how previous experience with family presence during resuscitation affected the acceptance of emergency department personnel of having patients’ family members present during resuscitation. Personnel at 3 different emergency departments were surveyed; the patients in all 3 included a significant number of children. The institutions had various levels of experience with family presence.

Sacchetti et al acknowledged that many medical personnel are not enthusiastic about incorporating family presence. These authors also identified the notion that nurses more than physicians favor family presence. The responses to the surveys indicated that experience with family presence, not length of practice experience, correlated with positive feelings about family presence. Sacchetti et al proposed that tangible exposure to the practice of family presence, such as providing personnel with observation experiences and role playing, may need to accompany formal educational preparation.

In the third study, reported in 1998, Jarvis examined the attitudes toward family presence of 60 staff members, physicians, and nurses in a pediatric intensive care unit in the United Kingdom. Subjects were given a quantitative and qualitative survey that included a comments section at the end. Although 89% of the 56 respondents who completed the survey thought that parents should be given the choice to be present during resuscitation of the parents’ child, many concerns were illuminated in the comments section. Staff concerns included fear of increased stress of personnel involved and uncertainty of the helpfulness of parental presence to the parents’ grieving process. However, of the 44 surveyed who had previous experience with family presence, 79% thought that being present during resuscitation efforts was a beneficial experience in the parents’ grieving process.

Common themes described in other reports, such as the need for a support person, the need for clear family guidelines, and the need for formal education of personnel, were consistently identified in the Jarvis study. Despite the concerns of the staff, Jarvis concluded that “the advantages of allowing parents to be present during their child’s resuscitation appear to outweigh any potential disadvantages.” As in previous studies, the small sample size limits the generalizability of the findings. However, the analysis of both quantitative and qualitative aspects of staff perceptions is beneficial.

**ADVANTAGES AND DISADVANTAGES**

Similar themes of staff members’ perceptions of the advantages and disadvantages of family presence recur throughout the literature. Staff members often focus on the potential disadvantages, many of which are not substantiated by research. Personnel state a fear that they will be interrupted by the family members during the resuscitation. Investigators at Foote Hospital, the birthplace of formal family presence, reported that during their 9 years of implementation, a family’s presence never interrupted a resuscitation.

Table 1 summarizes the proposed advantages and disadvantages of having patients’ family members present during resuscitation efforts. The validity of these proposed advantages and disadvantages is in question. An attempt to acknowledge an important concept about the fears expressed by hospital staff was included by the investigators at Parkland Hospital in Dallas in a review of the implementation of a formal protocol:

Studies show that providers initially opposing family presence have striking shifts in opinion when their experiences with family presence do not confirm their concerns and the benefits to families become apparent.

Critical care staff need to evaluate the depth and reality of their fears about family presence and be willing to examine the value of the fears.

The validity of both positive and negative perceptions of staff members involved in resuscitations of adult patients was examined in 3 studies (Table 2). In each study, investigators determined, analyzed, and dispelled similar concerns of staff about the staff’s perception of family presence.
Increased stress of staff members is often cited as a reason not to support family presence. In the study in which perceived stress in staff was examined by determining the symptoms of acute stress reaction the staff experienced, Boyd and White\textsuperscript{11} found no significant difference in the prevalence of stress among staff when patients’ family members were present during resuscitation. Use of the score of the symptoms of acute stress reaction provided objective, quantitative analysis. Limitations of the study for application in children include the small sample size, lack of a validated survey tool, and use of subjects who participated in cardiopulmonary resuscitation of adult patients.

In a study published in 1996, Redley and Hood\textsuperscript{12} found similar themes of staff concern, including increased stress, disruption, offending families, and fear of litigation. Concerns exist about increased stress for both staff and family members who are present during resuscitation efforts. Staff are specifically concerned about the possibility that patients’ families might disrupt the team’s efforts and about how they might offend the families when both the staff and family members are functioning in a crisis mode. As mentioned in Table 1, litigation by patients’ family members is often a concern of staff, but legal action by families present during resuscitation is rare. Despite these fears, 62% of staff members surveyed expressed a willingness for family presence.\textsuperscript{12}

Important implications from this study\textsuperscript{12} include the recognition that staff must be supportive and enthusiastic and must believe in the implementation of family presence. Structural guidelines were identified as a method to assist in alleviating staff members’ concerns. Again, this study was qualitative, the sample size was small, and the patients were adults, but the notion that the benefit outweighs the risk is similar to that of other investigations.

The follow-up research\textsuperscript{2} after implementation of a family presence protocol at Parkland Hospital also dispelled some of the concerns of staff members. Fear of disruption is often cited as a reason not to include patients’ families during resuscitation. Although 38% of the staff members surveyed expressed concern about disruption, disruption never occurred, and 97% of staff thought that patients’ families behaved appropriately.\textsuperscript{2} Another concern of staff is a fear of change in performance during resuscitation. A total of 84% of staff members thought their performance was the same despite the presence of patients’ families, and 97% thought that patients’ outcomes were unaffected.\textsuperscript{2} Related to performance is the notion that more aggressive treatment might be offered if patients’ family members are present. Only 15% of those surveyed estimated that more aggressive treatment was given.\textsuperscript{2} Consistent with these findings was the plea from family members, as described in the introductory example, to stop, rather than prolong, resuscitative efforts.

Meyers et al\textsuperscript{2} concluded after implementing the formal protocol and conducting this follow-up research that the greatest barrier to staff members’ acceptance of the implementation of family presence protocols is the need for formal education. Formal education should be provided for all who are involved in any aspect of

<table>
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<tr>
<th>Table 1 Proposed advantages and disadvantages of family presence during resuscitation\textsuperscript{1,3,10-14}</th>
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<tr>
<td><strong>Advantages</strong></td>
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<tr>
<td>Bonding between patients, patients’ family members, and caregivers is facilitated</td>
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<td>Family members can observe the efforts of the healthcare team</td>
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<tr>
<td>Family members can provide comfort to their loved one, speak words of encouragement</td>
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<td>Family’s freedom to obtain closure, accept outcome is facilitated</td>
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<td>Families perceive that they are actively participating in the resuscitation</td>
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<td>Family members can touch the patient while the patient is still warm</td>
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<td>Staff may view patient as part of a loving family</td>
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<td>The mystery of activities behind closed doors of resuscitation room is reduced</td>
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<td>Being present during the resuscitation, rather than hearing only a verbal accounting, may dispel family members’ doubts about the course of events</td>
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<tr>
<td>Holistic approach with acknowledgment of family as part of the patient is fostered</td>
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resuscitation efforts. Staff should know what might be encountered and how to be prepared for families to participate.

**IMPLICATIONS FOR PEDIATRIC CRITICAL CARE STAFF**

As indicated earlier, the fear and feelings that occur at a time of crisis cross all age groups. Implications from research on any age group can be applied to other groups, yet care of children has unique characteristics. Care of children should always strive to be family centered, with a focus on including and empowering the child’s family as an integral part of the child’s existence. Times of extreme crisis, such as resuscitation of a child, are no exception to the need for family-centered care. Incorporating the child’s family presents an opportunity to embrace a holistic approach to the child by promoting and maintaining the integrity of the family unit.

Healthcare professionals who provide critical care to children should not only strive to facilitate family-centered care but also recognize that research has validated parental desires to be with the parents’ children during times of crisis. To effectively fulfill these desires, staff must prepare both themselves and the families they will encounter.

Several investigators found that education of staff is crucial to the efficacy of any family presence protocol. Bassler specifically evaluated the impact of an educational intervention on the beliefs of 46 critical care and emergency department nurses about family presence. Issues addressed in the educational session included barriers to allowing families in, legal and risk management issues, timing, family support, and logistics of allowing families into the resuscitation room. Before the educational session, 55.6% of staff thought that patients’ families should be given the choice to be present. After the session, 88.9% indicated a need to facilitate a choice for patients’ families.

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<tr>
<th>Study</th>
<th>Purpose</th>
<th>Sample/methods</th>
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<tr>
<td>Boyd and White, 2000</td>
<td>Determine if family presence alters perceived stress of personnel by using symptoms of acute stress reaction</td>
<td>Survey of emergency department staff within 24 hours of participation in nontraumatic cardiopulmonary resuscitation of an adult</td>
<td>25 respondents indicated &gt;2 symptoms of acute stress reaction (13 with family present, 12 without family present)</td>
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<td>Redley and Hood, 1996</td>
<td>Determine if staff were willing to have patients’ family members present</td>
<td>N = 160 (response rate, 83%) Self-administered questionnaire to emergency department staff in 6 major metropolitan hospitals</td>
<td>No significant difference in prevalence of stress with or without family present as measured by acute stress response symptoms</td>
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<tr>
<td>Meyers et al, 2000</td>
<td>Examine attitudes, benefits, concerns of patients’ families and healthcare staff</td>
<td>N = 135 (39 families, 96 staff) Family presence attitude scale used, adapted for families and staff</td>
<td>Willingness to have families present = 62% (14% thought families should always be invited)</td>
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Thematic concerns of staff in order of importance: (1) offend family, (2) increase stress, (3) disruption by family, (4) fear of litigation

Overall, families thought participation was helpful.

88% of staff supported continuation of family presence protocol

Thematic concerns summarized by AACN on September 26, 2017
staff members’ own stress. Future research should evaluate not only the effects of educational interventions but also what content is most beneficial to prepare nursing staff for involvement with patients’ families during resuscitation efforts.

Although not the focus of this article, successful implementation of a family presence protocol is multifaceted. Staff in institutions that treat children need to systematically investigate key components of implementation. A key component of successful implementation is having a trained individual available to provide support for family members who wish to be present during the resuscitation efforts. The lack of a support person in the introductory example contributed to the unsettled, frustrated feelings of those involved. A variety of personnel, such as a volunteer, chaplain, social worker, or nurse, can act as a support person. Caring for the patient’s family should be the support person’s sole focus. Having a staff member function in dual roles, as a member of the resuscitation team and as support person for the patient’s family, is difficult. Shaner and Eckle provide excellent recommendations about crucial components of implementation, including a commitment on the part of leadership in the institution to promote the protocol, as well as formal guidelines and staff education. Parkland Health and Hospital System in Dallas created a family presence procedure, available online, that provides helpful guidelines for consultation when implementation of family presence protocol is being considered.

The plea from the parents is clear. The fears of the staff are being dispelled. First steps to facilitate successful implementation of family presence include initiating family presence protocols with a focus on preparing the healthcare staff for the participation of patients’ family members. The parents of a critically ill child have been there since the beginning of the child’s existence. Facilities that provide healthcare to children need to consider their perspective on the involvement of a child’s family in what may be the final moments of the child’s life.

References