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Family Presence During Resuscitation and/or Invasive Procedures in the Emergency Department: One Size Does Not Fit All

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Family presence during resuscitation and/or invasive procedures is receiving more attention today as it speaks to the heart of patient and family-centered care. Family members are the most important support for their loved ones during vulnerable times such as a life-threatening event. Although family presence during resuscitation and/or invasive procedures is becoming a more accepted practice in hospital settings, only 5% of hospitals in the United States have unit policies guiding the practice of family presence in specialty settings.[1-5] There is a need for family presence to be studied in non-academic hospitals and in other specialty settings such as emergency departments (ED) and adult intensive care units.[2] These environments are unpredictable and professionals have varying opinions regarding benefits of family presence during resuscitation and/or invasive procedures in adults. Currently, there is no hospital policy to guide practice of family presence at our 381 bed non-academic hospital in the Northwest. Acknowledging presence as central to patient care inspired our Evidence-Based Practice (EBP) committee to craft a hospital policy providing guidance for the healthcare team to determine when it is appropriate to offer the option of family presence.

Based on years of experience working as a nurse in the community, a member of our hospital EBP committee reminded us of the importance of presence at all stages in a person's life. When healthcare professionals develop therapeutic relationships with patients and loved ones through presence, patient outcomes and satisfaction may improve. To be present is to be with a patient and loved one in an authentic relationship promoting mutual respect, honesty and dignity.[6] Transferring the concept of presence to families during resuscitation and/or invasive procedures may help facilitate healing, grieving, and creating more positive experiences for both patient and family.

Searching and critiquing the literature. An extensive literature search was conducted. The search yielded 34 articles critiqued by the EBP committee. There were no true experimental studies, but there were 12 quantitative descriptive studies, 3 qualitative studies plus 1 mixed methods study published between 2003 and 2008. Seven expert opinions, 5 literature reviews, and 1 practice guideline were also evaluated. Strong support for policy development was found in the literature.

Literature findings noted that absence of a family presence policy can lead to misunderstandings and variations in practice among healthcare team members.[7,8] Having a policy in place can lessen conflicts among the healthcare team, increasing the responsibility felt by the healthcare team to focus attention on caring for the patient. Policies help to define roles for the healthcare team and contribute to a more family-centered approach.[3,9] There have been no comparative studies evaluating hospitals with and without family presence policies.[10] Professional organizations including the Emergency Nurses Association[11-15] all support family presence and have practice guidelines which endorse offering the option. Therefore, the purpose of this article is to describe our experiences of researching, creating, implementing and evaluating a family presence policy in our emergency department.

Themes in the literature on family presence include both benefits and barriers. Benefits include promoting holistic patient and family centered care[16,17,9,4,7] because family members can be with loved ones during a life-threatening event having a better understanding of the patient's condition. They can see what is being done for their loved one and may ask that resuscitative efforts be stopped sooner[18,16,3,17,4] Family presence may contribute to decreased anxiety and fear leading to higher levels of satisfaction with the care experience.[18]

To date, no nursing publications have reported litigation associated with family presence.[19,18] This may be due to the families gaining trust in staff members through observing their actions. Families may benefit emotionally by feeling supportive and present for their loved one, especially in the time of death. Opportunities to say good-bye to a loved one can assist with bereavement and may facilitate the grieving process when death occurs.[18,19,4,7] Family members also felt their presence was beneficial to the dying person and would agree to be present again if given the opportunity.[20,1]

Barriers to family presence include healthcare team members' skepticism of being watched by family members, fear of litigation, performance anxiety, and worry that family members may interfere with patient care.[21,5,18,20,19,4] A noted concern was that family members may experience negative psychological effects after witnessing a traumatic event.[5,17,4] These concerns combined with possible confidentiality violations are some of the contributing factors to why trauma surgeons are less open to family presence and may even strongly oppose the option.[2,4]

Evidence-Based Practice Project

The EBP task force volunteered to take on this EBP project consisting of writing a hospital policy on family presence during resuscitation and/or invasive procedures. The Iowa Model [22] adopted by our hospital guided our EBP process. A PICO question was developed (See Table 1) from an experience-based idea, followed by a literature search and critique of available evidence. The policy was written and the pilot study was endorsed by the ED staff, nurse manager and medical director.

Acting on the Evidence

Policy development. Prior to writing the FP policy the EBP task force contacted other hospitals within the Trinity Corporate system and learned no family policy existed. This made the need to create a policy even greater. Additional references reviewed included the Emergency Nurses Association [23] and clinical practice guidelines [24,13,15,11] Key to developing the policy was an evidence-based practice guideline from a pediatric ED providing a step by step approach to individual situations where family presence could be applied.[19] Following policy development and implementation is policy evaluation. The purpose of the evaluation is to measure policy effectiveness. In this case a policy evaluation tool was created using a checklist format based on specific procedure points from the draft written policy.

Staff education. Prior to the policy being implemented education was provided by the ED unit based educator and medical director for the healthcare team. The ED healthcare team included registered nurses, ED physicians, trauma surgeons, respiratory therapists, radiology technicians, social workers, chaplaincy, ED technicians, and guest relations specialists. Content included definitions of the terms (See Table 2), staff roles and responsibilities as noted in the Emergency Nurses Association [23] text and power point, *Presenting the Option for Family Presence*. Informal education, such as visual reminders on bulletin boards in the staff break room and fliers describing family presence were strategically placed in high traffic areas throughout the ED.

Critical to the success of family presence is the role of family facilitator (FF).[25,13,1,4] Family facilitators have been used in family presence options within the pediatric population.[26] This role may be filled by a licensed professional nurse, chaplain, social worker, or a guest relations specialist.[27,28,18,26,25] In our hospital a guest relations specialist is hired to provide family support and fulfills the FF role. According to the ENA, the option should not be offered without someone serving in the role of FF. The FF is trained to provide support, prepare the family regarding what to expect, provide rationale for any procedures and will remain with the family at all times as there can be highly emotional moments. Key elements to the role of the FF are excellent communication skills, knowledge to make an initial assessment of the family's wishes for family presence, and evaluation of readiness to enter the event room. The FF then conveys the family's option for presence to the direct care providers and seeks consensus from the healthcare team. The family is instructed outside the event room about where they should sit and expected behaviors so as not to interfere with the on-going patient care. There will be times when a family member may not be allowed into the event room due to the physical context of the ED, provider preference, or inappropriate family behavior.[1] The FF will inform the family of these reasons and strive to meet their needs with frequent updates on the patient's known condition. After the event the FF is available to connect family members with appropriate resources tailored to meet their needs. When the family facilitator or healthcare team member are in need of support there are hospital resources available to assist.

Results of policy evaluation. The new family presence policy piloted in our emergency department proved to be controversial as evidenced by a low return rate of completed checklists. The healthcare team provided unsolicited verbal and written responses to the checklist including comments that the policy did not fit the culture of this emergency department. There were concerns family presence may violate privacy and HIPAA laws due to the emergency department environment. For example, the emergency department consists of a 2-bed trauma bay and 17 small exam rooms divided only by curtains. There are two small enclosed rooms that provide privacy but do not have the space for family presence in addition to medical equipment and healthcare providers. Currently only one room exists to accommodate family presence, and its primary use is for pediatric patients.

Other comments brought to the attention of the EBP task-force were regarding the terms *resuscitation and/or invasive procedure(s) being* conceptualized differently in our own ED. *Resuscitation* could mean a cardiac arrest, trauma, or a medical emergency such as a drug overdose. An *invasive procedure* can have several meanings such as intubation accompanying a cardiac resuscitation, external fixation of a broken bone, or insertion of a chest tube.

There is a need to understand the cause of the resuscitation and reason for invasive procedure(s) as it may affect the healthcare team's response and subsequent choice of whether or not to honor a family's option for presence. Knowing the emergency department is not a controlled environment makes it especially clear that policies need to be written specific to each context, one size does not fit all.

Pilot Study

A pilot study was conducted in the emergency department while the policy evaluation was ongoing. The purpose for the pilot study was to understand feelings and attitudes of the healthcare team towards family presence with adult patients. A survey was distributed to the ED healthcare team using a quantitative measurement tool adapted with permission from Duran.[2] The measurement tool having established reliability and validity consisted of 23 questions. IRB approval was obtained prior to data collection.

Data Collection. Two surveys were distributed, the first in June 2008 and the second in March 2009. A 34% return (N=84) and a 38% return (N=88) were received. Data were collected using a 4-point Likert Scale, with indicators of 1 = Strongly Agree and 4 = Strongly Disagree. Analyses were run using the Statistical Package for the Social Sciences (SPSS) version 17. Descriptive analyses were conducted, but sizes of specific healthcare disciplines were too small to establish reliable comparisons. Results from the first survey showed large standard deviations on most questions suggesting a lack of consensus among members of the healthcare team. Mean scores were in the Agree to Disagree range and did not reflect Strongly Agree or Strongly Disagree, further suggesting a lack of strong feelings of support or non-support of family presence. Informal discussions among healthcare team members regarding the survey centered on operationalization of the terms *resuscitation and/or invasive procedure(s).* Combining the terms instead of separating them caused confusion. Comments suggested the terms are interpreted differently in an ED environment than on a unit where patient care is more controlled. Comparing this unpredictable ED environment to a more predictable environment, such as a medical-surgical unit, supports the opinion that a hospital-wide family presence policy is not practical.

Therefore the next step was to re-visit the literature and re-evaluate best available evidence to more effectively operationalize the terms. The updated literature review found 35% of publications referenced the term *resuscitation and invasive procedure(s)*, while 65% referenced only *resuscitation*.

Prior to distributing the second survey a statistician was consulted and five questions were revised by creating a part A and a part B to the questions, expanding the survey from 23 to 28 questions. (See Table 3). By separating the concepts and more clearly operationalizing the terms *resuscitation* and *invasive procedures*, a more reliable tool was produced as evidenced by Cronbach alpha scores. The Cronbach's alpha of the first survey was .858. After separating the two terms, the second survey had a Cronbach's alpha score of .928. (See Table 4). The higher alpha score from the second survey suggests separating the terms into two questions helped the healthcare team conceptualize them as independent of each other. It further suggests the Cronbach's alpha scores reflect the dynamics of patient care experienced in an emergency department. This perception was supported with descriptive findings from the second survey that differentiated the terms *resuscitation* and *invasive procedure(s).*

The ED healthcare team was more supportive of family presence during resuscitation than during invasive procedures as noted by smaller standard deviations in the second survey.

Conclusions

The next step will be to work in collaboration with an interdisciplinary ED team to create two policies: one for family presence during resuscitation and a second for family presence during invasive procedures. However before beginning this process, there needs to be clear definitions of the terms: *resuscitation* and *invasive procedure(s)*. In re-writing the policies, the first priority will be searching for best available evidence on definitions of family presence during resuscitation and invasive procedures. Based on the best available evidence findings will be incorporated into a draft policy and given to the ED healthcare team along with the expectation clinical experts will validate the policies. A third survey will be distributed to query two distinct concepts: 1) attitudes and feelings during *resuscitation* and 2) attitudes and feelings during *invasive procedures*.

The EBP task force thought the family presence policy would be well suited to our emergency department. The evaluation did not give us the answers we were expecting; instead it raised more questions surrounding family presence. A policy for family presence in any clinical setting requires careful consideration of both culture and environment. Involving key stakeholders, including the healthcare team, patients and families, will promote a culture of holistic patient family-centered care. Afterall, the goal of patient family-centered care is focused on meeting needs of the patient's and family. This may include the need for information, support, being in close proximity to a loved one during a health-related crisis, or saying goodbye when death occurs. These policies will offer appropriate guidelines to assist staff in evaluating each family situation, determining when it is fitting to offer the option of family presence. There is the realization not all situations are conducive to family presence, and barriers and benefits will always remain. As each family situation is unique the important lesson learned from this EBP project is that one size policy does not fit all.

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Table 1: PICO Question

***P**roblem*: There are no hospital or unit policies for family presence during resuscitation and/or invasive procedures in a 381-bed, non-academic hospital; ***I**ntervention*: Creation and implementation of a hospital-wide policy; ***C**omparative Intervention*: Practicing family presence without a policy; ***O**utcome*: The hospital EBP committee will create a policy for Family Presence and/or Invasive Procedures.

Table 2: Operational definitions

Family presence: the presence of family members in a location that allows physical or visual contact with the patient during resuscitation, invasive and/or painful procedures.
Resuscitation*:* a sequence of interventions initiated to sustain life and/or prevent deterioration of the patient's condition.
Invasive procedures: any intervention that involves manipulation of the body and/or penetration of the body's natural barriers to the external environment.
Family Facilitator (FF): a designated staff member, trained in the process of explaining current medical care in broad general terms, providing assessment, preparation, and support of families during resuscitation, invasive and/or painful procedures. FF may include nurses, physicians, chaplains, social workers, technicians, or guest relations personnel.

***Emergency Nurses Association. *Presenting the Option of Family Presence* 2007. (3rd ed.)**

Table 4: Comparison of content validity for measurement tool when terms are combined and separate.

Duran, et al. (2007) using term ***resuscitation and/or invasive procedure*** in multiple units:

- Cronbach's alpha = .93

Survey 1 using term ***resuscitation and/or invasive procedure*** in ED only:

- Cronbach's alpha = .858

Survey 2 separating terms ***resuscitation*** **and** ***invasive procedure*** in ED only:

- Cronbach's alpha = .928

*Duran CR, Oman KS, Abel JJ, Koziel VM, Szymanski D. Attitudes toward and beliefs about family presence: a survey of healthcare providers, patients' families, and patients. *American Journal of Critical Care* 2007;16(3):270-9.