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Evaluating Nurses perceptions of family presence during resuscitation efforts and invasive procedures before and after an educational intervention.

David Cross
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Evaluating Nurses perceptions of family presence during resuscitation efforts and invasive procedures before and after an educational intervention.

Abstract
Background: Since the 1980’s, family presence during resuscitation and invasive procedures has been supported in the literature as being beneficial to health care workers, family, and patients. Ongoing controversy related to misconceptions regarding family practice hinder its acceptance and practice in the hospital setting. To determine the effects of an educational intervention, the purpose of this project was to determine nurses’ attitudes, beliefs, and intent to practice family presence using the adult learning theory and theory of reasoned action. Methods: Pre and post surveys were used in this study. Nurses in a local emergency department, who volunteered for the project, completed the pre-test prior to the completion an educational podcast. After listening to the 20 minute podcast, nurses were asked to complete the same survey again to evaluate changes in attitudes, beliefs, and intent to practice family presence. Results: There was a statistically significant change between the pre and post surveys in four of six questions chosen to evaluate the effectiveness of the podcast. The two questions which did not have statistically significant changes had favorable responses in both pre and post surveys supporting family presence. Two short answer questions all indicated a change in attitudes and beliefs. Conclusion: The change in pre and post education survey scores supports that the educational podcast was effective in changing attitudes, beliefs, and intent to practice family presence during resuscitation and invasive procedures.

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Evaluating Nurses perceptions of family presence during resuscitation efforts and invasive procedures before and after an educational intervention.

by

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Submitted in partial fulfillment of the requirements for the degree Master’s in Advanced Practice Nursing

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Spring 2011
Title: Evaluating Nurses perceptions of family presence during resuscitation efforts and invasive procedures before and after an educational intervention.

The above student has successfully completed this project / thesis is partial fulfillment of the requirements for the MS in Advanced Practice Nursing degree from the Wegman’s School of Nursing at St. John Fisher College

This project/ thesis fulfills the requirements of project/thesis seminars and assists in meeting the program outcomes for the MS in Advanced Practice Nursing degree from the Wegman's School of Nursing at St. John Fisher College
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Abstract

**Background:** Since the 1980’s, family presence during resuscitation and invasive procedures has been supported in the literature as being beneficial to health care workers, family and patients. Ongoing controversy related to misconceptions regarding family practice hinder its acceptance and practice in the hospital setting. **Purpose:** The purpose of this project was to determine the effects of an educational intervention on nurses’ attitudes, beliefs, and intent to practice family presence using the adult learning theory and theory of reasoned action.

**Methods:** Pre and post surveys were used in this study. Nurses in a local emergency department, who volunteered for the project, completed the pre-test prior to the completion an educational podcast. After listening to the 20 minute podcast, nurses were asked to complete the same survey again to evaluate changes in attitudes, beliefs and intent to practice family presence.

**Results:** There was a statistically significant change between the pre and post surveys in four of six questions chosen to evaluate the effectiveness of the podcast. The two questions which did not have statistically significant changes had favorable responses in both pre and post surveys supporting family presence. Two short answer questions all indicated a change in attitudes and beliefs. **Conclusion:** The change in pre and post education survey scores supports that the educational podcast was effective in changing attitudes, beliefs and intent to practice family presence during resuscitation and invasive procedures.
Chapter One

Traditionally, family members of patients undergoing cardiopulmonary resuscitation (CPR) or invasive procedures have been asked to leave the patient care area and go to a waiting room where they would anxiously await news of the outcome. The rationale behind this practice was the belief that family members would not want to be present during such an event. It wasn’t until the 1980’s that this practice was challenged by the emergency department of Foote Hospital who, after surveying family members and surviving patients of CPR, discovered that families and patients wanted to be together during the resuscitation (Doyle, Post, Burney, Maino, Keefe, & Rhee, 1987).

Family presence is defined as family members being in close visual or physical contact with the patient during CPR or invasive procedures. The concept of family presence (FP) during resuscitation efforts and invasive procedures has been a controversial topic in health care since the 1980’s. In fact, much debate has occurred around the concept of FP since its first documented occurrence in 1982, sparking the beginning of decades of research to explore this concept (Oakland, Lieader, Young, & Jefferson, 2007). Qualitative and quantitative researchers looking at FP have investigated the views of nurses, physicians, psychologists, clergy, lawyers, family members, and even surviving patients. The 30 year accumulation of research regarding FP has helped support its benefits in practice not only to family and patients, but also to the health care workers who participate in it. As a result of the controversy, and despite the years of research, it is still a practice that is unlikely to occur in most health care settings, according to a 2003 study published in the American Journal of Critical Care (MacLean et al., 2003).
Studies support that there are numerous reasons why health care providers fail to practice FP, despite the favorable research regarding FP. These reasons include the fear of increased litigation, fears of family hindering patient care, or the potential emotional trauma to family members who witness the event. Another possible reason for FP not being adopted is a lack of knowledge regarding FP, and its benefits, among health care professionals.

Purpose

Nurses can assume a critical role in the practice of FP which can influence the practice of FP with other health care professionals. However, nurses may not feel prepared to assume this important role because of their lack of knowledge and individual attitudes or beliefs that may interfere with practicing FP. Therefore, the purpose of this project was to determine the effects of an educational intervention on nurses’ attitudes, beliefs, and intent to practice FP.

Hypothesis

Research supports that education has a favorable impact on knowledge and attitudes (Max, 1990 & Howell, Butler, Vincent, Watt-Watson, & Stearns, 2000). It is hypothesized that with the completion of the educational podcast on FP during resuscitation and invasive procedures, nurses with more knowledge will have improved attitudes toward FP with an increased likelihood of practicing FP.

Theoretical Framework

The theory of reasoned action (TRA) served as the overall conceptual framework for this project. According to Ajzen and Fishbein (1980), a person’s behavior is determined by his/her intention to perform the behavior and this intention, in turn, is a function of his/her attitude...
toward the behavior. Therefore, according to this theory, the best predictor of a behavior is intention. The TRA further suggests that behavioral intention depends on a person’s attitude toward the behavior and subjective norms. Attitude consists of beliefs about the consequences of performing the behavior. Subjective norm is, according to Fishbein and Ajzen (1975), the person’s perception that people who are important to him or her think he or she should or should not perform the behavior. Thus, behavioral intention is a function of attitude and subjective norms although not always weighted equally. Therefore, for this project, it is hypothesized that educating nurses regarding the benefits of FP, and dispelling myths, will change their attitudes and beliefs regarding FP, resulting in a change in behavioral intention favoring FP.

Adult learning theory, pioneered by Malcolm Knowles, guided the actual educational intervention, because the education of adult health care workers poses unique challenges when compared to the education of the traditional student. Knowles’ (2005) theory states that adults have special needs and requirements as learners compared to children and teens. Some of these special needs include adults needing to be autonomous and self directed, and needing to associate new education with life experiences to help make the education relevant to them (Knowles, 2005).

The need for autonomy and self direction in adults choosing what they learn and how they learn was a crucial consideration in the development of this project. Participation in this educational intervention was voluntary, therefore nurses who chose to participate did so likely due to interest in the topic and/or the ability to complete the education at their own pace with the self directed podcast format. Furthermore, with the knowledge that adult learners often have little time for extra activities, the podcast was developed to be time sensitive so that it could be completed in a minimal amount of time, thereby lessening any inconvenience to the nurses.
Keeping the podcast short was also essential to prevent overloading participants with information, as well as keeping in mind that sustained attention generally waxes and wanes after 20 minutes (Dukette and Cornish, 2009).

Another premise of adult learning theory is that adults have accumulated a foundation of life experiences and knowledge. They need to connect new skills to this knowledge/experience base (Knowles, 2005). Participating health care workers could possibly relate their past experiences, as well as current attitudes and beliefs about FP, to what the podcast reviews. Along with presenting new information about FP, it was hoped that the program would prompt the learner to draw on previous experiences to more effectively influence their intent for future practice of FP. According to adult learning theory, adults are relevancy-oriented people who need to find relevance in what they are learning (Knowles, 2005). The podcast helps outline for its viewers the importance and relevance of FP to family centered care and why it is necessary for health care workers to take it into consideration when the opportunity arises.

Literature Review

Multiple sources of data were reviewed for information pertaining to FP. Any literature that articulated viewpoints that either supported or refuted the idea of FP were taken into consideration to gauge the scope of the information available on the topic. The sources of the data came from research studies, other literature reviews, revered professionals’ accounts with FP, and professional organizations’ position statements regarding FP. Information was collected from printed peer review nursing journals, while most of the information came from the use of the Internet in the form of research databases and professional organizations’ websites. The research databases that were extensively utilized included CINAHL, Medline, ProQuest,
PubMed, and Science Direct. Science Direct proved to be most useful in obtaining research articles involving FP, as it seemed to have access to articles that the other databases either did not have access to, or were unable to be located in the primary search.

When searching for information on FP in research databases, the words “family presence during resuscitation” where initially used which yielded thousands of keyword hits. The search was then limited to English, to references with either full text availability or PDF files, to articles printed in the past fifteen years, and finally, to articles originating from the U.K. and North America. This yielded approximately 100 articles from any given database, with most of the different databases finding the same articles as the other databases that were primarily used. These articles were then narrowed down by hand for relevance to the topic of review. After applying the criteria listed above eight articles were chosen and used for the purpose of this literature review. Of these eight studies and sources, five were research studies, one was considered literature reviews, one was a position statement of a professional association, and the last was an abstract of a research study which will be explained in greater detail.

These eight articles effectively highlight the issues of FP by giving the reader a good representation of what FP is, along with its origins, where it fits into the practice of health care professionals today, as well as ideas for future trends and issues with FP.

The articles were also selected for this project to give background on the depth of available research and current support for FP among the various organizations that publish these articles.

The eight articles that will be reviewed are all similar in the aspect that they explore the various factors associated with failure to practice FP, as well having research supporting its importance. The differences among them include target population, interventions, depth of research, and design of the article.
Family perspectives regarding FP have been documented as far back as 1982 when the Doyle et al., (1987) research group interviewed a sample of surviving relatives of cardiac arrest victims who expressed their desire to have been with the patient during the resuscitation. This sparked a larger, more in-depth study which explored family members’ desire to be present during resuscitation, done by the same researchers. The article published by Doyle et al., (1987) is accepted to be the first research study done regarding FP that resulted in a program that allowed FP. In this study, family members were asked if they wanted to witness FP, if they were accompanied by supporting staff, and how the resuscitation effort was explained to them prior to entering the code room. The results are similar to that of what would be future research, with the majority (94%) of the participants finding FP beneficial, sharing themes such as helping them better come to terms with the impending death, or being able to comfort their dying loved one. Also, none of the seventy cases of FP in the study interrupted or affected the resuscitation efforts. This study demonstrates an early example of published information regarding the benefits of FP and lack of interference on the part of its participants.

In a later study conducted by Meyers et al., (2000) qualitative and quantitative data was collected from family members, nurses, and physicians to describe their views of and practice of FP during invasive procedures (IPs) and resuscitations. Although the concept of FP was hardly new at the time, this was one of the first studies that looked at the effects of FP on families who participated in it. The study surveyed 39 family members and 96 health care workers (nurses, attending physicians, and residents) regarding their experiences of FP during both CPR and IPs. To determine attitudes about potential benefits and problems of FP, a 37 item family survey, and a 33 item provider survey were put together by the researchers. The survey used a 4 point Likert
scale to give researchers quantitative data, showing the acceptance or lack thereof, of FP (Meyers et al., 2000). The research tool also included semi-structured questions to obtain qualitative data.

The results of the research provided extensive supportive data on FP. Family members’ attitudes and perceived benefits showed that 98% of the family members indicated they had a right to FP, and that they would do it again given the chance (Meyers et al., 2000). Common themes among family members were that FP helped them comprehend the seriousness of the patient’s condition, FP was comforting for the patient, FP allowed those present to better explain the situation to other family members, they gained more closure from the experience, and FP gave them a feeling of empowerment. Family members were also able to help the health care team by answering questions for the unconscious family member, such as any significant past medical history that could be detrimental to their care if not elicited. Family members also reported that being present allowed them to see how hard the health care team was working to resuscitate their family member, and that everything possible was being done for their loved one.

In this study, the acceptance of FP from a health care provider’s perspective varied among nurses, attending physicians, and residents. Overall, most (88%) of the health care providers surveyed supported the continuance of FP; 96% of nurses compared to 79% of physicians supported FP (Meyers, et al., 2000). There was less support from residents (50%). According to their findings, providers who supported FP saw FP as a way for family members to meet the emotional and spiritual needs of the patient, as well as a way to understand the patient’s condition, and the gravity of the situation. Family presence also served as a way to remind the staff that they were taking care of a person, a family member, not just a room number; it curbed nonessential talk that can sometimes be perceived as black humor. These findings were
consistent with other studies in the literature review such the Oakland et al., (2007), and Doyle et al., (1987).

Meyers et al., (2000) also found that the list of negative responses from family members regarding FP was relatively short. Family members cited concerns about not knowing what they would see, if they could cope with it, or if they would interfere with the care of their loved ones. Regardless of these negative aspects, 95% of the study’s participants did not find the experience too upsetting for them, nor did they feel that they affected the care delivered to the patient.

Despite the overall supportive attitude of providers toward FP, there were several potential problems that providers cited. These potential problems included such things as family members interrupting CPR, becoming irate or violent, misinterpreting the actions of the health care team, or using what they saw as a way of initiating future legal action against the health care team (Meyers et al., 2000). Also, the study pointed out that health care providers felt there could be negative long term effects on families witnessing their loved ones being resuscitated, as the event can be considered to be quite gruesome to the lay person. These findings were consistent with other studies in the literature review such the Oakland et al., (2007), and Doyle et al., (1987). Even with the potential for such things to cause trouble during CPR or IPs, 97% of all providers said that the family members’ behavior was appropriate and that there had not been a single reported case of FP as the cause of litigation (Meyers et al., 2000).

Although not the main focus of the Meyers et al., (2000) study, other key concepts were discovered, such as the need for screening acceptable candidates for FP and having a family spokesperson available to be with the family during FP to answer questions and provide support. A family spokesperson would be part of the medical staff whose main focus was to stay with the family member to help explain and answer questions.
The results of the Meyers et al., (2000) study were supported by a study published in 2007 by Oakland et al. They used the survey tool designed by the Meyers et al., (2000) study, which by 2007, proved to be one of the most reliable and valid tools available. The study also went further than previous studies by assessing mental and health functioning after FP and investigating the risk of long term negative psychological effects on family members (Oakland et al., 2007). A mirror survey tool was also used to assess the acceptance of FP with family members who were not able participate in FP due to circumstances such as arriving at the hospital after resuscitation efforts stopped. This was done to gauge whether or not being present during resuscitations influenced the individual’s perspectives on FP, or if just the mention of it after the fact would elicit the similar reactions. The quantitative and qualitative results were congruent with previous studies, showing that almost all of the studies’ participants supported FP regardless of whether or not they actually witnessed the resuscitation (Oakland et al., 2007). Themes such as the right to be there, making a difference, helping understand the situation, and helping explain things to other family members came from the qualitative analysis of the participants’ responses.

As in the Meyers et al. study, many perceived provider disadvantages of FP were disproved in the Oakland et al., (2007) study. For example, there was never an instance when FP interfered with the care of the patient. The participants of the study were also tested for psychological stressors resulting from FP, which revealed similar scores as that of the general population. The conclusion was that FP had no adverse mental health repercussions. It is worth noting that the Oakland et al., (2007) study investigated FP as a practice in a children’s hospital. Its findings were consistent with that of other studies done at adult and other children’s hospitals, demonstrating over all acceptance of FP making it relevant in the generalized scope of FP.
research. The findings of the Oakland et al., (2007) study were consistent with other studies, including the studies in this review of literature.

The previous three studies reviewed the feelings and beliefs of health care workers and families regarding FP. Although these studies did, to a small degree, include patient views, the views of patients who had survived CPR had been left out of the literature until recently. In the past few years new research has been published that focuses on the surviving patients’ thoughts and beliefs of FP. One of the more recent articles with this focus was published in Europe in 2009 (McMahon-Parkes, Moule, Benger, & Albarran, 2009). The aim of the study was to compare patients who survived resuscitation to other patients admitted for emergencies not needing resuscitation on their views and beliefs about whether family members should be present during resuscitation. This was accomplished by using a case control design and recruiting from four large hospitals: there were 21 survivors of resuscitation and the control group consisted of 40 patients admitted as emergency situations without the experience of resuscitation (McMahon-Parkes et al., 2009).

The two groups were matched by age and gender at a ratio of 1:2. Data was collected by face-to-face interviews using a standardized 22 item questionnaire (McMahon-Parkes et al., 2009). Data analysis was used to identify differences between the two groups. The results of the data analysis demonstrated that both groups were broadly supportive of the practice. However, resuscitated patients were more likely to favor witnessing the resuscitation of a family member, preferred to have a relative present in the event they required resuscitation, and believed that relatives benefited from such an experience. Additionally, both groups indicated that staff should seek patient preferences about family witnessed resuscitation following hospital admission, and stated that they were unconcerned about confidential matters being discussed
with family members present during resuscitation (McMahon-Parkes et al., 2009). The article also points out that even though there were differences between the two groups it was not enough to be statistically significant.

This study helped strengthen the argument that FP is perceived as a benefit even from the standpoint of surviving patients. These findings, although from a different perspective, are consistent with the findings of other studies in this literature review because there is generally a perceived benefit in practicing FP.

Because of the number of studies supporting FP throughout the past 20 years, FP has been accepted by some health care providers and most major nursing and medical organizations, such as the Emergency Nurses Association, American Nurses Association, and American Medical Association. These organizations recognize and support the practice of FP to its members and in some instances have done so for over a decade, yet FP remains infrequently practiced as it is often left to the discretion of individual health care providers to initiate it during a resuscitation or procedure. The support of major health care organizations and the inconsistent practice of FP have prompted the need to find ways to create policies that support FP.

Although there are several possible reasons why FP is not consistently being integrated into daily practice, one of the major reasons could be the lack of formal written policies allowing family presence. In one survey with nearly 1000 respondents, nurses identified that at least half of them had participated in FP for either CPR or IPs; however, only 5% of them worked on units with written policies allowing FP (MacLean et al., 2003). The majority of the respondents favored some form of FP, at a lesser extent (75%) then that of similar research studies. The nurses who completed this survey also reported being asked by family members to be at the bedside during CPR or IP’s, and that they would choose to bring the patient’s family into the
room if given the opportunity but stated that having a policy in place would provide more guidance and more consistent practice.

The results from these two studies, along with others, unequivocally supports that FP should be accepted and practiced by health care providers in almost all settings. However, this has not been the case, according to MacLean et al., (2003), who found that less than 5% of the nurses who participated in the study worked in hospitals with written FP policies allowing FP to take place. MacLean et al., (2003) also points out that less than half of the nurses who participated in the study had ever participated in FP.

The need for instituting policies guiding FP is also defended in the position statements of several professional organizations, including that of the Emergency Nurses Association (ENA). The ENA identifies that research regarding FP, such as the MacLean et al., (2003) survey, indicates that very few institutions have written policies offering FP. The ENA position statement also outlines the issue of the acceptance of FP via presenting research that supports FP by voicing popular positive themes among family members and health care providers, as well as disproving the negative ideas regarding FP. The ENA’s official position on FP is that of support, calling for collaboration of multidisciplinary teams, education about FP, and nursing taking an active role in the research and support of FP. ENA claims that lack of a written policy for FP can create inconsistencies in the practice and may deprive patients and families of needed support, which is inconsistent with a family-centered model of care (ENA, 2007).

The inconsistency of the practice of FP, which the ENA blames on a lack of written policy, has gotten attention from health care professionals who are interested in developing a written policy. In an article published in Nursing, 2007, FP is defined, past research pertaining to FP is described, and its current acceptance in health care is explained (Laskowski, 2007). The
authors of the article then give an outline on how to create a FP protocol. The outline can be summarized as: assessing staff attitudes, comprehensive literature search, surveying staff, and then coming to a general consensus. According to Laskowski (2007) some things to take into consideration when developing protocol involve fully exploring situations that would negate FP, such as violent family members. Another important consideration in developing a FP protocol is assigning staff members that will act as the family spokesperson to stay with the family member during the time they are in the resuscitation room and to heed the development of scripted responses to medical questions in laymen’s terms. Laskowski (2007) also suggests that after the protocol has been written it should be reviewed by the hospital risk manager before being finalized to identify potential liabilities.

Educating staff about FP and about a protocol, to encourage consistent use, is the last major step in developing and utilizing the protocol. Another need that Laskowski (2007) points out, that is often overlooked in both literature and practice, is a family debriefing after the event. This consists of a follow up letter or card to the family allowing them the option of a debriefing. Debriefing can allow families to openly talk about fears and to ask the health care team questions after the event.

An article written by Feagan and Fisher (2010) picks up where Laskowski (2007) leaves off in that it assesses an institution’s knowledge and feelings on FP before and after implementing a hospital-wide written policy with an educational in-service. The article outlines a 2-phase before and after study which was conducted at a 388-bed academic trauma center, and at a 143-bed community hospital. In phase one of the study, there was a convenience sample of physicians and registered nurses from both facilities whom were surveyed about their opinions
and beliefs regarding FP. The survey tool for both phases was an adaption of the ENA’s 2007 survey for assessing health care provider’s views of FP.

In phase two of the 2008 study, provider subgroups in the community hospital were re-surveyed after an educational program that used evidence based information (Feagan & Fisher, 2010). The educational program consisted of the ENA’s published power points on presenting the option of family presence totaling 40 minutes in length. It was presented to groups of participants by the research team with follow up question and answer sessions after. The education took place during mandatory training which was initiated for the study. Following education of staff, a hospital wide FP policy was put in place in both facilities. Stage two resulted in 44 completed and returned surveys to the research team out of an original 83 distributed surveys. Independent T-tests and one-way ANOVAs were used in the study to compare pre and post education mean scores of subgroups on effectiveness of teaching strategies and improved FP support. The post education mean scores improved for the chosen survey variables as indicators of FP support.

The work by Laskowski (2007) and MacLean et al., (2003) highlight the disparities in the actual practice of FP in the presence of an overwhelming number of studies support FP. Both articles allude to the next step in FP research, which focuses on staff education as the key to policy change and the more consistent practice of FP, with increased knowledge and changes in attitudes and beliefs about FP in health care providers. Feagan and Fisher’s (2010) research was a timely answer to the call for health care provider education of FP. Though the study’s results supported that ENA’s material for FP education was successful, it did so in the format of a lengthy formal educational intervention. This educational intervention may not be suitable in all applications as there may not be time allocated in other health care settings that allow staff a full
hour of training for FP. Additional time would need to be scheduled for the health care providers to meet with the educators, away from the clinical setting.

Methods

Sample and Setting

A convenience sample of nurses was recruited from the Emergency Department of an urban community hospital located in Rochester, New York. The hospital has 261 licensed in-patient beds, 9 observation beds, and a 26 bed Level II emergency department. The department is staffed by approximately 26 full-time nurses. Nurses in this department have a minimum of one year of nursing experience prior to working in the emergency department, per New York state law, while some nurses have over 30 years of experience overall. An emergency department was chosen because of the nature of the patient population seen there, often with life threatening illnesses or injuries requiring invasive procedures or resuscitation. Therefore, nurses in the emergency department have frequent exposure to invasive procedures and resuscitation efforts, which makes them a logical choice for FP education. Emergency departments are also subject to the unpredictability of day to day acuity levels and patient volume. These factors play a role in the need for a clear understanding of FP as a patient may present at any time needing resuscitation or emergent invasive procedures.

Participants of this project were five nurses, three with over 20 years of experience, and two with approximately 5 years of experience. Of the five nurses, one had a master’s degree, three had bachelor’s degrees, and one had an associate’s degree. Two had experience with FP in the past two-five years, two had no experience with FP, and one had experience with FP within the past year. (Table 1)
Table (1)

Sample demographics.

<table>
<thead>
<tr>
<th>Procedures</th>
<th>Years as nurse</th>
<th>Highest Degree</th>
<th>FP during CPR</th>
<th>FP during Invasive</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nurse one</td>
<td>4-7 years</td>
<td>Associates</td>
<td>never</td>
<td>never</td>
</tr>
<tr>
<td>Nurse two</td>
<td>4-7 years</td>
<td>Bachelors</td>
<td>within the last year</td>
<td>within the last year</td>
</tr>
<tr>
<td>Nurse three</td>
<td>20+</td>
<td>Masters</td>
<td>within last 2-5 years</td>
<td>never</td>
</tr>
<tr>
<td>Nurse four</td>
<td>20+</td>
<td>Bachelors</td>
<td>never</td>
<td>never</td>
</tr>
<tr>
<td>Nurse five</td>
<td>20+</td>
<td>Bachelors</td>
<td>within last 2-5 years</td>
<td>within last 2-5 years</td>
</tr>
</tbody>
</table>

Procedure

All registered nurses working in the Emergency Department full-time or regular part-time, during the time of this project, were invited to participate in the educational program. Participants had to be English speaking and willing to watch the 20 minute podcast and complete pre and post intervention surveys. Health care providers who were not registered nurses, English speaking, and/or did not work in the Emergency Department during the project were excluded from this study. Nurses were recruited through hospital email with a letter explaining the purpose of the project and requesting their voluntary participation (Appendix A). Volunteers responded back to the email, or contacted the researcher directly with contact information provided in the email. IRB approval was obtained from St. John Fisher College, as well as the hospital where the program was implemented (Appendix B). Completion of the pre-survey served as implied consent for participants.
A podcast was created using the Emergency Nurses Associations (ENA) published material on presenting the option of family presence (ENA, 2007). With the approval of the ENA, its 50 slide power point presentation was reduced in length by the researcher by removing material that was considered redundant or not in line with the focus of the project. The remaining 37 slides (Appendix D) were then narrated with additional information contained and condensed from the original 50 slides by using Apple computer’s QuickTime Media Player which is able to be viewed on most modern computers. The result was a 19 minute podcast which was then put on to CDs that were included in the project packet.

Included and distributed in the packet with the CD were identical pre and post surveys labeled one and two with the instructions to complete survey 1, watch the podcast, and complete survey 2. These surveys where developed by the ENA in order to assess health care workers’ attitudes and beliefs regarding family presence (ENA, 2007). Permission to use the surveys was obtained from the ENA. The 20 question survey included 11 Likert-type questions, 8 short answer questions, and one demographic question.

Following the initial distribution of the material, participants were given one month to complete surveys and return them. Completed surveys were returned with the rest of the project packet to a secured location in the emergency department. Surveys were returned anonymously to protect the identity of the participants.

To evaluate the success of the podcast program in changing attitudes and beliefs, and intent to practice FP, a post survey was used (Appendix C). The survey collected both quantitative responses in the form of a Likert-type scale, and qualitative responses in the form of
short answer questions. Participants completed a pre survey, watched the 19 minute podcast, and then immediately take a post survey.

Ten nurses expressed interest in participating in the project through returned emails or direct communication with project director. Research material was distributed to all ten nurses. Of the ten original nurses, six nurses returned completed surveys. However, one returned survey was incomplete, therefore, only five were usable for analysis. The five usable surveys represent approximately 20% of the 26 full time nursing staff members of the emergency department.

Results

The purpose of this project was to evaluate the effectiveness of an educational program in changing nurses’ attitudes and beliefs about FP using a convenient, time sensitive program in the form of a podcast. An item by item statistical analysis was completed from pre and post surveys using SPSS Version 10.1 (SPSS Inc, Chicago, Ill). Descriptive statistics were used to characterize each of the survey items. Paired T-tests were used to evaluate differences between the pre and post surveys. Significance was set at <.05.

In order to focus on the survey questions which best assessed the purpose of the project, six specific questions were selected for data analysis. Four of the six questions demonstrated a statistically significant change pre and post program. Mean pre and post program scores, along with statistical significance are presented in Table 2. Two questions that asked nurses if they believed family members should have the option to be present during invasive procedures and resuscitation situations demonstrated a significant change pre and post program, indicating that nurses more strongly believed that family members should have the option to be present during resuscitation and invasive procedures after viewing the podcast.
Table (2)

*Paired T-Test comparing pre and post survey. Statistical Significance <.05.*

<table>
<thead>
<tr>
<th></th>
<th>n</th>
<th>mean pre</th>
<th>mean post</th>
<th>Sig.</th>
</tr>
</thead>
<tbody>
<tr>
<td>FP as an option during IP</td>
<td>5</td>
<td>2.40</td>
<td>1.20</td>
<td>.033</td>
</tr>
<tr>
<td>FP as an option during FP</td>
<td>5</td>
<td>2.40</td>
<td>1.40</td>
<td>.034</td>
</tr>
<tr>
<td>FP is a family/patient right</td>
<td>5</td>
<td>2.80</td>
<td>1.80</td>
<td>.028</td>
</tr>
<tr>
<td>FP would interfere with Pt patient care</td>
<td>5</td>
<td>2.80</td>
<td>3.60</td>
<td>.099</td>
</tr>
<tr>
<td>FP would cause stress for the code team</td>
<td>5</td>
<td>2.00</td>
<td>3.60</td>
<td>.003</td>
</tr>
<tr>
<td>I support FP when appropriate</td>
<td>5</td>
<td>0.80</td>
<td>1.00</td>
<td>.374</td>
</tr>
</tbody>
</table>

The two other questions that demonstrated a statistically significant change pre and post program addressed nurses’ beliefs about FP as a family’s right and whether or not FP would make the resuscitation effort more stressful for members of the code team. After the program, nurses believed more strongly that FP was a family’s right and that it would not make the resuscitation effort more stressful for the code team.

Two questions of the six chosen for analysis did not show a statistically significant change pre and post program (Table 2). One question addressed nurses’ beliefs and attitudes about whether family presence during resuscitation would interfere with patient care. The second question asked if the project participant supported a family presence policy with a family presence facilitator in appropriate situations. This question was chosen to evaluate intent to practice FP in the future. If nurses supported a policy, it is likely that they intended to follow the policy. Because three of the five nurse participants already supported FP prior to the project, only a change in two of the participants would be captured pre and post intervention.
Qualitative data was also obtained from the survey tool in the form of short answer questions. The seven questions (Appendix C) were analyzed by comparing each of the five participant’s pre and post surveys, looking for major themes. Of the seven questions, two had recurrent themes among participants. These questions addressed barriers to FP and personal reservations about FP during invasive procedures and resuscitation. A recurrent theme to the barriers to FP included provider comfort with having family members present, and how that may impact acceptance to its practice. These themes were consistent in both the pre and post surveys.

The theme that did appear to change pre and post program was related to personal reservations about FP. In the post-program survey, respondents who had no consistent feelings about personal reservations regarding FP pre program stated that after watching the podcast, they felt more comfortable with FP under appropriate circumstances and were more likely to consider its practice when appropriate.

Discussion

The purpose of this project was to evaluate the effectiveness of an educational program in changing nurses’ attitudes and beliefs with the hope that this would increase behavioral intent to practice FP among nurses. According to Ajzen and Fishbein (1980) and TRA, the best predictor of a behavior is intention. Nurses were the primary focus of the program because of their long history of patient and family advocacy, an essential part of FP, and their ability to influence other health professionals.

The practice of FP has been studied and presented in literature since the early 1980’s (Doyle et al., 1987), generating a great deal of interest and controversy. Research findings by Meyers et al., (2000) and Oakland et al., (2007) explored the views of families, patients, and
health care workers regarding FP. These studies took several different aspects of FP into consideration such as the spiritual, psychosocial, cultural, legal and ethical issues associated with FP, and documented the many reasons why FP is beneficial to families, patients, and providers.

Studies such as the MacLean et al., (2003), Meyers et al., (2000), and Oakland et al., (2007) have also pointed out the potential risks and shortcomings of FP. These include health care providers’ lack of knowledge, acceptance, and practice of FP. It is this observed lack of knowledge in the Emergency Department that initiated the creation of this project in the hopes of changing attitudes, beliefs and, ultimately, practice.

Although the results of this project are encouraging, with four of the six key questions demonstrating a statistically significant improvement in attitudes and beliefs after the program, it is important to note that other questions may demonstrate a clinically significant change. In practice, clinical significance, in this case indicating a positive change in beliefs and attitudes, as well as intent, is important to note. It is likely that more of the questions did not demonstrate statistically significant changes pre and post program because of the small sample size (n=5) and the fact that some of the nurses already had positive beliefs and attitudes about the practice of FP. Furthermore, significant changes in beliefs and attitudes are challenging to elicit with just one short program, as they are often developed over a long period of time with many different experiences. However, the results of this program indicate that an educational program such as this can have an impact on how nurses feel about FP and that these new attitudes and beliefs may lead to the intent to practice FP.
Limitations

A significant limitation of this study was the small sample size. As mentioned previously, with only five participants it is difficult to determine any statistically significant change that can be generalizable. Furthermore, of five participants, some had already supported or practiced FP prior to the program so little change in attitudes and beliefs would be expected. Future research would include a larger sample size and would possibly include other health professionals.

Another limitation of this study is that the ENA survey was changed to be more time efficient for the participants. This was done because the original ENA power point presentation for presenting the option of family presence would have been over an hour in length when converted to a pod cast. Keeping the pod cast short and the participation time to a minimum was done in order to entice more participants. Doing this could have affected the reliability and validity of the original survey and, therefore, the results of this study. If this tool were to be used in future research, validity and reliability should be determined for the shortened version of the survey.

Conclusion

As with any educational intervention, there is risk that changes in behavior or practice will not be sustained for long periods of time after the intervention. Therefore, it would be essential that some type of follow-up occur after the initial intervention to assess the need for more education periodically. Along with assessing current beliefs and attitudes, a follow-up could provide data on how many participants had practiced FP as a result of the program, and if policy
had been changed. Data could be collected summarizing events as well as perceived benefits or
detriments to patients and families. This data can be used to augment the current research.

The future of FP depends largely on nurses and other health care providers. FP has been slow to gain favor in practice, but is starting to gain momentum as more professional organizations endorse its practice. If the practice of FP is to become policy, education of the key stakeholders, such as members of the healthcare team, families, and patients, is essential. This education is important to present the data that supports the practice, as well as the research that dispels the myths in order to change attitudes and beliefs about FP. Continuing development of methods of mass awareness and educational techniques which can be done in small increments of time is where the future of FP needs to be. As hospitals embrace family and patient centered care, it is more important now than ever to encourage FP and ensure its proper practice.
References


Appendix A: Recruitment Letter

Emergency Department Nurses,

I will be conducting a voluntary research project in conjunction with my requirement for completion of the Masters program at St John Fisher College. My project will assess the beliefs and attitudes towards the practice of allowing a family member(s) to be present during resuscitation efforts and invasive procedures. To do this, I will ask participants to complete a survey, watch a pre-recorded educational video, and then take a post survey. Surveys will be anonymous and will be secured in a locked location after they are turned in. Surveys will take approximately 10 minutes to complete, and the video will take approximately 30 minutes to complete. Participation is voluntary and will not affect performance reviews or employment. Please contact me if you wish to participate. I will then give you the appropriate material and instructions. Thank you for your time,

David Cross, RN, BSN

David_Cross@urmc.rochester.edu
Appendix B: IRB approval

Dear Mr. Cross:

Thank you for submitting your research proposal to the Institutional Review Board.

I am pleased to inform you that the Board has approved your Expedited Review project, “Evaluating Nurses perceptions of family presence during resuscitation efforts and invasive procedures before and after an educational intervention.”

Following federal guidelines, research related records should be maintained in a secure area for three years following the completion of the project at which time they may be destroyed.

Should you have any questions about this process or your responsibilities, please contact me at 385-5262 or by e-mail to emerges@sjfc.edu, or if unable to reach me, please contact the IRB Administrator, Jamie Mosca, at 385-8318, e-mail jmosca@sjfc.edu.

Sincerely,

Eileen M. Merges, Ph.D.

Chair, Institutional Review Board
Appendix C: Survey

Circle the response that most closely represents your attitudes and beliefs about having families at the bedside during a loved one’s resuscitation or invasive procedure: Please note that if this is your post survey, please write NO CHANGE on the narrative answers that did not change from the pre survey.

1. Providing psycho-social-spiritual support to family members is part of my job/practice.
   Strongly Agree Strongly Disagree
   1 2 3 4 5

2. I feel comfortable providing psycho-social-spiritual support to family members during treatment situations.
   Strongly Agree Strongly Disagree
   1 2 3 4 5

3. I feel appropriate psycho-social-spiritual care is provided to patients and their family members when patients are undergoing invasive procedures.
   Strongly Agree Strongly Disagree
   1 2 3 4 5

4. I feel appropriate psycho-social-spiritual care is provided for family members of patients undergoing resuscitations.
   Strongly Agree Strongly Disagree
   1 2 3 4 5

5. I believe family members should have the option to be present during invasive procedures.
   Strongly Agree Strongly Disagree
   1 2 3 4 5
6. I believe family members should have the option to be present during resuscitation situations.

Strongly Agree                      Strongly Disagree

1  2  3  4  5

7. The option of family presence during resuscitation is a patient/family right.

Strongly Agree                      Strongly Disagree

1  2  3  4  5

8. Family presence during resuscitation would interfere with patient care.

Strongly Agree                      Strongly Disagree

1  2  3  4  5

9. Family presence during resuscitation would make the effort more stressful for members of the code team (health care providers responsible for the resuscitation).

Strongly Agree                      Strongly Disagree

1  2  3  4  5

10. Excluding families during resuscitation exposes caregivers to greater risk for litigation.

Strongly Agree                      Strongly Disagree

1  2  3  4  5

11. I support a hospital family presence policy if the situation is appropriate and a designated family presence facilitator is present.

   Yes No

**Health Care Provider Attitudes and Beliefs Toward Family Presence Assessment Survey**

12. Have you participated in a treatment situation in which a family member was present during the performance of:

   Invasive procedures? Yes No
   Resuscitation? Yes No
13. Has your job performance ever been hampered by the presence of a patient’s family members?

Yes  No

If yes, please explain:

________________________________________________________________________________________

14. If your family member was ill or injured, would you (as a health care provider) want the option to be present during

Invasive procedures? Yes  No

Resuscitation? Yes  No

Why?

________________________________________________________________________________________

15. If your family member was ill or injured, do you feel other members of your family (non-health care providers) should have the option to be present during:

Invasive procedures? Yes  No

Resuscitation? Yes  No

Why?

________________________________________________________________________________________

16. If you were critically ill/injured, would you want the option to have your family member present at your bedside?

Yes  No

Why?

________________________________________________________________________________________

17. What do you believe are the system barriers to family presence?

________________________________________________________________________________________

18. List any personal reservations you have about families being present during invasive procedures or resuscitation:

________________________________________________________________________________________

19. Additional comments:
Appendix D: Pod Cast Out Line

- Presenting the Option for Family Presence
- Emergency Nurses Association
- Family Presence
  - Attendance of family in the patient care area
    - Location affords visual or physical contact with the patient during invasive procedures and/or resuscitation events
  - Family is defined by the patient
    - May be related or unrelated to the patient
    - Individuals who provide support
    - Individuals with whom the patient has a significant relationship
- Patient/Family-Centered Care
  - Recognizes the integral role of family in the health and well-being of the patient
  - Evaluates and responds to psycho-social-spiritual needs of the patient and his/her family (in addition to physical needs)
  - Applicable across all age groups, specialties, levels of care, and health care settings
- Principles of Patient/Family-Centered Care
  - Treating patients/families with dignity and respect
  - Communicating complete and unbiased information
  - Integrating patient/family participation and involvement in care and decision making
  - Collaborating among patient, family, and professionals in delivery of care
- Review of the Literature
- Family Needs
- Considerations in Holistic Care
  - All individuals, patients, and nurses are products of some family unit
  - The family will remain a viable way of life for the majority of the population
  - Incorporating the family into care is essential if nurses are to provide high quality, holistic patient care
- Meeting Emotional Needs of Family Members
  - Families object to any process that makes them feel helpless, uninformed, and uninvolved
• Staff/Family Interactions
• Influences coping and family grief responses
• Relationship needs to be established
• Needs of Family Members During Anticipated Losses
  • Be kept informed of loved one’s condition
  • Be aware of loved one’s impending death and be present at the time of death
  • Participate in the care when possible
  • Receive comfort from other family members
  • Receive acceptance, support, and comfort from health care professionals
• Review of the Literature
• Family Presence Facilitation
• “What-If-I-Were-There”: Surveys of Families Who Were Asked Whether They Wanted to Be Present
  • Majority state they “wished they had been present”
  • Majority would have gone into the resuscitation room if given the option
  • Believe family members should be able to be present
  • Would want to be present if their loved one were to likely die
• Research from Actual Family Presence Events:
  Family Member Experiences
  • Want to be offered option
  • Assert it is their right to be present
  • Majority accept the option
  • Nearly all would participate again
  • Were no more distressed (compared to family members who were not present)
• Benefits of Family Presence:
  Family Members
  • Fosters family understanding of loved one’s condition
  • Provides visual and verbal communications of events
  • Supports and meets emotional needs of family
    • Decreases worry and anxiety
    • Removes doubt about what’s happening
Reinforces everything possible was done
Facilitates grieving

- Benefits of Family Presence:
  - Family Members
    - Enhances active family participation
    - Fosters collaborative relationship with health care team
    - Provides sense of closure on lives shared together
    - “What-If-My-Family-Was-There”: Surveys of Patients Who Were Asked Whether They Wanted Their Families Present

Themes from surveys:
- Patients voiced a desire for family to be present
- Family members they wanted included: spouses, parents, children, siblings, and others.
- Research from Actual Family Presence Events: Patient Experiences
  - Patients believed having family there outweighed the risks for their family member
  - Patient themes were similar to those reported by family members:
    - Received comfort from family members
    - Felt more connected to the family
    - Valued knowing family member could act as their advocate
- Benefits of Family Presence: Patients
  - Right to have family members present
  - Reminded the health care team that the patient was a real person
  - No feelings that their privacy or dignity were compromised
- “What-If-We-Tried-It”: Surveys of Health Care Providers

Themes from surveys:
- Less than half favor family presence
- Nurses more likely to support family presence
- Providers support simple procedures; less likely to support as invasiveness increases
- More support if dedicated staff person available
• Research from Actual Family Presence Events: 
  Health Care Provider Experiences

Themes

• Nurses more supportive than physicians
• Majority support the practice during invasive procedures and during resuscitation
• Experience with family presence primary determinant of support
• Benefits of Family Presence 
  for Health Care Providers
• Facilitates communication with families
• Provides an opportunity to educate families about the patient’s condition
• Assists families in understanding that providers did everything they could for the patient
• Reminds staff to consider the patient’s dignity, privacy, and need for pain management
• Provides families with a chance to say goodbye
• Research on Effects of Family Presence on Patient Care Processes 
  and Outcomes
• No evidence that families have interfered with patient care
• Regardless of whether the family was there, majority of providers reported no differences in:
  - Provider performance
  - Times to completion of key components of evaluation and procedures
  - Medical decision making
  - Treatments given to the patient
  - Patient outcomes from procedure or resuscitation

• Professional Organizations
  
• ENA
• AACN (Family Presence Practice Alert, 2004)
• SCCM (Family in Patient-Centered ICU, 2007)
• National Association of Social Workers (1999)
• Emergency Medical Services for Children (2000)
• National Association of Emergency Medical Technicians (2001)
• American Academy of Pediatrics (2006)
• American College of Emergency Physicians (2006)
• National Consensus Conference on Family Presence (JEN, 2006) representing 18 national organizations
• Professional Organization Recommendations
• Offer all families the option of family presence
• Use a multidisciplinary approach including a family presence facilitator
• Develop family presence guidelines/policies
• Implement staff education
• Conduct additional research
• Components of Family Presence Guidelines
  • Philosophy of patient/family-centered care
  • Invasive procedures and resuscitation situation
  • Staff roles and responsibilities
  • Psycho-social-spiritual support for patients and families
  • How decisions are made to initiate family presence
  • Process of family presence facilitation
  • Protocol for supporting family and staff after the event
• Staff Roles and Responsibilities
• Assure support needs of patient/family are evaluated and addressed
• Identify process for obtaining additional support resources
• Core Responsibilities of Family Presence Facilitator
• Guides family through the bedside experience
• Assess patient’s and family’s coping needs and preferences for bedside presence
• Seeks agreement of direct care providers
• Prepares family for experience
• Escorts family to room and facilitates family involvement and presence
• Provides information and support
• Key Aspects of Family Presence Facilitation
• Before Family Presence
• Deciding to Initiate Family Presence: Patient and Family Assessment
• Prior to offering the family presence option, assess families for:
  – their level of coping
absence of combative behavior
their emotional volatility
behaviors consistent with an altered mental status

- Determine the patient’s desire to have the family member present
- Determine the family member’s desire to be present
- Family Presence Facilitation:
  Preparing the Patient and Family
  - Validate patient’s and family’s level of understanding
  - Inform family of the patient’s clinical status
  - Describe sights, sounds, and smells to be encountered and interventions and procedures being performed
  - Repeat previously stated information and provide updates
  - Provide opportunities for questions and clarify details
  - Family Presence Facilitation:
    Preparing to Enter the Room
    - How many family members may enter room at a time
    - Where family members may stand
    - Instruct families that their emotional support is an important part of their role while in the room
    - Because patient care is the priority, families will need to leave the room if they are disruptive
    - Facilitator will explain care and answer their questions
    - Need for personal protective garb and restrictions on cell phones and cameras while in the room.
  - During Family Presence
  - Family Presence Facilitation:
    Family Support Interventions
  
  Family members should never be at the patient’s bedside during resuscitation without an identified family presence facilitator

- After Family Presence
- Supporting Families After the Event: When Death Occurs
  - Inform family about what to expect—what they will see and hear
  - Facilitate family’s viewing of the body
  - Offer family time alone with loved one
  - Provide support
• Let the family know when it is okay to leave
• Provide family information concerning disposition of the body, contact person, and phone number
• Implementing the Family Presence Program
• Implementing a successful family presence program depends on:
  – Consideration of needs and concerns of staff
  – Interdisciplinary involvement
  – Written family presence guidelines/policy
  – Staff education
  – Ongoing follow-up programs and research
• Final Thoughts
• Your perspective is important to the success of this program
• Help us make patient/family-centered care our gold standard
• Based on the evidence, it’s the right thing to do