Family Presence during Cardiopulmonary Resuscitation Survey

Hannah Bayram
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Family Presence during Cardiopulmonary Resuscitation Survey

Abstract

Background: Many studies have shown the benefit of allowing families to be present during cardiopulmonary resuscitation (CPR). However, healthcare providers exhibit concern and hesitation about encouraging families to be at the bedside during cardiopulmonary resuscitation. Purpose: Promote insight concerning the barriers that prevent health care providers from encouraging family presence during CPR. Research question: What are the attitudes of health care providers toward family presence during cardiopulmonary resuscitation (FRDR) and are they more willing to welcome family presence during cardiopulmonary resuscitation if a family support person present is present? Method: A survey was presented to medical intensive care unit staff. Results: A total of 40 Medical Intensive Care staff members participated which consisted of 26 nurses, 4 doctors, 3 patient care technicians, and 7 respiratory care therapists. Eighty percent of nurses, 75% of doctors, 100% of patient care technicians, and 71.5% of the respiratory therapists who participated in this study either strongly agreed or agreed with the questions “I support a hospital family presence policy if the situation is appropriate and a designated family presence facilitator is present.” A significant correlation among two of the survey questions was shown. These questions suggested a moderately strong tendency for people who agreed with FPDR also agreed with a hospital family presence policy if the situation was appropriate and a designated family presence facilitator was present. Conclusion: The findings of this study identified barriers to FPDR, and future research is necessary to make changes to better serve patients and their families while also meeting the needs of health care workers.
Family Presence during Cardiopulmonary Resuscitation Survey

By

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Submitted in partial fulfillment of the requirements for the degree

Master’s in Advanced Practice Nursing

Supervised by Dr. Christine Nelson-Tuttle

Wegmans School of Nursing

St. John Fisher College

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Biosketch of Author

Hannah Bayram earned a bachelor’s of science degree in Psychology and Nursing. She is currently completing her Master’s degree in Nursing from St. John Fisher College. She is completing the Family Nurse Practitioner program. Mrs. Bayram has completed her Essentials of Critical Care Orientation training (ECCO) and has worked as a critical care nurse for four years. Her most recent position as a float nurse has given her exposure to the emergency department, surgical, cardiac and medical intensive care units. She is a faculty member at St. John Fisher College where she teaches nursing clinical. Her previous work experience has allowed her to partake in cardiopulmonary resuscitations. Her interest in this research stems from direct involvement with family presence during cardiopulmonary resuscitation.
Abstract

**Background:** Many studies have shown the benefit of allowing families to be present during cardiopulmonary resuscitation (CPR). However, healthcare providers exhibit concern and hesitation about encouraging families to be at the bedside during cardiopulmonary resuscitation.

**Purpose:** Promote insight concerning the barriers that prevent health care providers from encouraging family presence during CPR. **Research question:** What are the attitudes of health care providers toward family presence during cardiopulmonary resuscitation (FRDR) and are they more willing to welcome family presence during cardiopulmonary resuscitation if a family support person present is present? **Method:** A survey was presented to medical intensive care unit staff. **Results:** A total of 40 Medical Intensive Care staff members participated which consisted of 26 nurses, 4 doctors, 3 patient care technicians, and 7 respiratory care therapists. Eighty percent of nurses, 75% of doctors, 100 % of patient care technicians, and 71.5 % of the respiratory therapists who participated in this study either strongly agreed or agreed with the questions “I support a hospital family presence policy if the situation is appropriate and a designated family presence facilitator is present.” A significant correlation among two of the survey questions was shown. These questions suggested a moderately strong tendency for people who agreed with FPDR also agreed with a hospital family presence policy if the situation was appropriate and a designed family presence facilitator was present. **Conclusion:** The findings of this study identified barriers to FPDR, and future research is necessary to make changes to better serve patients and their families while also meeting the needs of health care workers.
**Key Words**

Key words and phrases that can be used to index this article are: family presence during cardiopulmonary resuscitation, barriers, attitudes, family support person, and patient family centered care.
Introduction

The health care industry is increasingly more aware of and accommodating to the needs of patients and their families. Conceptual frameworks such as the patient-family centered approach are being implemented throughout all areas of health care. Paired with compassion, evidence-based knowledge, and dedication, patients and families are given exceptional care throughout their medical experience. This patient-family centered approach is holistic, treating each patient as an individual and addresses each person’s needs and works closely with the family to facilitate a working relationship. However, there are still situations, especially involving cardiopulmonary resuscitation, where the standard appears to be inconsistent when it comes to patient-family centered care. Despite the vast amount of evidence-based literature that demonstrates the benefits of family presence during resuscitation (FPDR), health care providers are reluctant to allow family members the opportunity to be present during the resuscitation of their loved one allowing them to see that everything possible was done (Lowry, 2012). Not only does allowing the family to be present impact the family; but it also increases nurses’ confidence that they did everything they could during the resuscitation event (Lowry, 2012).

The hesitation of health care providers to allow families the opportunity to be present during resuscitation is important to examine because denying patients and their families the right to be present may compromise the wishes of the patient and the trust built between health care providers and families. Cardiopulmonary resuscitation can lead to a very stressful and hectic environment; therefore, developing a standard that includes FPDR can offer consistency throughout healthcare. Before this can be accomplished, however; understanding the barriers
that are preventing healthcare providers from offering families the opportunity to be present during resuscitation and making efforts to remove those barriers, may increase compliance and lead to the delivery of safe, compassionate care that encompasses the patient and their family. Introducing a family support person into the hectic environment of resuscitation to aid and support the family member by offering comprehensible information, consoling them, and keeping the health care team, the patient, and the family member safe may be one way to remove these barriers. This study examined the impact a family support person has on eliminating barriers that prevent FPDR.

**Background and Significance**

Patient-family centered care does not stop when emergencies arise. Introducing the practice of allowing family presence during cardiopulmonary resuscitation stems from this model and a large body of research has demonstrated it benefits. Research suggests that it helps families cope with the loss of their loved one when given the option to be present during the resuscitation process by reducing post-traumatic stress disorders (Bradford et al, 2005). Not all family members accept the offer to be present, but being given the option to be present and not feeling excluded helps them feel involved (Tinsley et al, 2008). Family members believe it is their right to be given the option (Tinsley et al, 2008). According to the American Heart Association, in 2013 only 29% of adults and 40% of pediatric patients who suffered a cardiac arrest survived in the hospital; therefore, allowing families the chance to be involved is imperative.

Despite research supporting family presence, many hospitals are not implementing it. A variety of barriers exist within the healthcare system that hinder the use of this practice. Most
healthcare providers are supportive of family presence during cardiopulmonary resuscitation but there is a lack of collaborative multidisciplinary guidelines that enforce this practice (Zavotsky et al, 2014). In fact, many hospitals do not have policies and are not enforcing this practice and those that do are not educating their staff and making them aware of this policy (Tomlinson et al, 2010). In addition, facilities that do have policies and intentions to enforce family presence are facing challenges among the healthcare team and do not have a way of addressing the barriers due to a lack of insight and education. A lack of communication between team members, hospital expectations, patient and family expectations, exposure and education has led hospitals to abandon patient-family centered care when patients are being resuscitated.

Both system, and developmental barriers exist in healthcare settings that prevent providers from allowing families to be present during cardiopulmonary resuscitation and invasive procedures. Providers that have not had a significant amount of exposure to cardiopulmonary resuscitation are not comfortable allowing families to be present due to anxiety (Feagan et al, 2011). The fear of making a mistake and appearing incompetent stops them from delivering patient-family centered care (Feagan et al, 2011). Although providers possess positive attitudes about having families present during resuscitation, they do not feel confident enough to have an audience when trying to resuscitate a patient.

Also, fear of family disruption has prevented providers from allowing families to be present (Tomlinson et al, 2010). In the past, hospitals have assigned a support person to help families cope with their emotions and minimize any kind of interference during the resuscitation. Many hospitals have reported fear of interference and do not have a program in place to help support the families. The stress level naturally is elevated for the entire health care team during resuscitation. Many of the barriers leading to the dismissal of families during cardiopulmonary
resuscitation and invasive procedures come from barriers that are rooted in anxiety related to the situation. Addressing these anxieties with education and training can lead facilities to implement this practice by accommodating the needs of the patients, the families and the healthcare team.

**Research Goal**

The purpose of this study was to identify attitudes of health care providers toward FPDR and whether having a family support person promoted willingness to consider the use of FPDR.

**Methodology**

This study was conducted in a medical intensive care unit (MICU) in a hospital in Western New York. The sample consisted of the MICU health care team, including nurses, attending physicians, medical residents, patient care technicians, nurse practitioners, physician assistants and respiratory therapists. Recruitment took place during morning huddle meetings where nurses and patient care technicians discussed unit updates and announcements. The researcher presented the survey to the medical staff (doctors and midlevel providers) prior to the start of the morning rounds. These presentations took place several times in one week. Both day and night staff were present for these meetings and had the opportunity to participate. The survey did not require identifying information to protect confidentiality and consent was implied with participation. Participants were given informational sheets about the study. The researcher left the unit after asking participants to return surveys to a sealed purple box placed outside of the clinical nursing educator’s office on the unit. Data was collected on multiple days to ensure a greater number of participants. The study was approved by the Institutional Review Board of the hospital and college where the researcher was a graduate student.
This quantitative study used an established survey with permission from the authors that was originally developed by the Emergency Nurses Association (ENA) titled “Health Care Professional Attitudes and Beliefs toward Family Presence Assessment Survey” (Guzzetta, Clark & Halm, 2007). The survey examines the beliefs and attitudes of health care professionals towards FP, prior experience with FP, perceived barriers and benefits of FP, and perceptions towards policies and procedures regarding FP. Questions regarding family presence during invasive procedures were removed from the survey. Respondents were asked to answer 15 questions: 9 questions used a five-point Likert scale, 5 questions required a “yes” or “no” response, and one question asking participants to indicate what role they were in.

**Results**

A total of 40 Medical Intensive Care staff members participated which consisted of 26 nurses, 4 doctors, 3 patient care technicians, and 7 respiratory care therapists. A significant correlation among two of the survey questions was identified. These questions suggested a moderately strong tendency for people who agree with FPDR to also agree with a hospital family presence policy if the situation was appropriate and a designated family presence facilitator was present.

The Pearson Chi-Square test demonstrated that 96.2% of nurses and 75% of doctors either strongly agreed or agreed that providing psycho-social spiritual support to family members was part of their job. Furthermore, 92.3% of nurses, 75% of doctors, 100% of patient care technicians, and 57.2% respiratory care therapists believed family members should have the option to be present during resuscitation. (See Table 1).
A Pearson Chi-Square test showed that 80.7% of nurses, 75% of doctors, 100% of patient care technicians, and 71.5% of the respiratory therapist who participated in this study either strongly agreed or agreed with the question “I support a hospital family presence policy if the situation is appropriate and a designated family presence facilitator is present.” (See Table 2).
The majority of the participants who participated in this study support having family presence during cardiopulmonary resuscitation if a family support person was available. The remaining questions in the survey did not show any significance.

**Discussion**

The main finding of this study was that most health care providers supported family presence during resuscitation when it was appropriate and a designated family support person
was available. This suggests that if a family support person role was developed and implemented, health care providers might be more willing to encourage families to be present. These findings can be utilized to initiate a family support position for family members during cardiopulmonary resuscitation. This study looked at attitudes toward a family support person in four different health care professional roles and identified barriers toward FPDR.

Previous studies have also identified that most healthcare providers are supportive of family presence during cardiopulmonary resuscitation (Zavotsky et al, 2014). However, in this study it was identified that providers are even more willing to implement FPDR if a family support person is available. Furthermore, a positive correlation was identified among those who supported FPDR and felt having a family supportive is needed. This suggests that having a family support person present might eliminate barriers that prevent healthcare providers from supporting and encouraging FPDR.

Previous studies have identified that healthcare providers fear the disruption family members might cause by being present during cardiopulmonary resuscitation (Feagan et al, 2011). In this study, a family support person was introduced to healthcare providers and was well supported. Therefore, utilizing a family support person may eliminate such fears and eliminate barriers to FPDR.

Previous studies have demonstrated that policies around the practice of FPDR are not well established and implemented in hospital settings (Tomlinson et al, 2010). This study demonstrated that healthcare providers supported FPDR if the situation was appropriate and a designated family support person was present. This suggests that establishing a policy for a
family support person that is supported by healthcare providers, might result in a favorable outcome for the development and implementation of policies related to FPDR.

**Study Limitations**

The limitations of this study included only investigating one critical care unit in one hospital in upstate New York. The data collection occurred over one week. This excluded any participants who may not have been at work the week of data collection and reduced the number of participants. The study had a small sample size and the majority of participants were nurses with few participants from other professions.

**Conclusion**

This study added to the research involving having family support person available during cardiopulmonary resuscitation and reinforced the need for policy modification. The next step is to develop a family support person role and implement education, training and policies for the use of a family support person during FDRP.

**Protection of Human Subjects**

This project was approved by the Institutional Review Board at St. John Fisher College. There are no known risks if you decide to participate in this research study. No identifying information will be collected from participants to assure anonymity and confidentiality. Consent will be assumed with participation but every participant will be given an information sheet. Participants are free to decline to answer any particular question they do not wish to answer for any reason. Current and future employment opportunities won’t be impacted by participation in this project.
Informational Letter

You are invited to participate in a research study about exploring attitudes concerning family presence during cardiopulmonary resuscitation and the impact family presence has on willingness to allow family to be present during resuscitation. This study is being conducted by Hannah Bayram, a Graduate Nursing Student completing a Capstone project at the Graduate Nursing Department at Saint John Fisher College.

You were selected as a possible participant in this study because you work in the two areas that will be examined; the medical intensive care unit.

There are no known risks if you decide to participate in this research study. There are no costs to you for participating in the study. Each questionnaire will take about 5 minutes to complete. The information collected may not benefit you directly, but the information learned in this study should provide more general benefits.

This survey is anonymous and will conducted using a paper survey. No one will be able to identify you or your answers, and no one will know whether or not you participated in the study. Individuals from the Institutional Review Board may inspect these records. Should the data be published, no individual information will be disclosed.

Your participation in this study is voluntary. By completing the survey, you are voluntarily agreeing to participate. You are free to decline to answer any particular question you do not wish to answer for any reason. Current and future employment opportunities won’t be impacted by participation.

If you have any questions about the study, please contact Hannah Bayram at hbayram@sjfc.edu
The St John Fisher College and RRH Review Board has reviewed my request to conduct this project and have approved it. If you have any concerns about your rights in this study, please contact the Saint John Fisher IRB at irb@sjfc.edu.
References


“Why Stop Now?”

By Hannah Bayram, RN, BSN
Introduction

• “The family is able to see evolving events and loved one’s condition change over time, and is able to validate efforts to save the life of their loved one” (Lowry, 2012).
Research Overview

- Tinsley et al 2008
- Tomlinson et al, 2010
Purpose Statement

The purpose of this study is to examine the attitudes of healthcare providers concerning FPDR and whether a family support person available during resuscitation would increase the professional’s willingness to allow FPDR.
Methodology

FPDR attitudes survey given to measure the current views of the health care team and willingness to allow FPDR. In a medical intensive care unit.
Results

What is the profession of the respondent?
Results

Bar Chart

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

- Strongly agree
- Agree
- Neutral
- Disagree
- Strongly disagree

What is the profession of the respondent?
Discussion & Implications

- Identifies barriers to FPDR
- Having a family support person may lead health care providers to be more welcoming of families to the bedside during cardiopulmonary resuscitation.
- Developing a family support person who is able to determine if the situation is appropriate to give the family an option to be present at the bedside.
- Having a family support person may reduce the barriers related to fear of family disruption
- Having a family support person policy may promote FPDR
Limitations

• Only investigating one critical care unit in one hospital.
• The data collection occurred over one week.
• Limited number of participants
Dissemination Plans

- Survey results will be disseminated to Rochester Regional Research department and the managers and staff of the medical intensive care units via email and potentially present findings during nurse’s week poster presentation at Rochester General Hospital.
References


**Literature Review**

*Inviting Family to be Present During Cardiopulmonary Resuscitation: Impact of Education*

<table>
<thead>
<tr>
<th>Author/Date/Citation</th>
<th>Purpose</th>
<th>Design &amp; Year Data Collected</th>
<th>Sample Characteristic &amp; # of subjects</th>
<th>Data Collection &amp; Analysis Method</th>
<th>Results</th>
<th>Implications</th>
<th>Strength &amp; Weaknesses</th>
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<tbody>
<tr>
<td>Dwyer, T. &amp; Friel D. (2016). Inviting family to be present during cardiopulmonary resuscitation: Impact of education. <em>Elsevier, Journal of Nurse Education in Practice</em> (16) 274-279.</td>
<td>Explore the influence of education on changing health care provider (HCP) attitudes and intent to provide families with the option to be present during cardiopulmonary resuscitation.</td>
<td>Quantitative, exploratory, quasi-experimental design that utilized survey methodology. The data was collected in 2015.</td>
<td>A purposive sample of 29 health care providers including nurses and doctors from an acute care teaching hospital in Australia. This hospital also had an emergency medical team (MET) who participated in this study. This hospital did not have a policy in place to allow family presence during cardiopulmonary resuscitation.</td>
<td>The developed survey was used in an earlier study of 100 registered nurses (Dwyer, 2007) and consisted of closed and open ended items. The items included attitudinal questions and included a five point Likert type scale. Data Analysis was done using SPSS paired t-test with Bonferroni correction.</td>
<td>The majority of participants had previous experience with family presence during cardiopulmonary resuscitation (62%) and supported family presence (69%). Participants had slightly more positive attitudes towards family presence post education was implemented but was not significant.</td>
<td>The results imply that self-directed education packets did not change the attitudes of HCP in the hospital setting. The scores of participants pre- and post-education were not significantly different therefore this implies study material about family presence isn’t what changes the attitudes of providers. The survey did show that the majority of providers would like a designated</td>
<td>Strengths involved the design of the study. This study utilized and pre- and post-education test as well as a self-education packet that was disbursed to 200 people in a teaching hospital. It examined not only attitudes towards family presence during cardiopulmonary resuscitation but also focused on elements that were reported to be barriers that were preventing</td>
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family representative present during cardiopulmonary resuscitation that can help the family members understand and cope with the resuscitation, prevent the family members from interfering. In order to make changes in the attitudes of HCP around this topic, different approaches may be necessary such as offering more support to family and providers because based on these findings self-directed education does not have a significant impact on changing attitudes of providers.

Weaknesses including the limited sample size, one single hospital and the education implemented was only self-directed and not interactive. Also, the majority of the providers that did participate in this study were experienced and also had positive attitudes about family presence.

providers from welcoming families. This allows researchers an opportunity to identify and explore other areas that, if manipulated, can yield positive attitudes.
<table>
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<th>Author/Date</th>
<th>Purpose</th>
<th>Design</th>
<th>Sample</th>
<th>Operational Definitions</th>
<th>Data Collection Method</th>
<th>Design Limitation</th>
<th>Findings</th>
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<td>Dalio et al, 2008</td>
<td>Examine differences in perceptions of nurses who have and who have not invited families during resuscitation and also to investigate demographic variables and perceptions of nurses’ self-confidence and how it relates to their perception of the risks and benefits related family presence.</td>
<td>Exploratory cross-sectional design</td>
<td>375 registered nurses and licensed practical nurses employed at Ball Memorial Hospital in Muncie, Indiana.</td>
<td>Family presence: Whether or not the family members were offered to be present by nurse during resuscitation. Risk-Factors: RN’s perceived risks such as, administering medications and difficulty performing duties while family is present. Responses were rated using the Likert Scale. Confidence: RN’s level of comfort in carrying out his/her role in the presence of family members.</td>
<td>Two surveys: The Family Presence Risk-Benefit Scale (FPR-BS) The Family Presence Self-confidence Scale (FPS-CS) Both of these scales were designed by the researchers and are not a tool utilized by other studies. The likert scale was used</td>
<td>Cross-sectional design</td>
<td>Nurses who encouraged/invite family presence during resuscitation were significantly more self-confident in managing the resuscitation and perceived more benefits and fewer risks. Perceptions of more benefits and fewer risks were related to RN’s membership in professional organizations, professional certification, and working in an emergency department.</td>
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<td>Duran et al, 2007</td>
<td>To describe and compare the beliefs about and attitudes toward family presence during cardio pulmonary resuscitation of clinicians, patients’ families, and patients.</td>
<td>Quantitative, exploratory, descriptive study that utilized survey methodology</td>
<td>Clinicians, patients’ families, and patients in the emergency department and adult and neonatal intensive care units of a 300-bed urban academic hospital were surveyed. This team included a multidisciplinary group involving nursing, medical providers, pharmacist, technologist, chaplain, patient care technician, and respiratory therapist.</td>
<td>“Family presence” defined as the presence of patients’ family members during resuscitation and/or invasive procedures. An “invasive procedure” was defined as a procedure involving penetration or breaks the skin or enters a body cavity.</td>
<td>The surveys used in the study were adapted, with permission, from the family presence study completed at Parkland Health and Hospital System, Dallas, Tex. The original Parkland survey was written in an interview format with items scored on a 4-point Likert scale. Open-ended questions were used to collect quantitative and qualitative data.</td>
<td>The survey instrument used was reliable and valid. The response rate of healthcare providers was low, and qualitative data from families and patients were minimal. The study may have non-respondent bias because of the length of the survey and/or because only those who were interested in the subject completed the survey. The study also lacks external validity as the sample was limited to one hospital.</td>
<td>Healthcare providers, patients’ families, and patients have positive attitudes toward family presence and nurses have a more favorable attitude toward family presence than do physicians. Non-attending physicians had a more favorable attitude toward family presence than did attending physicians. Emergency department nurses had more positive attitudes toward family presence than did adult ICU nurses.</td>
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<td>Ganz et al, 2012</td>
<td>The objective of the study is to determine the attitudes of nurses toward FCC (family centered care) and FPDR (family presence during resuscitation) and whether there is an association between FCC and FPDR.</td>
<td>Quantitative, exploratory, descriptive study that utilized survey methodology</td>
<td>A convenience sample of 96 intensive care unit and cardiovascular registered nurses</td>
<td>“Family presence” defined as the presence of patients’ family members during resuscitation, which was described as CPR.</td>
<td>The study utilized 5 questionnaires: a demographic data, one related to attitudes toward FCC (Nursing Activities for Communication with Families) previous used in other studies. The Barriers to Providing Family-Centered Care-Revised), and attitudes related to FPDR (Nurses’ Experiences of Family Witnessed Resuscitation).</td>
<td>This study used a convenience sample in only 2 medical centers in 1 country. One of the questionnaires used in the study had to be altered to reach an appropriate level of reliability, therefore possibly putting into question both the reliability and validity of the questionnaire for this sample.</td>
<td>The higher the perception of barriers (negatively scored), the higher the negative perception of FPDR.</td>
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<td>Tinsley et al, 2008</td>
<td>This study aimed to determine parents' perception of the effects of their presence during the resuscitation efforts of their child and whether they would recommend the experience to other families. Examines the barriers that stop families from being present.</td>
<td>Quantitative, exploratory, descriptive study that utilized survey methodology</td>
<td>This study included parents or guardians of children who underwent cardiopulmonary resuscitation in the pediatric intensive care unit and died at least 6 months before the interview. 41 interviews were conducted.</td>
<td>“Presence” group consisted of “parents who witnessed both the CPR and the death of their child at the end of the resuscitation.” “Not present” where those who did not witness the resuscitation and came to the bedside after the interventions were completed and patient had passed.</td>
<td>A survey questionnaire was completed. The interviewees answered whether they were asked to be present, whether they had physical contact with their child, and whether the experience frightened them or gave them and their child comfort. The interviewees were asked to express their feelings about what was helpful to them and improve the experience</td>
<td>This study lacked external validity due to the small sample size.</td>
<td>The findings support family presence during cardiopulmonary resuscitation. The majority of parents who had been present and those who had not been present believed that all families should be given the option to be present. A barrier that existed for families was the fear of seeing the resuscitation.</td>
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<td>Tomlinson et al.,</td>
<td>The purpose of this study was to evaluate the attitudes of registered</td>
<td>Quantitative, exploratory, descriptive</td>
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<td>2010</td>
<td>nurses and staff regarding family presence during cardiopulmonary</td>
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<td>nurse practitioners, LPNs, physicians, physician assistants, and</td>
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<td>resuscitation in the emergency department (ED).</td>
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<td>The definition of <em>family presence</em>: “the attendance of one or more</td>
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<td>family members or significant others in a location that affords visual</td>
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<td>The term <em>resuscitation</em> can encompass a variety of activities</td>
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<td>intended to revive and stabilize the life and health of the patient.</td>
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<td>In this study, <em>resuscitation</em> is limited to CPR, commonly called a</td>
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<td>“code” by members of the healthcare team.</td>
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<td>Family Presence During Cardiopulmonary Resuscitation</td>
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<td>Survey by email, flyers, and verbal request by members of the</td>
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<td>The sample analyzed was strictly emergency room nurses and</td>
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<td>involved only one hospital (low external validity).</td>
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<td>It was not determined in the survey whether these practices were</td>
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<td>predominately for children or adults.</td>
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<td>Most respondents reported increased stress with family presence (n = 38,</td>
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<td>48%), whereas 36 (46%) did not perceive extra stress; 6% were unsure.</td>
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<td>Zavotsky et al, 2014</td>
<td>To describe the multidisciplinary care provider's understanding and perceived barriers of family presence during CPR in an academic medical center.</td>
<td>Quantitative, exploratory, descriptive study that utilized survey methodology</td>
<td>588 employees who were eligible to complete the survey. In order to be eligible they had to be a part of the hospital’s code team. This team included a multidisciplinary group involving nursing, medical providers, pharmacist, technologist, chaplain, patient care technician, and respiratory therapist.</td>
<td>Code team was defined as, “blue code team” (adult resuscitation team) and the “white code team” (neonatal and pediatric). “Resuscitation” was defined as “artificial cardiac and respiratory support for a person who has a pulse or respiration.”</td>
<td>RWJUH Family Presence During Cardiopulmonary Resuscitation (CPR) Survey by email, flyers, and verbal request by members of the research team.</td>
<td>Nonprobability sampling method and small group size. Study was restricted to one institution, which limits generalization of results and therefore external validity.</td>
<td>Suggest that team members have generally positive attitude and beliefs related to family presence. General agreement that psychological/emotional support to family members is a component of their job/practice. The amount of responses were not equally distributed throughout the disciplines who participated in the codes. Security, for example, did not provide as much input as nurses and therefore they study did not clearly examine all participants. 80% of participants were not aware of the institutions policy on family presence during resuscitation, methods for incorporating family members into the code process, and interventions to support the psychosocial needs of the family members. Certain disciples were clearly against the presence of families (security members).</td>
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Literature Review

*A Study of Turkish Critical Care Nurses’ Perspective Regarding Family-Witnessed Resuscitation*

<table>
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<tr>
<th>Author/Date/Citation</th>
<th>Purpose</th>
<th>Design &amp; Year Data Collected</th>
<th>Sample Characteristic &amp; # of subjects</th>
<th>Data Collection &amp; Analysis Method</th>
<th>Results</th>
<th>Implications</th>
<th>Strength &amp; Weaknesses</th>
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<tbody>
<tr>
<td>Yapucu, U. &amp; Zaybak A. (2009). A study of Turkish critical care nurses’ perspective regarding family-witnessed resuscitation. <em>Journal of Clinical Nursing</em>, 18, 2907-2915.</td>
<td>Explore the influence of education on changing health care provider (HCP) attitudes and intent to provide families with the option to be present during cardiopulmonary resuscitation.</td>
<td>Quantitative, exploratory, quasi-experimental design that utilized survey methodology. The data was collected in 2015.</td>
<td>A purposive sample of 29 health care providers including nurses and doctors from an acute care teaching hospital in Australia. This hospital also had an emergency medical team (MET) who participated in this study. This hospital did not have a policy in place to allow family presence during cardiopulmonary resuscitation.</td>
<td>The developed survey was used in an earlier study of 100 registered nurses (Dwyer, 2007) and consisted of closed and open ended items. The items included attitudinal questions and included a five point Likert type scale. Data Analysis was done using SPSS paired t-test with Bonferroni correction.</td>
<td>The majority of participants had previous experience with family presence during cardiopulmonary resuscitation (62%) and supported family presence (69%). Participants had slightly more positive attitudes towards family presence post education was implemented but was not significant. The results imply that self-directed education packets did not change the attitudes of HCP in the hospital setting. The scores of participants pre- and post-education were not significantly different therefore this implies study material about family presence isn’t what changes the attitudes of providers. The survey did show that the majority of providers would like a designated</td>
<td>Strengths involved the design of the study. This study utilized and pre- and post-education test as well as a self-education packet that was disbursed to 200 people in a teaching hospital. It examined not only attitudes towards family presence during cardiopulmonary resuscitation but also focused on elements that were reported to be barriers that were preventing</td>
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family representative present during cardiopulmonary resuscitation that can help the family members understand and cope with the resuscitation, prevent the family members from interfering. In order to make changes in the attitudes of HCP around this topic, different approaches may be necessary such as offering more support to family and providers because based on these findings self-directed education does not have a significant impact on changing attitudes of providers.

providers from welcoming families. This allows researchers an opportunity to identify and explore other areas that, if manipulated, can yield positive attitudes.

Weaknesses including the limited sample size, one single hospital and the education implemented was only self-directed and not interactive. Also, the majority of the providers that did participate in this study were experienced and also had positive attitudes about family presence.
### Literature Review

#### Policies Allowing Family Presence during Resuscitation and Patterns of Care during In-Hospital Cardiac Arrest

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<tr>
<td>Goldberger, Z.D; Nallamothu, B.K; Nichol G., Chan, P.S., Curtis, R., Cooke, C. (2015). Policies Allowing Family Presence during Resuscitation and Patterns of Care during In-Hospital Cardiac Arrest. <em>Journal of Cardiovascular Quality &amp; Outcomes, 8</em>(3), 226-234.</td>
<td>Examined the impact family presence during cardiac resuscitation (FPDR) has on overall patient safety, quality of care, resuscitation efficacy and outcomes.</td>
<td>Quantitative, exploratory, observational cohort study. The data was collected in 2007-2010.</td>
<td>Total of 41,568 adult patients who suffered a cardiac arrest and required resuscitation from 252 different hospitals in the United States. The patients were selected from hospitals with and without FPDR policies.</td>
<td>Data was collected from the National Registry of Cardiopulmonary Resuscitation (NRCPR) &amp; the American Heart Association’s (AHA) captured in-hospital cardiac arrests reports across the United States. The registry provided precise information about outcomes, FPDR, and interventions.</td>
<td>There were no significant differences in facility characteristics between hospitals with and without an FPDR policy.</td>
<td>Due to the fact that no significant difference in care and outcome existed between hospitals that have FPDR policies compared to those that do not, this can imply that FPDR does not have negative impacts on care and safety.</td>
<td>A major strength of this study is the large number of cases that were examined throughout many hospitals across the United states. The use of data collected from the NRCPR eliminates data collection bias. It is also required that hospitals report data accurately according to set standards. Many different conditions...</td>
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models were used to evaluate patterns of care at hospitals with and without an FPDR policy. A significant decrease in the average time to defibrillation at hospitals with an FPDR policy compared with hospitals without the policy was found. The slight increase in time to defibrillate needs to be further studies. However, it could imply that a disruptive occurred initially as a result of shock on the family’s behalf.

were eliminated when filtering through samples. The involvement of the family during resuscitation was not mentioned. Examining this variable will allow researchers the ability to compare outcomes and errors in care with disruptive family members compared to those who are perhaps supported by a family support representative and less disruptive.
## Literature Review

**The Impact of Education on Providers Attitudes Toward Family-Witnessed Resuscitation**

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<tr>
<td>Feagan, L. M., &amp; Fisher, N. J. (2011). The Impact of Education on Provider Attitudes Toward Family-Witnessed Resuscitation. JEN: Journal Of Emergency Nursing, 37(3), 231-239.</td>
<td>To evaluate trends in provider attitudes toward offering the option of family presence during resuscitation. This information would be used to develop an educational program aimed toward addressing common concerns among acute care physicians and nurses. To test the effect of an educational program that used evidence-based information to improve clinician acceptance</td>
<td>Quantitative, exploratory, descriptive study that utilized survey methodology</td>
<td>This 2-phase, before/after study was conducted in a 388-bed academic trauma center, and in a 143-bed community hospital in eastern Washington State. Surveys were distributed to 55 physicians and 465 nurses in both facilities.</td>
<td>“Family presence” defined as the presence of patients’ family members during resuscitation, which was described as CPR.</td>
<td>The surveys used in the study were adapted, with permission, from the Emergency Nurses Association. An additional survey was used to collect demographic information.</td>
<td>The study was limited to examination of the impact of education on clinician subgroups; therefore a change in study methodology to examine the impact of family presence education on individual clinicians’ attitudes was not examined. Data on cultural, ethnic, and spiritual variability of subjects were not measured. These variables could be significant.</td>
<td>Results of this study show that the more experience providers have with CPR, the more likely they are to also support family presence. This is shown by the higher numbers of Family presence experience. Clinicians working in emergency and critical care settings are an example of this. The findings also show a correlation between nurses and physicians</td>
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in some geographic areas and may provide useful information about how personal beliefs and values affect pre- and post-education acceptance. With prior family presence experiences and their support of the family presence education, prior to education was also shown to be a significant determinant in support of family presence in each group. Understanding the benefit of family presence through either direct experience or didactic understanding seems to be the key in improving acceptance of family presence in the acute care setting.
Implications

The findings of this study suggest that exposing health care providers to situations involving CPR generally make them more accepting to having families present during resuscitation. This can imply that the more comfortable the providers feel the more likely they are to support family presence.

Education involving the benefits of family presence improved the attitudes of providers to having families present during resuscitation. This implies through education, changes can be made to help providers facilitate more family presence during resuscitation.
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<tr>
<td>Ganz, F. D., &amp; Yoffe, F. (2012). Intensive care nurses' perspectives of family-centered care and their attitudes toward family presence during resuscitation. <em>Journal of Cardiovascular Nursing</em>, 27(3), 220-227.</td>
<td>The objective of the study is to determine the attitudes of nurses toward FCC (family centered care) and FPDR (family presence during resuscitation) and whether there is an association between FCC and FPDR.</td>
<td>Quantitative, exploratory, descriptive study that utilized survey methodology</td>
<td>A convenience sample of 96 Israeli intensive care unit and cardiovascular registered nurses</td>
<td>“Family presence” defined as the presence of patients’ family members during resuscitation, which was described as CPR.</td>
<td>The study utilized 5 questionnaires: a demographic data, one related to attitudes toward FCC (Nursing Activities for Communication with Families) previous used in other studies. The Barriers to Providing Family-Centered Care-Revised), and attitudes related to FPDR (Nurses' Experiences of Family Witnessed Resuscitation)</td>
<td>This study used a convenience sample in only 2 medical centers in 1 country. One of the questionnaires used in the study had to be altered to reach an appropriate level of reliability, therefore possibly putting into question both the reliability and validity of the questionnaire for this sample.</td>
<td>The higher the perception of barriers (negatively scored), the higher the negative perception of FPDR.</td>
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The demographic questionnaire contained questions related to age, gender, religion and religiosity external validity in the United States.
Implications

These findings imply that providers who see barriers to providing patient family centered care tend to view family presence during resuscitation negatively. Assisting in eliminating the barriers to providing patient family centered care will help providers accept the presence of families during resuscitation.

Further investigating the barriers and eliminating them can potentially lead to better quality care for the patients and the families.
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<tr>
<td>Bradford, K., Kost, S., Selbst, S., Renwick, A., &amp; Pratt, A. (2005).</td>
<td>To describe resident acceptance of and comfort with family member presence (FMP) during pediatric invasive procedures and resuscitation in a large, multicenter pediatric residency program. To determine if increased level of training impacts on opinion toward FMP for procedures.</td>
<td>Quantitative, exploratory, descriptive study that utilized survey methodology</td>
<td>Seventy-six residents of postgraduate levels who have the opportunity to perform CPR in the emergency department, work in general pediatric ward procedure rooms; the Neonatal Intensive Care Unit; and the Pediatric Intensive Care Unit of 3 hospitals, including a freestanding children's hospital, a large community hospital, and an academic university-based hospital.</td>
<td>“Family presence” defined as the presence of patients’ family members during resuscitation and/or invasive procedures.</td>
<td>The surveys used in the study consisted of 4 Likert-scale questions and 1 multiple-choice question of resident acceptance of and comfort with family presence during procedures and cardiopulmonary resuscitation (CPR).</td>
<td>Surveys were not anonymous. The survey was sent electronically and was returned electronically or printed and returned to the pediatric residency office.</td>
<td>This study showed that pediatric and medicine-pediatrics residents accepted family presence for procedures but do not favor it for CPR. Residents indicated that their 2 major reservations about FMP were that their anxiety may cause them to fail at the procedure or resuscitation or that they may appear inexperienced or unknowledgeable.</td>
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Implications

The findings of this study suggest that performance anxiety is a major barrier for residents during CPR. Residents did not exhibit as much anxiety about family presence during procedures. What this could imply is that increasing family presence during procedures may allow residents to overcome their performance anxiety.

Making efforts to decrease anxiety during CPR could help residents be more welcoming of family presence allow them to perform their responsibilities comfortably and safely.
Literature Review

*Experience of families during cardiopulmonary resuscitation in a pediatric intensive care unit*

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<tr>
<td>Tinsley, C., Hill, J., Shah, J., Zimmerman, G., Wilson, M., Freier, K., &amp; Abd-Allah, S. (2008). Experience of families during cardiopulmonary resuscitation in a pediatric intensive care unit. <em>Pediatrics</em>, 122(4), 799-804.</td>
<td>This study aimed to determine parents' perception of the effects of their presence during the resuscitation efforts of their child and whether they would recommend the experience to other families. Examines the barriers that stop families from being present.</td>
<td>Quantitative, exploratory, descriptive study that utilized survey methodology</td>
<td>This study included parents or guardians of children who underwent cardiopulmonary resuscitation in the pediatric intensive care unit and died at least 6 months before the interview. 41 interviews were conducted.</td>
<td>“Presence” group consisted of “parents who witnessed both the CPR and the death of their child at the end of the resuscitation. “Not present” where those who did not witness the resuscitation and came to the bedside after the interventions were completed and patient had passed.</td>
<td>A survey questionnaire was completed. The interviewees answered whether they were asked to be present, whether they had physical contact with their child, and whether the experience frightened them or gave them and their child comfort. The interviewees were asked to express their feelings about what was helpful to them and improve the experience.</td>
<td>This study lacked external validity due to the small sample size. The parents that were interviewed were limited to those who lost their child. The perception of those parents who witnessed their child’s resuscitation and survived it was not included.</td>
<td>The findings support family presence during cardiopulmonary resuscitation. The majority of parents who had been present and those who had not been present believed that all families should be given the option to be present. A barrier that existed for families was the fear of seeing the resuscitation.</td>
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Implications

The findings of this study suggests that all families would want to be given the opportunity to be present during the resuscitation of their child. Thus, it is important for the health system to accommodate this in the most safe way possible.

Addressing the fear and anxiety families have about being present could remove the barrier that stops families from being present for their child. Offering education regarding what to expect during resuscitation and preparing families could help support them through this fearful experience and potentially help them cope with their loss.