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## Geriatric Nursing

journal homepage: [www.gnjournal.com](http://www.gnjournal.com)

GAPNA Section

## Family presence during resuscitation: Updated review and clinical pearls

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## ARTICLE INFO

## Article history:

Available online 14 November 2019

## Keywords:

Family presence during resuscitation  
End of life  
Family presence  
Family  
Cardiac arrest

## ABSTRACT

There is mounting evidence that Family Presence During Resuscitation (FPDR) can benefit family members who wish to observe the resuscitation efforts of a loved one. Given that older patients have poor resuscitation outcomes, presence of a family advocate could add value to the process of end of life decision making. A review of the current literature from the perspectives of patients, families, and health-care providers will help in reassessing family involvement during resuscitation and developing best practices for health care facilities.

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## Introduction

Cardiac resuscitation is fast-paced, physical, intense, and often emotional for both health care professionals and observers. Onlookers are often rushed out of eyesight for fear of both immediate and long-term consequences to the family, the patient, and the health care team.<sup>1</sup> Many times, health care professionals are concerned that families would be traumatized by witnessing Advanced Cardiac Life Support (ACLS) or demand futile treatment during what may be the end of their loved one's life. However, research has shown that family presence does not worsen resuscitation outcomes and can improve outcomes for family members. Family Presence During Resuscitation (FPDR) is especially relevant for elderly patients who have lower survival rates after cardiac resuscitation and who have shown to generally receive less aggressive treatment.<sup>2</sup> Family advocacy before and during resuscitation can be pivotal in helping clinicians provide benevolent and holistic care at the end of life.

Despite endorsement of the use of facility guidelines for FPDR by many health care professional organizations<sup>3–5</sup> and evidence of decreased Post Traumatic Stress Disorder (PTSD) rates in family members who observe,<sup>6–8</sup> there is great variability in FPDR implementation. The American Association of Critical Care Nurses, the Emergency Nurses Association, and the American Heart Association support giving family members the option to be present at the bedside during resuscitation, if deemed appropriate and safe by staff,<sup>3–5</sup> however the topic remains controversial amongst practitioners.<sup>9</sup> It is

crucial for health care providers to review evidence and engage in discussions about the experience so that they can approach this pivotal moment in our patient's lives with an understanding of best practice (Table 1). This manuscript will discuss FPDR from the perspective of family members, the patient, and health care providers. It will also examine the significant role of family facilitator.

## Interprofessional healthcare team

While research has shown positive outcomes related to patient and family perception of FPDR, there is great variation in health-care professionals' clinical practice. The quality most predictive of a clinician's favorable attitude towards FPDR is previous experience with it.<sup>3</sup> There is variation in opinion towards FPDR between disciplines with nurses tending to be more supportive than physicians.<sup>9,10</sup> The literature demonstrates that those who approve of family presence believe that it facilitates understanding and conviction that everything that could have been done to help the patient was actually done, thereby reducing emotional distress in days to come.<sup>8</sup> In the case of an unsuccessful resuscitation, health professionals report that FPDR enhanced communication, humanized the patient, provided dignity, and supported the grieving process.<sup>9–11</sup> Another expected benefit is the facilitation of the family's decision-making regarding the goals of the resuscitative efforts,<sup>3,11</sup> although this has not yet been studied.

Conversely, reluctance to adopt FPDR is frequently centered around concerns that family members would misunderstand ACLS protocols, interfere with the resuscitation process and increase likelihood of litigation due to misinterpretation of procedures.<sup>3,11</sup> The experience of

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**Table 1**  
Best practice pearls.

| Practice pearls  |
|--|
| Discuss FPDR best practice at your institution   |
| Create and publish a guideline for your area of practice   |
| Consider developing formal training for the family facilitator role                                    |
| Offer the option of FPDR to family when safe to do so  |
| Include family variables in code/emergency response debriefings to facilitate education and reflection |

watching a resuscitation may be traumatizing and some providers use this argument to deny family members the choice to be present. In a survey of 592 health-care professionals, 79% cited this point as the primary reason for not allowing families to be present at the resuscitation.<sup>12</sup> Health care professionals without FPDR experience may be distracted by this and find it difficult to work effectively in the presence of a frightened, grieving family, and many professionals have reported performance anxiety as a reason for disallowing FPDR.<sup>13,14</sup> Notably, there is no data to support that family presence worsens the overall quality of resuscitative efforts.<sup>7,15</sup>

## Family

Overall, family members have been shown to be supportive of FPDR and feel that they should be offered the option to observe by the medical team.<sup>16,17</sup> In fact, relatives who were not able to witness CPR on a loved one experienced symptoms of anxiety and depression more frequently than those who were present.<sup>8</sup> In a landmark study where 570 patients were randomized to either participate in FPDR or standard care, there were zero occurrences of family interference or medicolegal conflict.<sup>7</sup> Furthermore, families randomized to have the option of presence showed a significant reduction in the rates of PTSD, a reduction in anxiety and depression scores 90 days after the event, and less complicated grieving 1 year afterwards.<sup>8</sup>

Many family members have reported feeling a sense of helpfulness and eased grieving after witnessing a resuscitation resulting in patient death.<sup>17</sup> In the outpatient setting, family caregivers have reported a desire to observe the resuscitation not only because they were the ones to initiate ACLS, but also to communicate medical information to the care team.<sup>19</sup> In the same study, family who did not choose to witness resuscitation did so for reasons such as wanting to protect themselves from the disturbing scene and 'not being ready to say goodbye'.<sup>19</sup> Offering family members the choice to be present during CPR contributes to a sense of agency felt by observers.<sup>19</sup> Given these reported benefits, it is imperative that healthcare team members prioritize offering the choice of family presence to improve family member experiences and outcomes.

## Patients

There is a paucity of literature on FPDR from a patient perspective, due to the generally low survival rates of those undergoing resuscitation,<sup>9,16</sup> but most patients seem to support the idea of FPDR, even knowing that it may be traumatic for their loved ones.<sup>18</sup> Eichorn et al. (2001) were the first to study patient perspectives after FPDR had been performed and the nine patients interviewed stated that they were relieved that their family was present to advocate for them and act on their behalf.<sup>18</sup> Family presence can provide comfort to patients with awareness; however, some studies have suggested that some patients feel strongly about which particular family members were to be involved.<sup>18</sup>

## Implications

The evidence suggests that it is reasonable and desirable to offer the option of FPDR to appropriate candidates, but not that it should not be

**Table 2**  
The family facilitator responsibilities.

| Family facilitator role                           |  |
|---|--|
| Determine appropriateness of family's involvement | <i>Disallow combative or disruptive people and limit the number of observers to 1–2</i>        |
| Dedicate attention to the care of the observers   | <i>Focus on the family, facilitator is not a part of the resuscitation efforts</i>             |
| Provide support                                   | <i>Physical needs- chair, water, tissues, emotional support</i>                                |
| Answer family's questions                         | <i>Clarify actions of the code team (compressions, intubation)</i>                             |
| Manage reactions                                  | <i>Assist with grieving and provide care for any adverse reactions i.e. fainting, vomiting</i> |

mandated or widely applied without careful consideration and implementation planning.<sup>3–5,7,8</sup> Organizations that support family presence, including the American Heart Association, the Emergency Nurses Association, and the American Association of Critical-Care Nurses have released supportive statements and recommendations regarding implementation of FPDR.<sup>3–5</sup> Institutions are encouraged to create and publish protocols, communication guides, and interdisciplinary training modules to guide implementation of FPDR.<sup>6,7,13,15,16</sup> This training has been shown to increase team member's comfort with family observation and involvement.<sup>13</sup> To standardize best practice of FPDR, there must be further development and implementation of guidelines.<sup>10</sup>

A common theme in the literature and recommendations is that onlookers should be assigned a staff advocate to provide support and education throughout resuscitation efforts.<sup>1,14</sup> The evidence demonstrates that family members desire guidance from a health care provider during resuscitation.<sup>17</sup> A nurse, nursing supervisor, clinical nurse specialist, physician, chaplain, or social worker can fulfill the role of a family facilitator. These staff members are dedicated to facilitating the witness's experience and do not participate in the resuscitation efforts. This facilitator addresses emotional, physical, and intellectual needs of the family- first evaluating their candidacy for safe observation, then attending to questions and providing comfort measures (Table 2). The advocate role has also shown to increase staff comfort with FPDR.<sup>9,16</sup> Extra consideration must be given for geriatric patients, as their partners may also be elderly and frail. Family facilitators may benefit from both standardized training and assimilation into the code/emergency response team within each institution's structure. Developing and implementing training modules is a logical next step to prepare the people undertaking this role.

Providers are sometimes faced with the ethical decision of limiting therapy or pursuing aggressive care in the geriatric population.<sup>2</sup> The suggestion that family attendance can assist the healthcare team in deciding to cease resuscitative efforts is especially important for elderly patients who have less likelihood of survival and functional outcome due to advanced age, frailty, and multiple comorbidities.<sup>2</sup> Future research efforts should consider population-specific needs of older adults.

## Conclusion

As best practices continue to favor transparent, family-centered care, FPDR should be an option for patients' loved ones. Giving family the autonomy to choose their involvement in such a critical moment, and dedicating staff to their experience has been shown to have an emotionally protective effect.<sup>19,20</sup> Successfully implementing FPDR requires sound clinical judgement, utilization of evidence-based practice, and protocolization. Implementing the role of a family facilitator is an impactful intervention to ensure family's safety and understanding during a resuscitation event. More studies are needed to determine FPDR's effect on elderly patient's resuscitation length and family involvement in terminating aggressive efforts.

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