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Family presence during resuscitation (FPDR): A qualitative descriptive study exploring the experiences of emergency personnel post resuscitation

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ABSTRACT

Introduction: Family presence during resuscitation (FPDR), remains inconsistently implemented by emergency personnel. The benefits for family members is well documented, providing opportunities for family to say goodbye, facilitates closure and enables family to provide emotional support to the patient. The aim of this study was to explore the experiences and attitudes of emergency personnel towards FPDR immediately post resuscitation events.
Method: A descriptive qualitative design was used to explore the experiences of emergency personnel with FPDR. Data was collected from single rural and metropolitan emergency departments in the state of Victoria, Australia. The participants consisted of nurses and doctors who took active roles during resuscitation events. Following transcription of the audiotaped interviews Creswell's (2003) six step analysis process was employed.
Result: A total of 29 interviews of key personnel, following 6 paediatric and 18 adult resuscitation events. Interviews were conducted over a period of two weeks in each venue. The data was organised into six themes following analysis including: care coordinators inconsistently called, gate keepers to implementation, effective communication strategies helping to deliver bad news, life experience generates confidence, allocation of family support person, and family members roles dependent on age of patient.
Conclusion: FPDR is common practice in paediatric events however remains inconsistently implemented during adult resuscitations. A designated family support person is essential to successful implementation of FPDR and should be incorporated in to the allocation of the resuscitation team roles during both adult and paediatric resuscitation events. Education and training is important for clinicians to learn essential communication skills, building practice confidence, which is required to successfully implement FPDR.

What is known about the subject?

- Family presence helps with grieving process for family members.
- Although widely endorsed there remains little known about the implementation of FPDR.
- Family presence during resuscitation is widely supported by health professionals.

What this paper contributes?

- A care coordinator role is essential to the successful implementation.
- Emergency staff hold the balance of power over timing of FDPR implementation.
- Delivery of bad news is a clinically learnt skill.
- Life experience generated confidence when implementing family presence during resuscitation.

Introduction

Family presence during resuscitation (FPDR), in children, infant and adult resuscitations, ideally involves an assigned support person. This process is endorsed by the Australian and New Zealand resuscitation councils, American Heart Association and the Emergency Nurses Association (ANZCOR, 2016; American Heart Association, 2010; ENA, 2012)[2,5,27] however implementation has not been well documented in the literature. Many research studies continue to focus on attitudes without exploring how FPDR is implemented. For example, the role of the family liaison (or care coordinator) has been highlighted as essential to the successful implementation of FPDR.[10,17,18,25] The use of a designated family liaison role has been recommended by the National Clinical Guideline Centre[14] as best practice however, the extent to which emergency departments follow these guidelines remains unknown.[14] There are a number of studies that focus on the perceived barriers to implementation of FPDR, including: fear and concern around resuscitation actions being observed, conversations heard, in particular clinical decision-

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making.[16,29] In comparison, allowing family to be present enables comfort and support to the patient.[9,30]

The benefits for family members includes enabling opportunities to say goodbye, realizing the seriousness of the patient's clinical condition as well as providing an opportunity for family to emotionally support the patient.[7,28,15,22] Facilitating closure and healing, helping with the grieving process and allowing family to recognise the efforts of the staff are highlighted as occurring when family are present.[12] Many medical and nursing staff continue to be concerned that having family present may be too traumatic for some relatives and that staff may become distracted during the resuscitation.[16,26] Physicians in particular believe that there are more risks than benefits to having family present enhancing emotional trauma while being a potential disruption to the resuscitation efforts.[28] The enablers to implementation of FPDR include: education and training, having a formal FPDR policy and the introduction of a support person.[16,20] In the absence of formal policies decision-making around family presence is influenced by peoples' values, preferences and pre-existing expectations around societal roles.[4]

Clear and concise communication remains essential to the success of effective and efficient resuscitation teamwork.[23] How emergency staff communicate during a resuscitation can have a lasting impact on the experience for the family with many family members being left in the waiting room while the resuscitation event takes place. Family presence may impact negatively on the resuscitation team and the family members due to the traumatic nature of the event.[1] Keeping the family informed and apart of the clinical decision-making process is well documented during paediatric resuscitations, however in adult resuscitations remains dependent upon the staff mix. The extent in which family presence is implemented in emergency departments remains unknown. The aim of this study was to develop an understanding of the experiences and attitudes of emergency personnel immediately post resuscitation events using a descriptive qualitative methodology.

Method

Study design and setting

Descriptive and qualitative data was collected from emergency personnel post resuscitation events to ascertain how family presence was implemented during both adult and paediatric resuscitations. Face to face interviews of key nursing and medical personnel were conducted shortly after resuscitation events to develop an understanding of how, why and when family were permitted to be present during resuscitations. This paper reports findings of the interviews of the emergency personnel following resuscitation events and forms part of a larger observational study. The observational data has been previously reported.

Setting/sample

A single rural and a single metropolitan emergency department in the state of Victoria, Australia were the venues for the current study. The rural department had a two bay resuscitation area and 10,000 presentations per year compared with the metropolitan department which has two paediatric resuscitation cubicles and a separate four bay adult resuscitation area and 30,000 presentations per year. The departments were deliberately chosen in order to explore staff attitudes and experiences of FPDR. Inclusion criteria stipulated that staff had duel skills, caring for both adult and paediatric presentations in the emergency department. Nursing and medical emergency staff working as part of the resuscitation team were invited to participate in an individual interview immediately after each event. Inclusion criteria included: registered nurse, medical personnel, employed in department, active member of the resuscitation team. Allied health workers and enrolled nurses were excluded from the study. Data was collected following all observed resuscitation events constituting using a convenience sample approach.

Research ethics statement

Ethical approval was obtained from the University Human ethics committee and subsequent hospital ethics committees. Limited disclosure, which incorporated the partial disclosure of the true nature of the project to participants was raised. The purpose of the study was not disclosed to the participants under the guidelines set out in the National Statement of Ethical Conduct in Human Research 2.3.[13] The rational for limited disclosure relates to the need to observe behaviour that was not affected by the studies research aims as described by the Hawthrone effect.[24] The larger study incorporated observational data collection techniques and has been previously reported.[19] The data for this study consisted of the audio recorded face to face interviews which incorporated semi-structured interview questions. Rapport with staff was established following a period of emersion in the departments, interview participation was voluntary. The interview questions related to the following: participants role during the resuscitation, teamwork and communication and interaction with family members. Using a story telling approach participants were encouraged to talk about the resuscitation event. Interview questions were aimed at clarifying points and explaining interactions with other staff and family members.

Data collection

Ethical approval was granted for a period of two weeks in each emergency department. A total of 162 h were spent observing in the rural setting and 138 h in the metropolitan emergency department which aided in staff becoming familiar with having an observer. In an attempt to minimise staff modifying their behaviour the researcher aimed to misdirect the participation focus[11,21] the staff were informed that the study was focusing on observing resuscitation teamwork and communication. Staff were invited to participate in individual face to face interviews following a resuscitation event in which a semi-structured interview process was employed. Interviews ranged from 30 to 70 min in duration, were audiotaped and transcribed verbatim. Recruitment of participants continued until data saturation was achieved satisfying the aims of the study. The interviewer was an emergency trained clinician and researcher. Resuscitation events consisted of life threatening conditions where by three or more team members were activated to attend to the patient. Using a story telling approach participants were guided using the semi-structured interview technique to recall the events of the resuscitation.

Data analysis

The data was analysed using the six step process as described in Creswell[6] and involved; transcription of interviews (organising and preparation of the data), gaining a general sense, coding into meaningful chunks, putting the coding into context (describing), covey analysis findings (representation of data) and interpretation or meaning of the data into main themes.[6] Transcription data was combined prior to analysis which was conducted after the interview period. The analysis was conducted by the author and two experienced academics. Data was coded and put into meaningful chunks by all members of the research team. Meaning was agreed upon and the authors organised the analysis into six themes. Trustworthiness was assessed using Guba and Lincoln (1998) method as cited in Bloomberg and Volpe,[3] incorporating credibility, dependability, confirmability and transferability. Journaling was used by the author post interviews to record key points and was then later confirmed by the research team. Each researcher coded the data set independently then together to confirm themes and interpretation of the data. Participant comments were allocated a code

to maintain confidentiality with "N" representing nurse and "D" for doctor with an "R" for rural and "M" for metropolitan participant in order to give context to the participant's comments.

Results

The 29 combined rural and metropolitan interviews consisting of 16 emergency nurses (3 males, 13 females) and 13 doctors (6 males, 7 females) were transcribed verbatim. The rural nurses worked a mean of 12.1 years in ED (range 4–22) compared to metropolitan nurses, 4.6 years (range 2–8). The rural doctors worked a mean of 8.6 years (range 1–24) compared to the metropolitan doctors, mean 7.3 years (range 1–13). The nurses ranged from general emergency nurses ($n = 8$), Associate nurses managers ($n = 6$), Clinical nurse specialist ($n = 1$) and a nurse unit manager ($n = 1$). The doctors included; junior registrars ($n = 2$), senior registrars ($n = 6$) emergency physicians ($n = 4$) and a director medical services ($n = 1$). There were a total of 6 paediatric and 18 adult resuscitation events. All participants played key roles during the resuscitation events. Following data analysis the author in agreement with two experienced academics organised the data into six themes: care coordinators inconsistently called, gate keepers to implementation, effective communication strategies helping to deliver bad news, life experience generates confidence, allocation of a family support person, family members roles dependent on age of patient.

Care coordinators inconsistently called

Care coordinators (CC), originating from a variety of disciplines, were utilised in both the rural and metropolitan emergency departments. They were activated when family were expected to attend a critically unwell, a resuscitation or a dying patient. The CC became an independent support person, someone who was not directly involved in the resuscitation but who had the ability to explain what was going on clearly. As described by one study participant, "*It's good to have someone that's not involved in managing the patient, just looking after family*" (MD8).

The CC role was not always activated, so deciding when they would be beneficial appeared to be at the discretion of the emergency personnel. "*When there's perhaps young kids or there's an elderly* (relative)" *like the partner of an elderly patient who's sitting there on their own or non-English speaking person who just needs someone to sit there and just be with them*" (MN2). A CC was activated as part of the normal care in paediatric resuscitation; however, this was not always the case during an adult resuscitation. "*It's funny; you're right, we call them the minute we know a* (child is) *coming in, but we don't call them so much for adults, maybe we should*" (MN2).

The CC remained an important role during resuscitation events as they do support the emotional and physical needs of the family.

Gate keepers to implementation

The timing of family presence was a matter of ongoing debate with many believing that it can be inappropriate at times. "*He* (the son) *didn't specifically ask* (to come into the resuscitation) *but I think we all felt it was probably a bit inappropriate at this point. I told him, if you could wait in the waiting room that would be good*" (RD3). The relatives were directed to a specifically allocated room, close to the resuscitation bays. "*As soon as the medical staff are free, you know once the resuscitations over, it's always our priority to go speak to the family*" (MD3). The presence of family members was seen as an additional pressure on the resuscitation team making them conscious of their actions, with concerns that relatives would be critical. "(Having family present) *creates a fairly high level of anxiety with some of our medical staff and that additional performance anxiety is quite confronting*" (RN3).

This notion of a "good relative" was indicative of the power held by the emergency staff who differentiated between those relatives who were "good" enough to be allowed in to the resuscitation, and those who were not behaving well, were subsequently escorted to the relative's room. "*If I thought they were a bit fragile, or they'll faint on me…maybe I'd kick them out, but generally if the patients happy and the doctors are happy. I don't mind if they sit … and have a cup of tea and watch*" (RN8). The parents of a child were allowed to be present while the relatives of an adult patient were escorted to the relatives' room. "*With older patients the family usually aren't there right from the very start*" (MD8). Emergency personnel were unsure as to why there was a difference in practice between adult and paediatric resuscitation patients but referred to the dependent nature of children.

Effective communication strategies helping to deliver bad news

Many of the participants identified the importance of using key words when delivering bad news. Using the words; died, death or dying is important to ensure that relatives understand the true nature of the patient's condition and the seriousness of the situation. "*I want to use the word death, I want to say, we've done everything that's appropriate*" (RD1). Repeating words or essential information was also identified as a strategy when delivering bad news to aid understanding. Participants suggested alternative statements to breaking bad news such as ascertaining what the family knew already, introducing the seriousness of the situation, and providing early hints to the possibility of a poor prognosis. "*What I used to do is ask them what they know …I ask them what they are aware of. I try to put in the hints, he may not survive, very early*" (MD7). Participants thought it was important to deliver news in teams, to ensure the relatives felt supported by the resuscitation team.

Life experience generates confidence

The participants stated that life experience and maturity were essential elements to successfully interaction with family members, especially in the CC role. The notion of being more mature, experienced and professionally comfortable was emphasised with participants noting that they avoided interactions with family members in their early career years. The lack of adequate training and suitable preparation combined with concerns that they would not be able to respond to relative's questions disabled some practitioners from engaging with family members. "*It's very hard to teach. You can teach people the theory of how to communicate with families in time of stress …you get more comfortable as you get older*" (MD8). The majority of the participants stated that they learnt to speak to relatives by watching others. They picked up techniques along the way, and used role modelling from experienced staff members, in order to learn the skills necessary to interact with family. "*You get to see how other doctors manage it. I think in all honesty it just comes from a maturity and confidence in what you do*" (MD8).

Allocation of a family support person

Participants described a variety of techniques used in their departments to identify the various resuscitation team members from high visibility vests to labelled stickers. While resuscitation roles were often clearly defined, and visibly identified it remained unclear as to whose job it was to speak to the family. The need to have one individual whose sole responsibility it was to support, inform and liaise with the family members, either the CC or in the absence of a CC, was often lost in the pressure of the situation. "*It doesn't happen in every resuscitation, it's kind of a fluid, who's here, who can support but largely if we haven't got someone who can, special the family*" (RN3).

Family members' roles dependent on age of patient

During events with infant or children, having parents present was seen as beneficial as they were likely to know their child's medical

history, presenting condition and medications, with the parents playing a key role in care during critical times. It was also deemed less traumatic for the child, to see a familiar face. "*If anything it's helpful because it keeps the child calm. I'm actually quite happy to have the parents there, to give the child a bit of support. It's much harder if they're not"* (MD5).Participants noted that parents focus is helping the child, in comparison, during adult resuscitation the family focus on the movements of the emergency staff, questioning their decisions and seeking clarification and rationales for each procedure adding to levels of anxiety for staff. "*If you have an 80 year old come in with one of their kids, it's often a very different picture where it's more, "what are you doing", "how are you fixing my dad or my mum"* (MD5).

Discussion

A family liaison role or CC continues to be highlighted as essential to the successful implementation of FPDR. Participants in the current study noted the need for a person allocated to care for the family. In a study by Tudor[25] participants noted that they were unable to care for the family and the patient at the same time and that resuscitation was the first priority therefore having someone assigned to care for the family was essential.[25] The CC is utilised extensively during a paediatric resuscitation however the role remains underutilised during adult resuscitations. There remains strong evidence for the need of a designated family liaison role.[10,18,25] This role would narrate and interpret the resuscitation activities while guarding against the potential for family to disrupt or intervene in the resuscitation.[26]

There was a defined balance of power noted in the current study with both nurses and doctors deciding, when and if, family were permitted to be present. Giles, de Lacey & Muir-Cochrane (2016)[4] grounded theory study found that conditional permission was controlled predominantly by health professionals with no input from family members, deciding to allow or deny entry into the resuscitation room in an authoritarian manner Giles et al., (2016).[4] During paediatric presentations there appears to be little debate, with participants in the current study, noting that allowing parents into a paediatric resuscitation has become common practice, however allowing family members into an adult resuscitation remains inconsistently practiced. The difference in practice between adult and paediatric resuscitations is well noted in the literature however no explanation is provided.[18,23]

There is a strong need for family to remain connected to the patient. In a study by Hung and Pang[7] participants stated that their greatest fear was being separated from the patient which led to a strong desire to be present in the resuscitation room.[7] Staff in the current study were more concerned about the family member's behaviour and that the possibility that the family would interfere with the running of the resuscitation. The term "good relative" was mentioned, with a description of the essential traits necessary in order to be allowed into the resuscitation room for example; sitting quietly and watching.

Learning how to implement family presence and effectively communicate with family members is a skill learnt on the job. The participants noted that it was not a skill that could be easily taught and it was learnt by observing more experienced staff. There remains limited, if any, formal education on FPDR[9,16] in nursing or medical curricula, leading to staff under preparedness to deal with the responsibilities of caring for the family. Formal educational sessions that highlight research evidence and disband myths about having family present were seen to be a strategy to address perceived concerns to implementation of FPDR.[26] Participants in the current study noted that the more experience one has working in the emergency department, the easier it is for them to implement FDPR including the delivery of bad news. Similar findings in a study by Twibell et al., (2018)[28] noted that physicians who were more self-confident also perceived more benefits to FPDR than risk and were more likely to support family presence.

The family liaison role remains outside the allocation of the resuscitation team especially when a venue has invested in a CC role. Regardless, the family liaison role remains an essential element to the successful implementation of FPDR.[8,25] It was evident that family centred care was practiced during paediatric resuscitations with parents being included in all aspects of the resuscitation process. However there was little evidence of this approach during adult resuscitations. There remains concern that the traditional exclusion of family members from the resuscitation room will continue to be a barrier to implementation,[8] in contrast participants in the current study noted that FPDR should be a supported option for all resuscitation events.

Limitations of the study

Due to the sensitive nature of the current study a lengthy ethical approval process occurred which alternately lead to the inclusion of a single rural and a single metropolitan emergency department for only a two week period of observation per hospital. The number of resuscitation events at each site was restricted by the approved time period and would need to be extended in order to make generalisations about emergency practice throughout Australia.

Recommendations for practice

During resuscitation events, family can play a vital role in supporting the patient and staff, regardless of the age of the patient. A designated support person or care coordinator is essential to successful implementation of FPDR and should be utilised during all resuscitation events. Ongoing training and education will enable staff to develop the communication skills required to have difficult conversations with family members and support the family through the resuscitation event. Formal FPDR policy should be developed in order to provide staff with clear practice guidelines.

Conclusion

FDPR is common practice during paediatric resuscitations however remains inconsistent during adult resuscitations. Emergency personnel are becoming more aware of the need for formal education in order to develop the necessary communication strategies to interact effectively with family members while maintaining the activities of the resuscitation. The family liaison role or care coordinator remains essential to the successful implementation of FPDR.

Uncertainty remains around whether to allow relatives into the resuscitation room, however the importance of having parents remain with a child has been well supported. The issue of when it's appropriate to allow relatives in to the resuscitation room was contentious with ongoing concern that witnessing a resuscitation event would be too traumatic for the patient's relatives. In the uncertainty of the situation, the emergency staff acted as gate keepers to allowing relatives the opportunity to be with the patient. Regardless of the age of the patient, supported family presence should be considered by emergency personnel, which will make a significant difference to the experience for the family members.

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Conflict of interest

The author declares there are no known conflicts of interested

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