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Abstract

Despite recommendations to allow family presence during resuscitation, mixed attitudes and practices persist in clinical practice today. The findings of three recent qualitative research studies are presented in this review. These phenomenological studies explore the lived experience of family presence from different perspectives. Miller and Stiles (2009) describe the experiences of hospital nurses, Maxton (2008) focuses on parental perceptions, and McMahon-Parkes, Moule, Bengner, and Albarran (2009) study the attitudes and beliefs of patients themselves. This article presents an analysis of these study findings and overall conclusions related to family presence during resuscitation.

Keywords

Family Presence, Parental Presence, Resuscitation, Family-Witnessed Resuscitation, Nurses, and Qualitative Research

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Review of Three Qualitative Studies of Family Presence During Resuscitation

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Despite recommendations to allow family presence during resuscitation, mixed attitudes and practices persist in clinical practice today. The findings of three recent qualitative research studies are presented in this review. These phenomenological studies explore the lived experience of family presence from different perspectives. Miller and Stiles (2009) describe the experiences of hospital nurses, Maxton (2008) focuses on parental perceptions, and McMahon-Parkes, Moule, Bengert, and Albarran (2009) study the attitudes and beliefs of patients themselves. This article presents an analysis of these study findings and overall conclusions related to family presence during resuscitation. Key Words: Family Presence, Parental Presence, Resuscitation, Family-Witnessed Resuscitation, Nurses, and Qualitative Research

Many family members are asked to leave the bedside of their loved one during times of medical crisis. Although national health care organizations endorse family presence during resuscitation (American Heart Association, 2005; Emergency Nurses Association, 1994; Henderson & Knapp, 2005), mixed attitudes and practices exist today. What are the views of patients, parents, and nurses about family-witnessed resuscitation efforts? This review of the findings of three different qualitative research studies answers this question. While some findings are unique to one study, common perceptions were shared by parents, patients, and nurses. In this article, these studies are described and analyzed. Based on this evidence, important applications for nursing practice are identified.

Background and Context

The model of care for acutely ill patients has changed over the last 100 years. Prior to that, patients were cared for by, or under the direction of, family members at home. The opening of hospitals resulted in visiting hours and other restrictions on family presence. Today, increased family expectations include remaining at the bedside during invasive procedures and resuscitation (Miller & Stiles, 2009).

Several organizations support family presence during resuscitation (American Heart Association, 2005; Emergency Nurses Association, 1994; Henderson & Knapp, 2005). Despite this, the attitudes of health care professionals remain mixed. While pediatric units are most likely to support this practice (Miller & Stiles, 2009), parents are often separated from their children during medical crises (Maxton, 2008). Fears persist that family members may interfere with resuscitation efforts or that they will be psychologically traumatized by the experience (McMahon-Parkes, Moule, Bengert, &

Albarran, 2009). Few qualitative studies investigate the lived experience of parents who are present or absent from resuscitation efforts (Maxton). No prior qualitative studies described nurses' perceptions (Miller & Stiles) and few studies explored patient preferences regarding family-witnessed resuscitation (McMahon-Parkes et al.).

Focus and Intent of Articles

The writer reviewed three recent qualitative studies conducted from very different perspectives on the issue of family presence during resuscitation. Miller and Stiles (2009) explored the experiences of nurses related to this practice. The authors of a second study focused on understanding the experience of parents who were present and absent from children who underwent invasive procedures and either successful or unsuccessful resuscitation (Maxton, 2008). McMahon-Parkes et al. (2009) described the views of successfully resuscitated patients and patients admitted to the emergency room who did not require resuscitation as to whether their family members should be present during resuscitation efforts.

Qualitative Methodologies Used To Support Best Practices

All three studies used a phenomenological design, small samples, and interview methodology. Different settings were used for these studies. Miller and Stiles (2009) utilized a sample of seventeen hospital nurses in a large metropolitan area in northeastern United States. Maxton (2008) studied parents of eight children in a metropolitan Pediatric Intensive Care Unit [PICU] in Australia. A third study involved twenty-one resuscitated patients and forty emergency room patients in four hospitals in two large cities in southwest England (McMahon-Parkes et al., 2009). Although the interviews were unstructured in Maxton's study and semistructured in the Miller and Stiles and McMahon-Parkes et al. studies, some steps were described in all three research reports to ensure methodological rigor. The authors in two studies utilized van Manen's framework for thematic analysis (Maxton; Miller & Stiles). Multiple readings of transcripts were conducted in all three studies. In addition, McMahon-Parkes et al. and Miller and Stiles used multiple reviewers and consensus decision-making methods in their studies. Although a second layer of analysis consistent with a hermeneutic phenomenological approach was performed, the Maxton study did not state whether multiple reviewers were used; they refer the reader to their full thesis to obtain this information.

Strength of Evidence

Miller and Stiles (2009) discovered that one of seventeen nurses particularly opposed family presence during resuscitation or invasive procedures. They found the ability for the nurse to forge a positive connection with families, the ability to engage the family in care, and transition to acceptance of family presence by the nurses were major themes in this study. Another major theme of caution revealed mixed feelings of the nurses regarding times or circumstances when family presence may be inappropriate. These include family behavior, staff safety, staff behavior or expertise, traumatic and bloody procedures, forensic cases and lack of time to establish a relationship with the

family. Maxton (2008) described four themes from her interviews of parents. These included the need to be there for a child, make sense of the situation, maintain hope when coping with the reality of the situation, and live in a relationship with staff. The parents who were present during resuscitation reported that the need to be with their child overrode their fear of remaining at the bedside. Parents did not report feeling traumatized by seeing medical interventions. They felt a greater sense of control, such as the ability to give information, say goodbye, and even stop resuscitation efforts. Parents who did not witness resuscitation attempts reported more feelings of distress than parents of those who did. McMahon-Parkes et al. (2009) found that the majority of patients supported family presence during resuscitation. Three themes were shared by participants who were resuscitated and participants who were not. Being there (i.e., to understand the situation, offer encouragement, emotional support and advocacy) was identified as a positive theme, although the idea of advocacy was challenged by some as potentially leading to irrational family decisions or conflicts of interests. The theme of welfare of others included some concern about the possible emotional consequences for relatives. Lastly, a theme of professionals' management of the resuscitation revealed concerns that professional efforts are unimpeded and focused on the patient, who takes precedence over family needs. Participants felt there may be reasons for family members to be asked to leave the bedside. As mentioned earlier, sample sizes are small in all three studies. Only eight interviews from parents of children in one Pediatric Intensive Care Unit are described in the Maxton (2008) study. This writer's question about whether data saturation occurred was not addressed in the article. Whether the technique for data analysis involved multiple reviewers and consensus is also missing. Although this study included parents who were present and absent from resuscitation attempt, no parents whose child had died and who did not witness revival efforts were included in the study. Therefore Maxton's goal of understanding parental experiences related to absence from both unsuccessful and successful resuscitation efforts is not fully realized. Miller and Stiles (2009) report taking many steps to ensure rigor during data collection and analysis and that data saturation occurred in their study. However, the writer feels that Miller and Stile's inclusion of invasive procedures [IPs] in the hospital was not a strength of their study. Although CPR is only performed in life-threatening situations, this may not be the case for IPs. Whether or not the procedure is life-threatening could greatly change the lived experience of the nurse participants and the study results. In the Miller and Stiles (2009) study, all nurses were white. An underrepresentation of ethnic groups is also noted in the McMahon-Parkes et al. (2009) study. In addition, McMahon-Parkes et al. report that a lack of consideration of religious beliefs was a limitation of their study. None of the three studies considered religious beliefs as a factor. This raises a question as to whether the perceptions described in these studies would have varied from those of participants from different ethnic and religious backgrounds.

Although the three studies occurred in different countries, they were all conducted in metropolitan areas. While McMahon-Parkes et al. (2009) report prior evidence that attitudes of health care professionals may vary between urban and rural areas, the described experiences of participants in rural areas is not accounted for and might have differed from those in the present studies. Despite these limitations, strong support is shown for the best practice of family presence during resuscitation in these studies. The authors complement each other in their unique perspectives on this issue. For example,

emotional trauma of family members resulting from seeing medical procedures was voiced as a concern by the nurses (Miller & Stiles, 2009) and patients (McMahon-Parkes et al., 2009) but not by the parents. Maintaining patient confidentiality during resuscitation was identified as an issue by the nurses (Miller & Stiles) but not the patients (McMahon-Parkes et al.). The authors of all three studies described benefits of family members remaining with their loved one. Concerns related to potential disruption of health care workers' efforts and family ability to leave when appropriate were common to all three studies (Maxton, 2008; McMahon-Parkes et al.; Miller & Stiles). A recent qualitative study of the lived experiences of relatives who were present during resuscitation of adult patients would yield yet another valuable perspective but such a study could not be located for review. Knowledge obtained from the three present studies is still helpful to healthcare professionals and institutions who adopt this practice. Application of research is discussed in the following section.

Application of Research Findings

Rich potential for application in clinical practice can be found in these studies. Miller and Stiles (2009) discuss hiring people to change the underlying culture as a strategy to promote family presence during resuscitation. They also report that few hospitals have written policies on family-witnessed CPR. Development of policies and procedures and changing the culture should decrease unwanted variation in practice caused by differences in the attitudes of healthcare professionals. All three studies reveal concerns about the discretion healthcare professionals exercise over family presence. Miller and Stiles (2009) and McMahon-Parkes et al. (2009) describe themes favoring the ability of staff members to ask relatives to leave the bedside when necessary. Taking a slightly different slant on staff discretion, parents in the Maxton (2008) study requested that they be allowed to leave the room and return at intervals. Parents fear that leaving may be seen as a sign of ineffective coping and that consequently they will not be allowed to return. These issues should be addressed in facility policies and procedures.

Upon reviewing the literature, it becomes clear that more qualitative studies of family-witnessed resuscitation are needed. Nurses are in key positions to conduct these studies, perhaps in collaboration with physicians, hospital social workers or psychologists. There is a particular need to study predictive factors of family coping; inability to identify individuals who can cope with witnessing the resuscitation of a loved one causes fear and uncertainty among nurses (Miller & Stiles, 2009). After this knowledge becomes available, education of healthcare professionals will help them identify and encourage coping mechanisms of family members. In addition, knowing that research shows many family members are able to withstand the trauma of witnessing resuscitation efforts without long-lasting effects can help dispel the fears of healthcare workers. Parental perceptions of support in the Maxton (2008) study reveal other potential applications to nursing practice. Parents feel that the support of clergy and social workers may not meet their need for medical information. They turn to nurses for support in crisis, but some parents prefer close proximity and silence over frequent talk. Maxton recommends the support role be assumed by experienced and intuitive nurses who can recognize and adapt to the changing needs of family members. If a nurse is not available to stay with the family, clergy or social workers should be able to obtain and

communicate medical information, as appropriate. Perhaps obtaining education in medical emergencies would better prepare clergy or social workers to assume a support role for family. In turn, nurses may benefit from additional education in therapeutic communication and crisis intervention. The patient perspective on family presence yields important implications for practice. Patient concerns about the ability of family members to determine their best interest in a time of crisis highlight the importance of staff discussion and determination of patient wishes in advance of medical crisis, if at all possible (McMahon-Parkes et al., 2009). Nurses can be instrumental in initiating these discussions and facilitating family communication regarding patient wishes. Lastly, the present studies yield some other important applications to end-of-life care. The presence of family members who are able to stop resuscitation efforts in futile situations is perceived as a definite benefit by nurses (Miller & Stiles, 2009). Parents regain a feeling of control in futile situations by being able to ask that attempts to resuscitate their child be discontinued (Maxton, 2008).

Potential Readership for Articles

These articles pertain to a variety of disciplines. Physicians, hospital social workers and clergy members may be interested in research findings related to medical crises and family presence. In addition, psychologists and counselors are concerned with the issues of family coping and psychological effects described in these articles. Hospital administrators have a vested interest in this topic because current trends place a greater emphasis on quality of care and patient satisfaction (Press Ganey, 2009). Because family presence influences patient satisfaction and because hospital policies and procedures guide clinical practice, administrators will benefit from reading these articles.

Conclusion

This article reviews three qualitative research reports on family presence during resuscitation. These research studies explore the lived experiences of nurses, parents and patients. Despite some reservations, strong support is found in all three studies for allowing family members to remain at the bedside during resuscitation efforts. Although further qualitative research is needed in this area, important applications for nursing practice are seen in these studies.

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Author Note

Bonnie Schmidt earned a Diploma from Madison General Hospital School of Nursing, a Bachelors Degree in Nursing from the University of Wisconsin Oshkosh and a Masters Degree in Nursing from the University of Phoenix. In over 30 years of nursing, Ms. Schmidt has practiced in intensive care, medical-surgical, home health, public health, and academic settings. She is currently an Associate Clinical Professor in the University of Wisconsin Oshkosh College of Nursing and is working toward a doctoral degree in Nursing Education at Nova Southeastern University. Ms. Schmidt earned Certified Nurse Educator [CNE] designation by the National League of Nursing in November of 2008. You can reach her at: UW Oshkosh College of Nursing, 800 Algoma Boulevard, Oshkosh, WI 54901 or at schmidt@uwosh.edu or Phone: 920-424-2311.

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