Discussion of Family Presence in the Emergent Setting

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I have no disclosures, or commercial interests or bias.
Objectives

- Present update summarization of data and studies of Family Presences in Emergency settings.

- Discuss family and staff support and concerns with Family Witnessed Resuscitation/Presence

- Encourage discussions of “End of Life Optimum support” in your facilities
Backtracking to origination......

- **1960’s**  Fathers allowed in delivery rooms
- **1982**  Foote Hospital Jackson, Michigan

{Police officer shot--wife requests to stay}
{Patient comes via EMS--family rides in ambulance-refuses to leave patient}
At Foote:

- After both incidents, families and staff provided positive feedback. Shortly thereafter, a policy for FPDR was established and studied.
- They studied family members of patients whom had recently died in the hospital.
- 72% said they wished they had been present, or at least offered the option
1990 Addenbrooke’s Hospital studies psychological effects on a person witnessing resuscitation. 2 groups chosen—3 months post resuscitation group excluded showed more psychological damage.

1992 Hansen & Strawser study shows 76% of families studied believed grieving made easier by their presence.
• **1993** ENA endorses FWR by adopting resolution to support FP during procedures and resuscitations.

• **1995** ENA offered first educational offering, revising it in 2007:
  
  “Presenting the Option for Family Presence”

• **1994** Dallas, TX A nurse helps a mother of severely injured child witness resuscitation. Media coverage provokes medical community to speak out on issue.
• 2000 American Heart Association supports the design of family presence during resuscitation in peds population

• 2000 Surge of articles written in support of FWR in Healthcare publications

• 2005 American Academy of Pediatrics supports FWR

• 2009 American Trauma Society endorses best practice-model development for TELOS “Trauma end of life optimum support”
TELOS recommends:

- Best practices related to each of the TELOS Pillars:
  - **Engagement:** Unbias approach to family
  - **Ethics:** Treat all equally and timely
  - **Education:** Palliative care into education
  - **Economics:** Fund TELOS-demo value quality end of life care
  - **Evaluation:** Revise and update according to evaluation of effectiveness

A framework related to the care environment in which to deliver information
• American Heart Association 2000
• “In the absence of data documenting harm and in light of data suggesting that it may be helpful, offering select family members the opportunity to be present during a resuscitation seems reasonable and desirable (assuming that the patient, if an adult, has not raised a prior objection”
What does it mean for family presence?

- Family Presence allows family in the patient care area, allowing visual or physical contact with the patient during invasive procedures, or resuscitative events. (FP)

- Family Witnessed Resuscitation means that family observes in patient care areas during active resuscitative events, such as CPR, acute trauma stabilization and critical care in emergent settings. (FWR)
• Family has to have a Family Support Person (FSP).
• A role assigned to individual with no patient care responsibilities whom can provide emotional and psychosocial support. Explain patient appearance, procedures performed, time restrictions, and escort from room when necessary.
The number of parents who want to be present with their children undergoing invasive procedures has increased sharply over past decade and many feel it is their right to witness resuscitation of their children.

Historically emergency care staff more supportive of FWR of children.

2010 only 5% US hospitals have written policies addressing FWR
What do families and patients say?

- It was a positive experience
- It was their right
- Provided comfort to the patient
- Helpful to them with grieving
- Would do it again if offered
- Felt “everything was done to save patient”
- Reduces guilt about leaving patient in crisis
- Allows closure
- Allows touch while still warm (warm is alive to the general public)
Perceived benefits from healthcare provider’s attitudes of FWR:

- Enhanced family understanding
- Family obtained closure with death
- Family appreciation of resuscitation efforts
- Staff attention to the ‘personhood’ of the patient
- Enhanced professional behavior among staff
- Holistic approach to care
The reality of the resuscitation room is far less horrifying than the fantasy of it.

{Parkland 1998}
• ENA drafts Clinical Practice Management Guideline
• Parkland study:
  • 95% of families supported FP/FWR, stating helped them realize the seriousness & understand the treatment. 95% felt it helped the patient
  • 97% would do it again
Who supports FP and FWR?

- Program’s grassroots beginnings have been started by nursing staff.
- Why should we remove family at end of life, as we have overwhelmingly encouraged presence at start of life.
- Support for the practice is not universal
- There is little research showing effects beyond 90 days on families
Who opposes FWR/FP

- Study from American Journal of Nursing 2000 indicates 96% of the nurses endorsed FWR compared to 50% of physicians. Survey found the less experienced physicians exhibited less enthusiasm, only 19% residents supporting.
An ER physician was quoted as saying “To watch a team of strangers shove tubes down the throat of a relative frantically, pierce each arm with needles, crack open chests, would not only be traumatic to observe, but also leave them with horrifying final memories”
Concerns for opposition:

- Fear staff would be distracted
- Staff experience more emotional distress
- Concern code prolonged
- Not enough space in room
- Limitations in teaching settings
- Disruptive family members
- Fear families might witness mistakes
- Not enough staff to support family
What do the patients say:

- Current studies indicate <10% of cardiac arrest patients survive to hospital discharge
- Studies show unconcerned about breech of confidentiality
- Felt families acted as advocates for them
- Encouraged them to survive
Do we document patient’s preferences on such documents as Advance Directives?
Where to start for your facility?

- Use National guidelines to ensure appropriate family member behavior and uninterrupted patient care
- Practice sporadically and without formal guidelines
- Use evidence based practice models
- Involve all of the patient care team
• Attempt to prescreen families and prepare them for bedside presence
• Success depends on consistency in practice established by the guideline and procedure
• Have a plan for disruptive family members
• Collect data and evaluate outcomes
• Relatives must not be viewed as an added complication but as a direct extension and reflection of the patient’s life.

• Resuscitation teams take for granted that they are often the last people to be in the presence of a dying person.

• Being present during these final moments is a privilege, not a side effect.
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Why do I support Family Witnessed Resuscitation?

- ER Nurse
- Trauma Nurse
- Advocate
- Mother
- Survivor
My experience with Family Witnessed Resuscitation...as a mother