

Family Presence During Resuscitation

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Section 4: Discussion And Consequences

Introduction

There was no policy in place when this project was started. The project team included the emergency nursing department, nursing education, the chairman of the emergency room, the clinical nurse specialist, the legal department, plus the quality assurance department. The team developed an accepted recorded practice document that would give the patient's family members a choice on whether to be present or not at the bedside at the time of resuscitation. The team was able to develop guiding principles for the healthcare practitioners to enable the presence of family at the time of resuscitation. The guiding principles were established and centred on the commendations by the Emergency Nurses Association (ENA). (Gold berger Z. D et al., 2015)

The family presence during the resuscitation (FPDR) Implementation Plan (see Appendix B) was established by the project team on the basis of ENA commendations. This strategy requires that all participants who are involved in the family presence during the resuscitation (FPDR) process comprehend their responsibilities and safety strategies. The participants include the healthcare practitioners, the chosen facilitator and the family members. The project team developed programmes for the distribution of the FPDR plan and practice through informal education meetings and staff gatherings.

The project team created the FPDR Evaluation Form (see Appendix C). The form was aimed at generating quantitative data. The form is made up of 10 questions along with answers that comprise yes or no. These questions permit the family members to have an opportunity to communicate feedback concerning their experience throughout the FPDR process. The feedback will then be gathered, recorded and revised for upcoming recommendations. (Strasen J et al., 2015)

Evaluation of the Project

Studies show that family presence, especially during resuscitation, has positive effects and is useful to the present family members. The project team will assess the achievement of this project on the basis of the patient contentment scores for the emergency department (ED). The project team will also compare the patient contentment surveys in the ED pre-policy application stage and post-policy application stage. I will take part in gathering and recording the findings from these surveys, which will give data as regards the differences in the satisfaction scores between the two stages. The ENA

gives the recommended standards to evaluate the procedure successfully.

Evaluation of the Policy

The project team will conduct an evaluation of the policy. This will be done by conducting a research study in the Facility's emergency department so as to analyse the achievements of this procedure. We will use the FPDR Evaluation Form to gather data to determine the rate at which a patient's family members choose to take part in the resuscitation procedure and evaluate their experiences. The project team will then record the findings. The findings will give information on areas such as the advantages of implementing policy versus the disadvantages of having no implemented policy. The ENA gives recommended procedures for successful evaluation of the procedure.

Evaluation plan

The evaluation plan is a secondary product of this project. The plan will play an important role in coming up with recommendations for the PFDR policy. The evaluation strategy consists of the program's organisation as well as the procedures and timelines of this project. I was able to direct the strategies alongside the complete participation and support of every team member of this project. The process of data collection will take a period of 8 weeks. The data analysis will take 4 weeks.

The project team designed the evaluation plan. (Hassankhani et al. , 2017) It was created to guide the healthcare practitioners on how they will move forward throughout the program. The guidelines will help determine the experiences of the participant's family members. The program guidelines give the outline to assist in the distribution of the questions and any additional activities for the participants as required. The strategies are precise and concern the objectives of the program. The strategies should ensure that healthcare practitioners have definite instructions to follow. Files containing the program instructions and doings will be made for each of the participants and the medical staff to instruct them during the practice.

The head of the hospital and its health care practitioners will employ the instructions and the set evaluation plan to evaluate the progress of every participant. They are also used to give the accepted level of support to the participant's family members. The healthcare practitioners will fill out an official evaluation by making use of the evaluation document at the conclusion of the FPDR session. This is done to classify any areas that would need extra resources or further interventions from the team in the project.

The evaluation strategy is useful in coming up with the goal of promoting family presence during resuscitation and ensuring that they get a positive experience. The plan was created to assist in influencing the follow-up and evaluation of the program. It comprises short-term as well as long-term goals that involve examining the participants' experiences during FPDR. Questions in this survey place emphasis on the experiences of the participants. Participants will fill out the survey after the

resuscitation sessions and answer a sequence of questions in the format of yes or no. The desired outcome is to increase the positive experiences of family members during FPDR.

T-test for independent samples

t-Test for independent samples relates two independent samples and seeks to determine whether there is statistical evidence that the associated population means have a significant difference. The project team will compare the patient contentment surveys in the emergency department pre-policy application stage with those in the post-policy application stage. The data collected is quantitative and continuous. The independent variables used in this test are the pre-policy application stage and the post-policy application stage. In this study, the t-test will be used to test the statistical differences between the average of the two scores.

The null and alternative hypotheses of the independent variables in the t-test can be expressed in two different ways:

HO: $\mu_1 = \mu_2$ the two means are equal

HA: $\mu_1 \neq \mu_2$ The two means are not equal

Strengths and Limitations

The family presence during resuscitation (FPDR) Policy had not been set in the emergency department before the application of this project. The strength of this project is the capacity to change the attention from the attitudes and insights of the healthcare workers towards FPDR to dealing with the results of having family members present at the time of resuscitation.

Even though we have argued the strengths of this project, there are some limitations that need to be recognized. There are delays to be deliberated upon when data is not recorded correctly. Delays can also occur when data is not made accessible to the project team for review within the agreed-upon time frame so as to assess the necessary commendations or adjustments. In addition, it is not possible to explain the preconceived attitudes regarding FPDR of people filling out the evaluation form. Negative attitudes towards the FPDR may affect the way these people respond. (Porter J. E et al, 2014)

Recommendations

The recommendations that have been made to make sure that this policy will support the presence of a patient's family members during resuscitation are:

1. Education and in-service to support staff so that they remain abreast of policy and procedure.

2. Develop a plan to determine compliance with policy and improve compliance.
3. Develop communication strategies to remind staff of the policy.
4. Develop a plan to incorporate a competency verification tool.

Conclusion

The presence of family during the resuscitation of the patient is of importance to the patients and their family members who desire to be there during a crisis incident so as to provide the needed support and comfort. The knowledge gained throughout this project has been helpful in the development and implementation of policy to promote a patient- and family-centred approach to care. The policy aims to provide documented strategies that will improve the patient and family experience.

Definition of terms

- Family Member: Relative related by blood or significant others with whom the patient has an established relationship
- Family Presence: The presence of one member of the family at the patient's bedside during resuscitation.
- Resuscitation: The restoration of breathing, circulation and/or normal heart rhythm with the use of chest compressions, medications, invasive procedures, and/or electrical shock.
- Invasive Procedure: Medical procedures that may involve penetrating the body through the skin or body cavity and manipulating and/or interrupting body functions. Some procedures may not be appropriate for a family member's presence.
- Healthcare Team Member: A Healthcare worker who is directly concerned with the care of the patient before, during and after resuscitation.
- Family Facilitator: A healthcare team member who facilitates the presence of family members by providing support before, during and after the resuscitation interventions. The family facilitator includes a patient representative, registered nurse, physician, respiratory therapist, child life specialist, social worker, or pastoral care.

Section 5

Abstract

The presence of the patient's family during resuscitation has become an important practice. The practice of FPDR has sparked substantial controversy all over the world. Over the years, a number of studies have been conducted to support this idea. Qualitative researchers explored the experiences of the members of the family present at any particular time during the resuscitation. They also looked into the perspectives of the family members as well as the attitudes and perspectives of the health care practitioners.

The aim of the study was to help understand the experience of the members of the family who are offered the privilege of being present during the process of resuscitation. The participants were given questionnaires to fill with the answers yes or no. The chosen theme was the patient and family member's contentment of surveys in the emergency department pre-policy application stage and post-policy application stage. The findings were collected, recorded, analysed and used to develop recommendations for the implementation of the FPDR policy. A survey was used to collect data, and the data for this study was quantitative and continuous. Analysis will be done using a t-test for independent variables.

In conclusion, family presence during resuscitation (FPDR) gives an opportunity for family members to show their support to their loved ones during the period of crisis. When FPDR choice is offered, family members are able to observe and take part in the decision-making process concerning the life-sustaining measures.

Introduction

The practice of allowing the presence of family members during the presence of resuscitation of their loved ones has currently grown as an important practice. However, the practice has sparked significant controversies all over the world. Researchers have examined the experiences of the members of the family present during the resuscitation process. They have also examined the perspectives of the patients and family members as well as the attitudes and perspectives of the healthcare practitioners (Powers et al., 2017). ENA (Emergency Nurses Association) reacted to the increasing demands arising from the position of family presence during resuscitation and invasive procedures.

The option of FPDR (Family Presence during Resuscitation) offers the members of the family the opportunity to be present with their loved ones during ongoing measures of saving lives. The literature has shown that FPDR has facilitated and supported grieving family members. However, in spite of the benefits of FPDR, there is a lack of policy implementation. Healthcare facilities need to implement an FPDR policy so families are provided with an option to be present during resuscitation.

There was no policy in place when this project was started. The project team included the emergency

nursing department, nursing education, the chairman of the emergency room, the clinical nurse specialist, the legal department, and the quality assurance department. The team developed an accepted recorded practice document that would give the patient's family members a choice on whether to be present or not at the bedside at the time of resuscitation. The team was able to develop guiding principles for the healthcare practitioners to enable the presence of family at the time of resuscitation. The guiding principles were established and centred on the commendations by the Emergency Nurses Association (ENA).

Problem Statement

In the early years, about 100 years ago, the symbol of worry for extremely sick patients was misleading. In the past, patients used to be treated in their homes with the instructions of the members of their families. When hospitals began, specific visiting hours were introduced together with other hospital restrictions on the presence of family in the patient's rooms.

At the moment, in the Emergency Department, many family members have opinions about the option of family presence during resuscitation. Their views involve being in the patient's room through the period of crisis. FPDR is reinforced by a number of organizations, including the Emergency Nurses Association. Despite these, the attitudes and perspectives of many medical practitioners remain mixed as many hospitals are beginning to support this practice.

Purpose Statement/Project Objective

Despite the recommendations that allow family presence during resuscitation, attitudes and perceptions still persist that vary in today's clinical practice. In research done in the USA by Miller and Stiles in 2009, when a medical crisis is happening, most family members are requested to move away from the rooms of the patient who is their loved one. Family Presence During Resuscitation gets endorsement from healthcare organizations nationwide. However, there still exist different opinions from family members, patients themselves, and nurses about this matter of the patient's family witnessing resuscitation attempts.

The emphasis of this DNP project will be based on the available literature on FPDR attempts. The DNP project looks into the development of policies expressing the practice of family presence during the process of resuscitation, re-training medical staff on the practice of family presence, and coming up with a plan for implementing and evaluating the policy.

Objectives and Outcomes

The objective is for the facility to develop and implement a policy (see Appendix A), implementation plan (see Appendix B) and evaluation plan (see Appendix C). Literature suggests that allowing the

presence of the members of the family during the process of resuscitation demonstrates a family-centred approach. The outcome of this DNP project was the implementation of policy.

Literature review

Burgeoning consumerism could be said to have been a major force that pushed for the presence of family members during the resuscitation process. The force arises from the increasing knowledge gained by the patients and their family members in the process of seeking healthcare. From the early founding works, subjective explanations have been complemented by a lot of research about the effects of FPDR on the patient's family members and medical staff.

Recent studies show that most families would want to be given the choice of being present in the resuscitation room. Those who have had the experience say that they would make the choice again. Critics of FPDR indicate that there is fear that since most family members want to be present in the patient rooms, the protocols may be disrupted. The family members can be anguished by the severe psychological trauma. There is also the risk of lawsuits by the family members in case things go wrong, and they feel there was malpractice by the health care practitioners (Tudor K et al., 2014).

In the United States, standards of how to deliver resuscitation have changed radically. This was after the American Heart Association recommended offering resuscitation based on the association's guidelines on cardiopulmonary resuscitation. Despite the changes, nurses and healthcare professionals are reluctant to fulfil their obligation to meet the patient's needs for FPDR. This practice still remains controversial among healthcare professionals and is, therefore, far from being the norm in a practice setting.

Supporters of this practice argue that protecting family members by preventing them from being in the resuscitation room is no longer necessary. (Giles, T. et al. , 2016) This is because individuals witness critical crisis events in the field many times. There are also television shows that have exposed many individuals to what happens during resuscitation. Being able to see your loved one, witnessing the efforts that the medical team are implementing to bring them back to life and communicating with them helps the family members to understand and accept the death in case it happens.

Some family members say that being in the resuscitation room for their loved ones was a good experience. The live-saving actions by the healthcare professional give them a chance to participate in decision-making about the health of their loved ones. The family members who expressed their satisfaction reported having been treated appropriately by the medical team during the resuscitation. Those who report bad experiences and dissatisfaction claim that there was no understanding and a lack of proper organisation of the crowd during the intervention. They also report poor communication and lack of interaction with the medical team. (Twibell R S et al, 2015)

The purpose of this study is to evaluate the success of the FPDR project based on the patient

satisfaction scores for the emergency department (ED). The project team will then compare the satisfaction of the patients prior to and after the implementation of the policy phase. Data from the results of these surveys will be collected and documented, and the data will be used to provide information regarding the difference in satisfaction scores between the two phases. The Emergency Nurses Association (ENA) provides the recommended criteria for the successful evaluation of the FPDR procedure.

It is important to identify the ethical and theoretical perspectives as they assist the nurses in understanding the FPDR process better based on the literature and promote critical thinking in clinical practice. Further studies are needed to provide information on the gaps left by our current knowledge of FPDR. (Hassankhani H, et al , 2017)

Dissemination Plan of Policy

The first phase in the dissemination process will be to partner with the Clinical Nurse Educator, Quality Improvement and Legal Team to present the policy to the key stakeholders, which includes the Nursing Clinical Practice Committee, ER Medical Directors Committee and the RRT committee. It is crucial to give all key stakeholders an opportunity to give their feedback on the FPDR policy and procedure, and this should be done on the basis of organizational culture and evidence. The following are some of the recommendations relating to the dissemination of FPDR guidelines:

1. There will be a sharing of the FPDR guidelines at huddles and staff meetings.
2. Education programs would be provided to all multidisciplinary staff members in the Emergency Department on matters relating to the current policy and purpose.
3. Efforts would be made towards establishing comprehensive education and training programs for the family facilitator roles.
4. The implementation of the policy will involve the multi-disciplinary staff members.
5. Progressive work aimed at supporting institutions that allow staffing of FPDR advocates during every shift.

Analysis of Self

In the event of a medical crisis, the patient's family members are often put away from the loved one. According to Professor McMahon, there exists the fear that the actual presence of the patient's family members at the time of their resuscitation may cause interference in the process of resuscitation. There is also the probability that present family members could be mentally affected by the trauma of this experience.

As a DNP-prepared student, I was able to initiate and participate in the process of establishing the

policy and the procedure. The procedure was to provide guidelines from which health care practitioners could refer. This would ensure that we are always offering the best care to patients and families and placing their needs first. The development and implementation of this policy have enhanced the departments' approach to a family-centred care concept.

One of the greatest challenges of this project was creating schedules to meet with the project team and staff in the planning stages of the process. Although there were many obstacles to overcome during this scholarly journey, I have learnt that it is not only important to discover what is lacking in our nursing processes, but it is more important to develop, implement and evaluate a plan to address the need through evidence-based practice.

Project designs and methods.

The DNP project was about the presence of family members during resuscitation. The presence of the members of the family during resuscitation of FPDR guidelines and evaluation plans was planned to be offered as a way of ensuring patient satisfaction while in the health facility. As an improvement to the FPDR policy, the project paid attention to the numerous methodologies that helped the participants ensure positive experiences during FPDR. The project focused primarily on evaluating the success of this project on the basis of patient satisfaction scores for the emergency department. This will involve a comparison of the patient satisfaction scores of the surveys conducted in the pre-policy implementation stage and the post-policy implementation stage. From these surveys, data will be collected, recorded and analysed. Information regarding the differences in the satisfaction scores between the two stages will be provided. (Porter et al. , 2017) Below are phases that were essential to the progress of the program.

1. Assembling of the project group
2. Leading the group through a thorough review of literature.
3. Developing guidelines and an evaluation plan.
4. Validating of subjects.
5. Developing a plan for project implementation.
6. Developing a plan for project evaluation.

The Project Group

The project group was selected on the basis of their knowledge and dedication to supporting patients to ensure they get quality care. The team consisted of the emergency nursing department, the chairman of the emergency room, the clinical nurse specialist, nursing education, the legal department, the quality assurance department and myself. The total wealth of knowledge of the team members, their years of nursing experience, and their qualifications in a number of specialities made them valued resources for the project. Their specialities comprised attending Stanford Emergency Nursing Education and obtaining certification, working with patients at the emergency department,

and undergoing invasive procedures. All of the team members were able to attend an 8-week conference centred on family presence during resuscitation. The responsibilities of the group members comprised of the following:

1. The Student: I wrote the project and served as project leader and facilitator.
2. Emergency nursing department: nurse practitioners working with patients at the emergency department.
3. Chairman of the emergency room: Instructor of the practices and procedures for family presence during resuscitation.
4. Clinical nurse specialist: a nurse with the experience of working at the emergency department.
5. The legal department: to ensure that the policy was implemented within the legal guidelines.
6. The quality assurance department: to ensure the quality of services in the emergency department and in the implementation of FPDR
7. Nursing education: Provided classes on good practices of FPDR

I used the logic model to direct the development of the project in terms of the timeline and plan. The project team was able to have a meeting weekly for 3 months to discuss and come up with the project's strategic plans. The goal was to evaluate the success of the FPDR project by creating a turnkey program with an effective implementation and evaluation plan. The project was based on my findings from a literature review on family presence during resuscitation.

Products of the DNP Project

Program Strategies with Objective

The program strategies offer a background of the FPDR program. I defined the several project aims, various duties carried out by the group members and participants, and finally, the weekly activities and aims in the program strategies. The first week emphasized good practices that are part of normal clinical activities.

At the beginning of the program, participants will receive instructions on the importance of giving the patient's family a choice of being present during the life-saving measures. The educational sessions were planned for a collective interaction that would give the participants the opportunity to ask their questions and facilitate discussions. Participants were taught how to identify the attitudes and perspectives of the respondents with regard to PFDR. The participants were also to complete the given curriculum subject, review the focuses in the team setting, and discuss potential or actual barriers. The participants were expected to collect a selected task for the following week before the end of the conferences.

Standardized Evaluation Rubric

The group members created the uniform evaluation rubric utilizing Lewin's change theory. In this theory, Lewin theorised that changes often take place in three phases: the unfreezing phase, the moving phase and the refreezing phase. Unfreezing includes motivating people by making them ready for change, and moving involves inspiring people to agree to new ideas that would empower them to agree that the present condition can be made better. The refreezing phase involves supporting new forms of new systems of behaviour. The objective of the project is to assess the important changes in the FPDR project. There were discussion sessions every week when the participants would gather to talk about the experiences they encountered, either positive or negative.

Validation of the Product

To validate this product, the group made for this project created a process to use in validation. Peer review was the standard method of use to advocate the legitimacy of any product. Peer review is thought to be part of specific practice. It combines the procedures of specialists in a particular field. The procedures are for the evaluation of distinction, production, and the contributions of other persons specialized in the same field. The procedure was important to this project. It gives responses that are of value to the project team. Peer review done for this project provided the chance for the analysis of the products in an all-inclusive exercise. At the same time, it allowed for valuable responses from the project team.

Project Implementation Plan

The project group created a plan for implementation for this project. The plan for implementation required planning harmonization together with the emergency department at the hospital faculty. The content specialists also helped come up with the plan. The implementation strategy was based on putting more emphasis on evaluating the success of the project based on the contentment scores for the emergency department. It was essential to ensure that participants would be able to have positive experiences during FPDR.

Project Evaluation Plan

The evaluation plan was designed by the group in charge of the project. It was planned to indicate how the health care practitioners will develop throughout the project program and to identify the experiences of the participant's family members. The program guidelines give the outline for the distribution of questions as well as any additional practices by the participants as required. The strategies are precise regarding the objectives of the program and should ensure that the health care practitioners have definite guidelines to follow. Files containing the program rules and practices will

be made so that the participants and the medical staff can offer guidance throughout this process.

The evaluation plan sets the goal of promoting family presence during resuscitation and ensuring that they get a positive experience. The plan was created to assist in influencing the follow-up and evaluation process of this program. It has short-term and long-term objectives that include following up on the participants' experiences during FPDR. Questions of this survey emphasise the experiences of the participants. They will fill out the survey after the resuscitation sessions and answer questions in the form of yes or no. The desired outcome is to increase the positive experiences of family members during FPDR.

Data and Participants

No data was collected concurrently with this DNP Project. Data (the satisfaction scores) shall be collected by the facility undertaking the evaluation. This will be in association with this suggested quality enhancement project as well as the primary products that were used in this project. Approval to do this project was obtained from (IRB). The proposal was used to develop the products listed for the project, plus a condition that I did not collect data or implement the project. A plan for evaluation was formulated to give guidance on assessing the efficiency of the products.

Primary Products

The main emphasis of the project was helping the family members of the patient to have positive experiences during resuscitation. I planned this project based on evidence to help potential participants understand how interior and exterior factors play an important role in making sure patients are satisfied at the emergency department.

To develop primary and secondary products, I formed a group led by nurses, me, and the medical staff working in the facility. The group members consisted of the emergency nursing department, nursing education, clinical nurse specialist chairman of the emergency room, legal department, and the quality assurance department.

Program Guidelines

The project team designed this program to complement patient care at the hospital. The guides to the program were made from data from a review of the literature. It was based on current evidence of family presence during resuscitation. It was designed to assist the participants in getting positive experiences from the practice. The FPDR policy has well-defined goals and objectives.

The curriculum (see Appendix C) will provide a formal evaluation plan. The formal evaluation plan was to be filled after the FPDR session. The curriculum contents provided the following information:

1. If the FPDR option was given in the event of an emergency.
2. If the option to be present during resuscitation was accepted.
3. If the facilitator was present to support the family and if the support offered by the facilitator was helpful.
4. If, at the time of resuscitation, there was a spiritual care provider offered and if they were helpful to the family.
5. The chance for the patient's family members to be present during resuscitation provides an opportunity for the loved ones to be supportive during the period of crisis.
6. The contents should inform if there is good crowd control and if the condition of the environment during resuscitation was favourable.
7. If the facilitator provided support after the resuscitation session and if the opportunity provided a better understanding of the resuscitation process.

After the participants execute the curriculum content after the resuscitation session, they should have an understanding of their individual roles in this project. There are many known factors that will influence the participant's attitudes and perspectives about FPDR in the future. The curriculum offers an opportunity to hold discussions on the challenges and victories the participants experienced.

The group acknowledged that the health belief model proposed by Pender was the right background for the program. Various components form the basis of this model, which include supposed susceptibility, supposed severity, supposed benefits, supposed barriers and clues to practice. With an understanding of Pender's background as well as the skill to recognise which stage of the background will be experienced, correct interventions by the medical staff can be performed in a manner that is timely

Evaluation Rubric

The evaluation rubric was created by the group to give measurable features on stages 1 to 5. The review of the development of the participants by using the measurable feature levels will be vital in recognizing which stages of Lewin's model strategies changed the participants' experience. The process will result in the creation of personalized care strategies for every participant on the basis of his or her needs. Personalized care strategies, which depend on the demands of the participants, have proven to be helpful and beneficial to all participants.

Implementation and Evaluation Plan

Implementation (see Appendix B) and evaluation plan (see Appendix D) are secondary to this program. They have an important duty in the products given to the hospital. The implementation plan entails the creation of a primary product and providing the procedure and timelines. I guided the plans alongside the contribution of all group members. The expected time required to execute the project would be 12 weeks in total.

An evaluation plan was created to assist in influencing monitoring and evaluation. It entails both short-term and long-term objectives involving monitoring the participants' experiences after FPDR. Questions in the survey focus on the experience and satisfaction of the participants. The participants in the study are required to conduct a survey at the termination of the resuscitation session and will answer multiple questions employing the yes or no format.

Implications

Policy

There was no policy in place when the project was started. The project team came up with guidelines for the healthcare practitioners to enable the presence of family during resuscitation. The guidelines were based on the recommendations of the ENA.

Practice

In the past, the patient's family were asked to leave the patient's room when a crisis occurred. Evidence from current studies shows that the patient's family want to be given the choice of FPDR. The program is organised, designed, and structured in an individual manner to satisfy the particular and various requirements of every participant. Every participant will take part in the curriculum contents that enable a conducive environment for FPDR. The choice of FPDR will enable individuals to be more knowledgeable about the process of resuscitation.

Research

The department head in the facility has set up a plan to follow up and check the results of the project for the first year of the study. The objective of this program is to evaluate the success of the project based on patient satisfaction in the emergency department. Data gathered during this program could contain of the data gathered at the start of program for a period 1 to 2 years.

Social Change

The presence of family during resuscitation has proven to be helpful. It gives the family members a chance to be involved in the life-saving decisions and practices of their loved ones. This practice is also of psychological benefit to the patients as well as the family members. Implementation of this project will be beneficial as it will give individuals a chance to understand the practice better. It will facilitate the improvement of patient care in the emergency department. Healthcare providers need to have a better understanding of their roles in patient care, especially in the emergency department, for better patient care.

Conclusion

Family Presence During Resuscitation (FPDR) provides an opportunity for families to demonstrate support to their loved ones during a crisis. When FPDR is offered, family members are able to witness and participate in the decision-making process regarding the life-sustaining measures. A trained individual will facilitate the FPDR Process while providing an explanation of all events.

Appendix A: Primary Product Policy

Family Presence During Resuscitation: Policy

Policy

Hospital Policy and Procedure Family Presence During Resuscitation

Purpose:

The policy of the Hospital is to facilitate and promote a family-patient-centred approach to care. The hospital has outlined guidelines that preserve the autonomy of patients and family members.

Description:

The family forms an integral part of the patient's care, and this is the basis of the patient and family-centred approach. It is important that healthcare professionals embrace the needs of patients and family members. The family of family members during resuscitation is advantageous to patients as it allows family members to demonstrate support, satisfy the need for information and involvement, and provide an outlet for psychological, social, emotional and spiritual needs to be met. The allowance of family presence should be determined based on the individual situation to maintain a safe environment, which will require the judgment of a healthcare team member.

Policies and Procedures:

A. Criteria for Assessing Family Presence:

1. Family members will be assessed by the healthcare team to determine whether they are suitable to be present at the bedside during resuscitation. Family members should display emotional stability and should not be combative, uncooperative, display extreme emotional outbursts, or present with altered mental status, suspected use of drugs or alcohol and/or suspected abuse. The allowance of

family presence will remain the judgment of a healthcare team member to maintain a safe environment and is not limited to the behaviours mentioned above.

2. The presence of one family member positioned at a designated area at the patient's bedside will be allowed. The family member may have visual contact with the patient.
3. The Family Facilitator will facilitate the needs and provide resources for family members to ensure that they are supported before, during and after the event; remain updated on developments regarding the patients' status and handle any untoward reactions.
4. The decisions of patients not to have family members present during resuscitation will be supported by the healthcare team.
5. The healthcare team will support the decision to exclude the family members during the resuscitation.

Appendix B: Secondary Product Implementation Plan

Family Presence During Resuscitation: Implementation Plan

FPDR will be implemented using the following steps:

1. The FPDR Policy guidelines will be disseminated to the nurses, physicians, and other staff involved in the FPDR process via informal educational sessions and hospital grand rounds.
2. Family Facilitator: a "family facilitator" will be given the responsibility of assessing the conditions for appropriateness and the readiness of the family members, answering questions, attending to the necessities of the families, and providing support. APNs (Advanced practice nurses), nurses, case managers, physicians, spiritual care providers and social workers are some of the personnel who constitute the facilitators.
3. Assessment: Assess the appropriateness of the FPDR for the current situation. Firstly, it depends on the agreement of the interdisciplinary team to the FPDR. Secondly, a stable patient is expected to give his or her consent. Thirdly, the FPDR facilitator should examine the suitability of the designated members of the family to the FPDR. The facilitator should eliminate family members who are disruptive, histrionic and combative. The family members possessing the required characteristics for FPDR should be given the chance to be present in the area of resuscitation. Lastly, the staff should support the members of the family who decide to exclude themselves from the resuscitation. The

staff should make the necessary efforts to meet the informational and emotional needs of such family members, even if they are not present at the bedside.

4. Number of Family Members Allowed: Only one family member is granted permission to be present during the resuscitation process. Greater numbers of family members increase the challenges in accommodation, bearing in mind that there are constraints associated with resuscitation rooms. Besides, many family members complicate the facilitator's capability of maintaining control of the visitors. In the case of the presence of a legal decision maker, FPDR will be preferentially offered to that person since he or she may be asked to make decisions during the resuscitation.

5. Family Preparation: The facilitator is charged with the responsibility of preparing the designated member of the family by offering instructions and guidance for the presence. Some of these instructions include the place to stand, how and when to make queries and advice him or her about interrupting medical care. The facilitator should orient the designated family member on the possible expectations, for instance, the appearance of the patient, the presence of blood invasive procedures, and the expedited pace at which the medical team will be working.

6. Surrogate: The designated FPDR family member might be requested to make decisions concerning the continuing resuscitative efforts. The presence of a legal decision-maker makes it mandatory for the healthcare team to follow the informed decisions made by that person. However, the absence of a legal decision-maker will force the healthcare provider to make decisions about the suitability of the continuing resuscitation efforts.

7. Post-Resuscitation Family Debriefing: Support and debriefing should be provided to family members after the resuscitation. In case the patient dies, then the family members will be allowed to see the body of their loved one, and staff should refer family members to a bereavement program.

8. Post-Event Staff Debriefing: The interdisciplinary team members should debrief after an emotional or traumatic FPDR event.

Appendix C: Secondary Product Formal Evaluation

Family Presence during Resuscitation: Formal Evaluation Form

Formal Evaluation Form to be completed after FPDR

FPDR Evaluation Form

Participant Name _____ Date _____

Questions

1. When the emergent event occurred, was the option given to the family to be present during resuscitation/CPR? Yes ☐ No ☐
2. Was the option to be present during resuscitation/CPR accepted?
Yes ☐ No ☐
3. Was there a facilitator or trained staff member present to provide support to the family? Yes ☐ No ☐
4. Was the support of the facilitator or trained staff member helpful?
Yes ☐ No ☐
5. Was the presence of a spiritual care provider offered, and was this helpful?
Yes ☐ No ☐
6. Did the option for family to be present during resuscitation provide an opportunity for loved ones to be supportive during a crisis?
Yes ☐ No ☐
7. Was there adequate crowd control?
Yes ☐ No ☐
8. Was the environment safe during the resuscitation/CPR process?
Yes ☐ No ☐
9. Did the facilitator provide support/debriefing after the resuscitation/CPR process? Yes ☐ No ☐
10. Do you think the option for family presence during resuscitation provided a better understanding of the resuscitation/CPR process?
Yes ☐ No ☐

Appendix D: The Evaluation Plan

Project

Evaluation:

The project team will evaluate the success of this project based on the patient satisfaction scores for the ED. The project team will compare the patient satisfaction surveys in the ED pre-policy

implementation phase and post-policy implementation phase.

Goal:

The goal is to assess the valuable information obtained regarding the increase or decrease in patient satisfaction scores between both phases.

Policy Evaluation:

The evaluation plan will assess the benefits of the implementation of the FPDR Policy by examining the frequency at which family members chose to be present during resuscitation.

Goal: The goal is to encourage a family-centred approach through the implementation of the FPDR Policy.

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