

❖ GLOBAL CONNECTIONS ❖

The Presence of Family Members During Cardiopulmonary Resuscitation:

European federation of Critical Care Nursing associations, European Society of Paediatric and Neonatal Intensive Care and European Society of Cardiology Council on Cardiovascular Nursing and Allied Professions

Joint Position Statement



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PRE-AMBLE

The European federation of Critical Care Nursing associations (EfCCNa), the European Society of Paediatric and Neonatal Intensive Care (ESPNIC), and the European Society of Cardiology Council on Cardiovascular Nursing and Allied Professions (CCNAP) have jointly formulated this Position Statement. It was ratified by EfCCNa 28 April 2007, ESPNIC 10 February 2007, and CCNAP 16 June 2007.

This Position Statement, where possible, is based on research evidence and expert opinion as expressed in the nursing and medical literature. It is acknowledged that there is a lack of high quality research evidence on the subject of family witnessed resuscitation, and that research on this topic is particularly scarce within Europe.

BACKGROUND

The European resuscitation guidelines (Baskett et al., 2005) are supportive of family presence during cardiopulmonary resuscitation (CPR). However, this practice is often discouraged based upon paternalistic attitudes and conjecture, as opposed to empirical evidence

(Boyd, 2000; Tsai, 2002; Kisson, 2006; Walker, 2006). Twenty years ago family members' presence during resuscitation was confined mainly to emergency departments. However, in recent years healthcare professionals are increasingly offering family members the opportunity to remain present during CPR (Jarvis, 1998; Robinson et al., 1998; Walker, 1999; Grice et al., 2003; Gold et al., 2006). Furthermore, the public demands more and more that family members should be able to remain with their loved ones during CPR, regardless of the predicted outcome of the patient (Mazer et al., 2006).

Despite changing trends, family-witnessed resuscitation is a controversial issue that is still debated widely (Albarran & Stafford, 1999; Tasker, 2005; Kisson, 2006). Concerns in the literature are centred on three areas. The first is the potential for family members' presence to affect the performance of resuscitation staff and increase their anxiety, or that a distressed relative might disrupt the process (Meyers et al., 2000; McClenathan et al., 2002; Blair, 2004; Weslien et al., 2006). As yet there is little evidence, other than isolated anecdotal reports to support these contentions. The second concern is that in witnessing a traumatic event, family members may experience negative emotional and psychological consequences (Crisci, 1994; Schilling, 1994; Fein et al., 2004).

However, this concern is unconfirmed by existing evidence (Robinson et al., 1998; Meyers et al., 2000; Eichhorn et al., 2001; Holzhauser et al., 2006; Weslien et al., 2006). Furthermore, Boyd (2000) observed that many of the presumed obstacles to family members' presence, such as infringements of patient confidentiality, are theoretical debates as no such concerns have been expressed to professional regulating bodies. Third, a number of studies in Europe and elsewhere have identified that members of the public would like to be given the choice whether or not to be present and would wish, if the situation arose, to have their family member close by during CPR (Barratt & Wallis, 1998; Meyers et al., 2000; Grice et al., 2003; Gulla et al., 2004). **The positive benefits**

of having family members present during CPR have been documented in several studies. These benefits include the development of a bond with the resuscitation team, the provision of a more humane atmosphere that allows for closure (Robinson et al., 1998; Van der Woning, 1999; Eichhorn et al., 2001) and the satisfaction of knowing that their family member is in safe hands (Wagner, 2004).

Two European surveys, undertaken in collaboration with EfCCNa and ESPNIC (Nursing), of adult, paediatric and neonatal critical care nurses investigated their experiences and views of family members' presence during CPR (Fulbrook et al., 2005; Fulbrook et al., 2007). These studies indicated that most European critical care nurses were supportive of

EfCCNa, ESPNIC and CCNAP POSITION

1. All patients have the right to have family members present during resuscitation.
See Note 1, below.
2. The patient's family members should be offered the opportunity to be present during resuscitation of a relative.
See Note 2, below.
3. Support should be provided by an appropriately qualified health care professional whose responsibility is to care for family members witnessing cardiopulmonary resuscitation.
See Note 3, below.
4. Professional counselling should be offered to family members who have witnessed a resuscitation event.
5. All members of the resuscitation team who were involved in a resuscitation attempt when family members were present should participate in team debriefing.
6. Family presence during resuscitation should be incorporated into the curricula of cardiopulmonary resuscitation training programmes.
7. All intensive and critical care units should have multi-disciplinary written guidelines on the presence of family members during cardiopulmonary resuscitation.

NOTES

Note 1

The decision to enable family members to be present during a resuscitation attempt should be made in the best interests of the person who is being resuscitated. In this regard, discussion should be facilitated by experienced healthcare professionals. When appropriate, spiritual leaders or other trained members of the health care team may assume this role. If the patient who is being resuscitated has expressed a prior wish, this should be respected.

Note 2

When the person who is being resuscitated is not able to communicate his or her wishes, or who has not previously expressed their wishes in an advanced directive, the decision about who should be present during resuscitation should be made jointly by the members of the resuscitation team and family members.

The decision of a family member about whether or not to be present during CPR of a relative should be made freely by the family member, without coercion or pressure.

Family members should be warned that on occasions they may be asked to leave the bedside if at any time it is thought to be in their or the patient's best interests, for example, for the purpose of obtaining radiographs or to avoid obstructing the work of the resuscitation team.

Europe is multi-culturally diverse, and the resuscitation team should take the individual patient's and family's beliefs, values and rituals into account. The patient's and the family's cultural background should be assessed with respect to the provision of appropriate individualised care.

Note 3

Whilst it is conceded that on some occasions it may not be possible to provide a health care professional whose sole responsibility is to care for the family member, this should not mean the exclusion of the family member from the resuscitation. Rather, an experienced member of the resuscitation team, who is not undertaking a lead role, should be designated primary responsibility for the continued care of the family member.

With respect to family members, the role of the designated health care professional is to:

- brief them about what to expect prior to entering the resuscitation area,
- provide a running commentary with appropriate explanations,
- help them to communicate their presence to their relative,
- respond truthfully and realistically to questions,
- maintain a safe environment,
- assess continually their emotional and physical status,
- if possible, accompany the family member if he or she wishes to leave the scene, continuing to liaise with the resuscitation team on their behalf,
- provide an opportunity for them to reflect on the resuscitation process after the event, participate in resuscitation team debriefing, providing feedback with respect to the needs and concerns expressed by them.

family-witnessed CPR. However, only a small number of intensive care units had resuscitation policies that included guidance about family members' presence. As a result a major recommendation from both surveys was for this lack of directive to be addressed at a Europe-wide level.

Although there is some evidence to indicate that not all European countries are supportive of family member presence (Badir & Sepit, 2007), in the light of the general consensus found in the two European surveys (Fulbrook et al., 2005; Fulbrook et al., 2007), and current guidance from the European Resuscitation Council (Baskett et al., 2005) it is reasonable that EfCCNa, ESPNIC and CCNAP should state their position on family presence during CPR. However, further research related to family presence during resuscitation and its impact on patients, family members and health care professionals is required.

POSITION STATEMENT

The EfCCNa, ESPNIC and CCNAP Position is stated above. It provides a series of statements about family presence during CPR. The Position is underpinned by the belief that family members are critical to the health and wellbeing of the patient.

For the purpose of this Position Statement the following definitions are used:

- **Cardiopulmonary resuscitation:** life-saving interventions when either cardiopulmonary or respiratory arrest occurs.
- **Intensive and critical care setting:** any in-hospital acute care setting where critically ill patients (children and adults of all ages) are cared for.
- **Family member:** those people who are most important to the patient. This definition includes the patient's family, loved ones and close friends. For newborns and children this is defined as the parents or significant others.
- **Family presence:** family member presence during CPR, including the witnessing of all life-saving interventions.

FURTHER INFORMATION

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