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Using Research to Determine Support for a Policy on Family Presence During Resuscitation

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National guidelines and professional organizations have recommended allowing family presence during resuscitation and bedside invasive procedures. Studies found that only 5% of critical care units have written policies. Periodic requests by family members prompted the creation of a task force, including nurses, physicians, and respiratory therapists, to develop this controversial policy. Before development, a research study of healthcare personnel attitudes, concerns, and beliefs toward family presence during cardiopulmonary resuscitation and bedside invasive procedures was done. This descriptive and correlational study showed support for family presence by critical care and emergency department nurses. Findings revealed both support and nonsupport for families to be present during resuscitative efforts. Providing family presence as an option offers an opportunity for reluctant healthcare team members to refuse their presence and an opportunity for those who support family presence to welcome the family.

Keywords: Bedside invasive procedures, Cardiopulmonary arrest Families, Resuscitation

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"When Jeff was coding, you let us sit right outside his room. It may have been upsetting for other families to see, but this is where we needed to be. Not out in the waiting room, or even in his room, but to be near by… if only for a minute." This was stated by a critical care nurse family member in a note to the staff after her brother-in-law died—the need for families to be near their loved ones in critical moments. Although professional organizations and critical care experts support family presence during resuscitation, only 5% of critical care units in the United States have written policies.[1] The lack of formal policies suggests that family presence during resuscitation remains a controversial practice.

National guidelines and professional organizations have recommended that healthcare professionals consider allowing family members to be present during

resuscitation and bedside invasive procedures (BIPs).[2-7] Over the past decade, the practice of excluding relatives during cardiopulmonary resuscitation (CPR) has been critically questioned.[8-10]

The development of formal guidelines to support the option of family presence allows for a consistent approach to address the support needs of patients and families. Assessment of healthcare professionals' familiarity, comfort, attitudes, concerns, and beliefs with family presence during resuscitation provides important information to guide discussions, develop formal guidelines, and design strategies for guideline implementation.

The Emergency Nurses Association (ENA)[3] was the first, in 1994, to develop a resolution to support the option of allowing patients' families to be present during CPR and BIPs. A program for implementing this practice was developed by the ENA in 1995 and updated in 2001 and 2005. Since 2000, CPR and Advanced Cardiac Life Support guidelines of the American Heart Association[11] have included recommendations for providers to consider offering patients' family members the option of remaining with patients during resuscitative efforts. The American Association of Critical-Care Nurses published a practice alert,[2] which recommends that healthcare organizations should have an approved written policy for presenting the option of family presence during CPR and BIPs.

Staff registered nurses (RNs) and physicians' attitudes, concerns, and beliefs about family presence during CPR are known primarily for individuals working in the emergency department and with pediatric populations. Little is known regarding the attitudes, concerns, and beliefs about family presence during CPR and BIPs of RNs in non–emergency department or critical care positions, certified RN anesthetists (CRNAs), respiratory therapists (RTs), orderlies, and spiritual care staff. Yet, these individuals may be involved in providing care during CPR and/or BIPs or supporting policies regarding family presence.

REVIEW OF THE LITERATURE

Witnessed resuscitation was first explored at Foote Hospital in Michigan in 1982 as a result of 2 instances in which family members demanded to be present during resuscitation of a loved one. This resulted in the development of a policy where relatives were given information about the patient's condition, asked if they wished to be present, and escorted to the resuscitation room if desired.[12] A second survey 9 years after implementation of the policy revealed that there had not been any disruptive behavior nor attempts to interfere with resuscitation activities.[13]

Positive responses of family members and healthcare providers have been reported in these initial studies and subsequent studies.[5,14-19] Some of the perceived benefits include the following: (1) fosters greater appreciation for code efforts, (2) enhances family understanding of patient's condition, (3) reduces family guilt and anxiety, (4) focuses staff attention on patients' privacy and dignity, (5) encourages professional behavior among staff, and (6) helps staff provide more holistic care.

Despite positive responses, RNs and physicians have raised concerns regarding witnessed resuscitation. Studies have found that reluctance of emergency staff to allow families to be present are based on the following: (1) fears that the family members may interfere, (2) poor staff performance will be observed, (3) family members will hamper the staff's performance, (4) family will misinterpret the team's activities, (5) future litigation may occur, (6) the room may be overcrowded, (7) there may be negative psychological effects to the family, (8) families would be more likely to complain that not enough was done/too much was done, (9) the resuscitation procedure was stopped too soon or not carried on long enough, (10) physicians or RNs may be uncaring in their attitudes, and (11) inappropriate remarks could be made.[5,20-24] Sherman[25] stated that both the benefits and possible negative effects of family presence must be considered.

Ellison[26] explored variables influencing hospital nurses' and ENA members' attitudes and beliefs about family presence during resuscitative and invasive procedures. The respondents were 208 RNs and licensed practical nurses who completed a survey. No demographic data were reported on the number of nurses working outside of the emergency department.

Registered nurses, physicians, and other healthcare personnel on all units work collaboratively in providing family-centered care. Since the attitudes of healthcare providers have been shown to affect the family member's decision to stay or leave the room during various procedures,[27,28] it is important to assess the attitudes, concerns, and beliefs for an entire organization in establishing policies regarding family presence during resuscitation.

Clark and colleagues[29] and Rattrie[30] urge that research continue with a variety of populations and settings. In addition, Boudreaux et al,[31] in their review of published research, recommend further research in multiple settings using established instruments. The authors noted that the research related to family presence during resuscitation is in the initial phases of development with many study limitations. Blair[32] continues to recommend that before initiating any policies related to family presence during resuscitation, healthcare personnel are surveyed so that concerns can be addressed.

Policy development requires stakeholder input and staff support when introducing a significant practice change. Mangurten et al[33] increased staff awareness of

family presence through the use of a family presence self-assessment survey adapted from the ENA. Results revealed that 71% of respondents supported a policy for family presence during resuscitation interventions. Lack of formal guidelines suggests that there is still controversy within the medical and nursing community related to family presence during resuscitation.[33] York[34] recommends the formation of a multidisciplinary committee for establishment of a family presence protocol.

Based on these findings, a research study was conducted to determine the attitudes, concerns, and beliefs related to family presence during CPR and BIPs of staff RNs, RNs in management positions, physicians, CRNAs, RTs, orderlies, and spiritual care staff from a variety of patient care units.

METHODOLOGY

Research Questions

1. What are the attitudes, concerns, and beliefs related to family presence during CPR and BIPs of staff RNs, RNs in management positions, physicians, certified RN anesthetists, respiratory therapists, orderlies, and spiritual care staff caring for patients from a variety of patient care units?
2. Is there a relationship between the attitudes, concerns, and beliefs of staff RNs, RNs in management positions, physicians, certified RN anesthetists, respiratory therapists, orderlies, and spiritual care staff caring for patients from a variety of patient care units and certain demographic variables?

Research Design

The 16-item Family Presence and Support: Staff Assessment Survey from the ENA[3] was used to identify the attitudes, concerns, and beliefs of healthcare personnel regarding family presence during CPR and/or BIPs. Three additional questions involving benefits, impact, and support of a hospital policy were added. Cronbach α reliability coefficients on the Likert-scale items in the survey was .63 on the first 6 items with and without the added item 15. The reliability was .77 on items 7 to 12 and 16. The study was conducted at a Midwest Magnet-designated hospital.

Results

Of the 1,402 distributed surveys, 625 were returned, indicating a 45% response rate. Most of the participants were white (97.3%), female (80.3%), and RNs (78.8%). The participants ranged in age from 23 to 81 years, with a mean of 42.6 years. Most were in their positions for more than 10 years (56.3%) and involved in 4 or more resuscitation events (72.2%). Forty-two percent were nationally certified. Twenty-nine percent of the participants were members of the Code Blue Team (n = 181). Table 1 provides a summary of the demographic characteristics of participants.

Respondents reported on a 1 to 5 Likert scale that providing psychosocial and/or emotional support to family members was part of their job/practice at 4.72 whereas comfort with providing this support was 4.43 (Table 2). Belief that family members should have the option to be present during invasive procedures was reported at 3.11 and, during resuscitation, dropped to 3.07.

Significant correlations were found between the demographic variables of (1) age, (2) highest level of degree obtained, (3) national certification, (4) member of a Code Blue Team, (5) critical care/emergency department nurses versus non–critical care/emergency department nurses, (6) gender, and (7) RNs versus non-RNs with the atti tudes and beliefs toward family presence. Table 3 summarizes these correlations and the nature of the relationships.

Table 4 displays the responses to statements regarding participation and experience with invasive procedures and family presence by total respondents and discipline. Most respondents (59.9%) had participated in a treatment situation in which a family member was present during invasive procedures and (48.8%) resuscitation. Among the respondents, 41.4% answered that their job performance had been hampered by the presence of a patient's family member. The top 3 explanations were (1) focus taken away from the actual patient, (2) emotional family, and (3) families in the way of staff.

If their family member was ill or injured, 69.4% indicated that they wanted the option to be present during invasive procedures. Positive comments included the following: (1) to provide patient support, (2) if requested by patient, (3) to provide family knowledge and to be informed, (4) to decrease family anxiety, (5) it is my right, (6) I am qualified, (7) I would want to be present, (8) it would be helpful, and (9) to help make decisions. Nonsupporting comments were as follows: (1) it would take the focus from the patient, (2) the family would be in the way, (3) it would be inappropriate, (4) it would not be helpful, (5) staff might not make good clinical judgments, (6) it would interfere or distract, and (7) it would be a worry to the health team.

If their family member was ill or injured, 53.9% indicated that they wanted the option to be present during resuscitation. Positive comments included the following: (1) to provide patient support, (2) if requested by patient, (3) it is my right, (4) I am qualified, (5) I

TABLE 1 Demographic Characteristics of the Sample

Sample Size		
1,402 Surveys Distributed	**625 Surveys Returned**	**45%**
Demographics	**n = 459**	
Mean age, y		**42.56**
		n (%)
Gender	Male	121 (19.4)
	Female	502 (80.3)
	No answer	2 (0.3)
Ethnicity	White	608 (97.3)
	Hispanic	3 (0.5)
	African American	3 (0.5)
	Asian	7 (1.1)
	Other	1 (0.2)
	No answer	3 (0.5)
Profession	Physician	88 (14.1)
	CRNA	17 (2.7)
	Registered nurse	490 (78.4)
	Respiratory therapy	17 (2.7)
	Orderly/spiritual care	9 (1.4)
	No answer	4 (0.6)
Years in position	0-1	25 (4.1)
	2-5	119 (19.3)
	6-10	121 (19.4)
	11-20	157 (25.1)
	>20	195 (31.2)
	No answer	8 (1.3)
Highest level of education	Physician	86 (13.8)
	Doctorate	4 (0.6)
	Master's degree	44 (7.0)
	Baccalaureate	234 (37.4)
	Diploma	106 (17.0)
	Associate	144 (23.0)
	High school	1 (0.2)
	Other	1 (0.2)
	No answer	5 (0.8)
Nursing specialty	Clinical	282 (45.1)
	Management	42 (6.7)
	Anesthesia	21 (3.4)
	Critical care, pediatric intensive care unit, neonatal intensive care unit	83 (13.3)
	Emergency	33 (5.3)
	Float pool	32 (5.1)
	Medical/surgical unit	85 (13.6)
	Pediatrics	19 (3.0)
	Practice nurse	11 (1.8)
	Outpatient	23 (3.7)
	Surgery	39 (6.2)
	Telemetry, progressive care unit	45 (7.2)
	Other	153 (24.5)
Physician specialty	Anesthesia	8 (1.3)
	Cardiologist	14 (2.2)
	Emergency	4 (0.6)
	Family Practice	18 (2.9)
	Hospitalist	8 (1.3)
	Intensivist	5 (0.8)
	Internal medicine	8 (1.3)
	Neonatal/pediatrics	18 (2.9)
	Obstetrics/gynecology	7 (1.1)
	Oncology	9 (1.4)
	Resident	4 (0.6)
	Surgery	9 (1.4)
	Other	30 (4.8)
National certification	Yes	261 (41.8)
	No	287 (45.9)
	No answer	77 (12.3)
Work hours	Full time	429 (68.6)
	Part time	173 (27.7)
	Casual	19 (3.0)
	No answer	4 (0.6)
Direct care of patients (percentage of time)	0	56 (8.96)
	1-50	78 (12.48)
	51-90	104 (16.64)
	>90	387 (61.92)
Involvement in resuscitation events during career	0-1	80 (12.8)
	1-3	88 (14.1)
	4-10	135 (21.6)
	>10	316 (50.6)
	No Answer	6 (1.0)
Member of Code Blue Team	Yes	181 (29.0)
	No	438 (70.1)
	No answer	6 (1.0)

Abbreviation: CRNA, certified registered nurse anesthetist.

TABLE 2 Psychosocial/Emotional Support to Family Members

	N	Mean	SD
1. Providing psychosocial and/or emotional support to family members is part of my job/practice.	619	4.72	0.671
2. I feel comfortable providing psychosocial/emotional support to family members during treatment situations.	614	4.43	0.775
3. I feel that appropriate psychosocial/emotional care is provided to patients and their families when patients are undergoing invasive procedures.	605	4.08	0.800
4. I feel that appropriate psychosocial/emotional care is provided for family members of patients undergoing resuscitations.	581	3.84	0.885
5. I believe family members should have the option to be present during invasive procedures.	617	3.11	1.438
6. I believe family members should have the option to be present during resuscitation situations.	617	3.07	1.493
15. How well informed do you think you are about the impact of family presence during invasive procedures or resuscitation?	599	3.41	0.978

would want to be present, (6) it would be helpful, (7) to help make decisions, (8) to see if proper procedure was being done, (9) to see if enough people were present, and (10) to see everything was tried. Nonsupporting comments were (1) discomfort, (2) emotional trauma to observer, (3) it would take focus from the patient, (4) the family would be in the way, (5) it would be inappropriate, (6) it would not be helpful, (7) staff might not make good clinical judgments, and (8) it would interfere. Nurses (75.5%) and physicians (51.9%) felt that if their family member was ill or injured, they would want the option to be present during invasive procedures, whereas 17.6% of CRNAs would want the option to be present. Nurses (58.2%) and RTs (52.9%) felt that if their family member was ill or injured, they would want the option to be present during resuscitation, with 17.6% of CRNAs wanting the option to be present.

When asked if their family member was ill or injured, should other members of their family (nonhealthcare providers) have the option to be present during invasive procedures, 56.1% indicated yes. Positive comments were (1) patient support, (2) requested by patient, (3) it is my right, (4) I am qualified, (5) I would want to be present, (6) it would be helpful, (7) to help make decisions, (8) to provide family knowledge, (9) to be informed, and (10) to decrease family anxiety. Nonsupporting comments were (1) lack of knowledge, (2) uncomfortable with procedures, (3) discomfort, (4) emotional trauma to observer, and (5) distracting and worry to healthcare team. Nurses (59.7%) and RTs (47.1%) felt that if their family member was ill or injured, other members of the family should have the option to be present during invasive procedures compared to 12.5% of CRNAs.

Participants were asked if their family member was ill or injured, did they feel that other members of their family (nonhealthcare providers) should have the option to be present during resuscitation. Of these, 49.7% indicated yes. Positive comments were (1) patient support, (2) requested by patient, (3) proper procedure, (4) enough people, (5) everything tried, (6) my right, (7) qualified, (8) want to be present, (9) helpful, and (10) make decisions. Nonsupporting comments were (1) discomfort, (2) emotional trauma to observer, (3) lack of knowledge, (4) uncomfortable with procedures, (5) focus on the patient, (6) family in the way, (7) inappropriate, and (8) not helpful. Nurses (53.4%) and orderly/spiritual care staff (55.6%) felt that if their family member was ill or injured, other members of the family should have the option to be present during resuscitation with 12.5% of CRNAs feeling family members should have the option to be present.

Participants were asked if they were critically ill/injured, would they want the option to have their family present at their bedside; 90.3% responded yes. The primary reasons given were support, comfort, and love. Only 50% of CRNAs would favor this option.

When asked if there were system barriers to family presence, 64.5% responded yes. Reasons given included personnel preferences and environmental factors. Examples included (1) biases of personnel, (2) resistance to change, and (3) number of people in the room.

Total respondent support for a policy giving family the option of being present during invasive procedures was reported at 67.9%, and during resuscitation, at 61.3%. Nurses (72.9%) and orderly/spiritual care staff (66.7%) would support a policy giving family the option of being present during invasive procedures, whereas 11.8% of CRNAs would support a policy. For a policy of family presence during resuscitation, most of the nurses, orderly/spiritual care, and RT staff are in support, whereas less than half of physicians (46.3%) and CRNAs (17.6%) would support a policy.

Additional comments from participants included the following: (1) having an appropriate designated team member to assist the family, (2) define "family members," (3) cultural background is important, (4) it is a step toward "human"-based healthcare, (5) pediatrics is different from adults, (6) parents should have the choice,

TABLE 3 Correlations Between Demographic Variables

Significance Level Using Pearson Correlations Indicated if $P = < .05$	Age	Highest Level of Education	National Certification	Member of Code Blue Team	Critical Care, Emergency Room Nurses, and Noncritical Care/ Emergency Department Nurses	Male and Female	Registered Nurses and Nonregistered Nurses	Physicians and Registered Nurses
Providing psychosocial and/or emotional support to family members is part of my job/ practice.			.011			.000	.000	.030
I feel comfortable providing psychosocial/emotional support to family members during treatment situations.	.127				.001	.004	.001	
I feel that appropriate psychosocial/emotional care is provided to patients and their families when patients are undergoing invasive procedures.				.039	.000			
I feel that appropriate psychosocial/emotional care is provided to patients and their families when patients are undergoing resuscitations.				.000	.000			
I believe that family members should have the option of being present during invasive procedures.		.001	.008	.004	.031	.000	.000	.000
I believe that family members should have the option of being present during resuscitation situations.		.019	.025		.000	.000	.000	.000
How well informed do you think you are about the impact of family presence during invasive procedures or resuscitations?		.016	.002	.000	.000		.000	

and (7) would like to see callbacks to families after the event by primary RN. Negative comments included the following: (1) healthcare workers "would quit," and (2) if there is support for this concept, there should be more psychologists and social workers to treat the dysfunctional families.

POLICY DEVELOPMENT

A task force consisting of physicians, nurses, social work, and spiritual care representing adult and pediatric practice reviewed the results of the study findings and recommended the implementation of a hospital-wide policy for family presence during resuscitation (see Figure 1). Although the survey revealed support for a policy during invasive procedures, the task force decided not to pursue family presence during invasive procedures at this time. The policy provides an option for family presence and guidelines for the role of a family support person.

The purpose of the policy is to provide patients and their families' care that is consistent with the philosophy of family-centered care by giving family members the option, when appropriate, of being at the bedside during resuscitation interventions. The policy was approved by

TABLE 4 Yes/No Responses to Statements Concerning Participants and Experience With Procedures and Family Members

		Total Responses[a]		Yes Response				
		n	%	Physicians, n (%)	Certified Registered Nurse Anesthetist, n (%)	Nurses, n (%)	Respiratory Therapist, n (%)	Orderly/ Spiritual Care, n (%)
7a.	Have you participated in a treatment situation in which a family member was present during the invasive procedures?	366	59.9	66 (77.6)	9 (52.9)	272 (56.8)	11 (64.7)	6 (66.7)
7b.	Have you participated in a treatment situation in which a family member was present during resuscitation?	297	48.8	40 (47.1)	6 (35.3)	224 (47.0)	15 (88.2)	9 (100)
8.	Has your job performance ever been hampered by the presence of a patient's family member?	246	41.4	37 (44.6)	6 (37.5)	194 (41.6)	5 (31.3)	3 (33.3)
9a.	If your family member was ill or injured, would you (as a healthcare provider) want the option to be present during invasive procedures?	409	69.4	42 (51.9)	3 (17.6)	348 (75.5)	8 (47.1)	4 (44.4)
9b.	If your family member was ill or injured, would you (as a healthcare provider) want the option to be present during resuscitation?	321	53.9	32 (37.6)	3 (17.6)	270 (58.2)	9 (52.9)	4 (50.0)
10a.	If your family member was ill or injured, do you feel other members of your family (nonhealthcare providers) should have the option to be present during invasive procedures?	324	56.1	36 (45.0)	2 (12.5)	270 (59.7)	8 (47.1)	4 (44.4)
10b.	If your family member was ill or injured, do you feel other members of your family (nonhealthcare providers) should have the option to be present during resuscitation?	291	49.7	29 (34.5)	2 (12.5)	243 (53.4)	8 (47.1)	5 (55.6)
11.	If you were critically ill/injured would you want the option to have your family present at your bedside?	543	90.3	69 (83.1)	7 (50)	441 (92.8)	14 (87.5)	8 (88.9)
12.	Do you believe that there are system barriers to family presence?	329	64.5	41 (60.3)	6 (54.5)	268 (66.3)	7 (43.8)	5 (62.5)
16a.	I would support a policy giving the family the option of being present during invasive procedures?	399	67.9	43 (52.4)	2 (11.8)	336 (72.9)	8 (53.3)	6 (66.7)
16b.	I would support a policy giving the family the option of being present during resuscitation?	359	61.3	38 (46.3)	3 (17.6)	300 (65.4)	8 (53.3)	6 (66.7)

[a]Not all indicated their profession.

nursing and medical department committees, with final approval by the Medical Executive Committee. Approval through medical departments was facilitated by 2 physicians, an adult intensivist and pediatric intensivist. After approval of the policy, the Code Blue Team was educated on the process of providing family support, including preparation of the family before entering the room, announcement of family presence, and management of unexpected family behaviors. Hospital staff were informed of the practice change through education and newsletters.

Since the policy was implemented, a reported 26% of cardiopulmonary arrests have had families present (see Table 5). Members of the Code Blue Team have reported positive experiences with family presence including the perception that families have made the choice to stop efforts earlier than what the team may have done. There have been no negative experiences reported with family

presence. A follow-up survey is in the process of being conducted to identify response to the policy change.

RECOMMENDATIONS AND IMPLICATIONS FOR PRACTICE

The traditional view from healthcare workers regarding family presence views it as a foreign concept, causing it to be a continued issue in healthcare as stated by Ellison.[26] Support for the development of a policy of family presence is gaining acceptance although there continues to be pockets of resistance.

Additional research and education in family presence are needed for the healthcare team. Education regarding family presence that heightens the awareness of the staff

TITLE: FAMILY PRESENCE DURING CARDIOPULMONARY RESUSCITATION

Original: 5/07 Revised: Replaces:
Responsible Person: Department Director, Intensive Care Unit
Approving Committee: Clinical Patient Care Committee
Medical Executive Committee
Category: Patient Care Page 1 of 3
Cross Reference:

POLICY: To provide patient families the option of being present during cardiopulmonary resuscitation always having an identified staff member with the family member present as family support. Family presence will not be offered in PACU or Surgery before confirming with the Anesthesiologist. The presence of children is discouraged and should be closely evaluated.

PURPOSE:
To provide patients and their families care that is consistent with the philosophy of family-centered care by giving family members the option, when appropriate, being at the bedside during resuscitation interventions.

DEFINITIONS:
Health care providers: a nurse, physician, or other health care provider providing physical care to the patient.
Family: a relative of the patient or any person (significant other) with whom the patient shares an established relationship.
Family presence: the presence of family in the patient care area, in a location that affords visual or physical contact with the patient during resuscitation events.
Family support person (facilitator): a hospital staff member (Administrative supervisor, Primary registered nurse, Spiritual Care, or other appointed registered nurse who is trained to provide family support will assess patient and family psychological/emotional needs and will initiate interventions that assist the family in meeting those needs. The family support person will be identified after patient care resuscitation needs are met.
Resuscitation: a sequence of events that are initiated to sustain life or prevent further deterioration of the patient's condition.

PROCEDURES/GUIDELINES:
The option of family presence during resuscitation efforts will be offered to the family, provided that the following criteria are met:

1. Patient care will remain the priority.
2. The family support person will assess the patient's family needs including cultural factors for appropriateness of family presence.
   A. Members of the health care team will participate with the family support person in evaluating whether the families are suitable candidates for bedside presence.
   B. If a language barrier exists and a certified interpreter is not present, family will be escorted to an area where an interpreter/language line can be accessed. When language line is accessed, updates will be given.
3. The health care team is informed of and is in agreement with the option of family presence.
4. The family will be offered the option of family presence. Family members who do not wish to be present will be supported in their decision. In this case, family will be escorted to a comfortable area by a hospital staff member, given frequent updates, and given the option of having a support person(s) remain present.
5. Understanding space may be limited, family will prioritize who will be present.
6. Before entering the room, the family support person will prepare the family for bedside presence by:
   A. Explain that patient care is the priority

Figure 1. Family presence during cardiopulmonary resuscitation.

B. Instruct the family there may be situations where they may need to be escorted out of the room if family responses interfere with patient care
C. Describe the patient's appearance and condition noting there may be times when the patient's body is exposed
D. Prepare them for procedures being performed
E. Reiterate the importance of the family's supportive role
F. The family support person will escort the family to the room, instruct them where to stand, and remain with the family.

7. The family support person will announce when family is at the bedside. They will also:
   A. Provide comfort measures, such as a chair or tissues at the bedside.
   B. Provide opportunities for the family to ask questions.
   C. Facilitate opportunities for the family to see, touch, and speak to the patient.
   D. Provide family with the option to leave at any time.

8. If a family member becomes faint, overwhelmed, or disruptive at the bedside, the family support person will immediately offer a chair or escort the family from the area and arrange appropriate supportive care.

9. After completing the patient bedside visitation, the family support person will escort the family to a comfortable area, answer their questions, provide comfort measures, facilitate discussion with the physician, and address other psychosocial needs identified during the intervention.

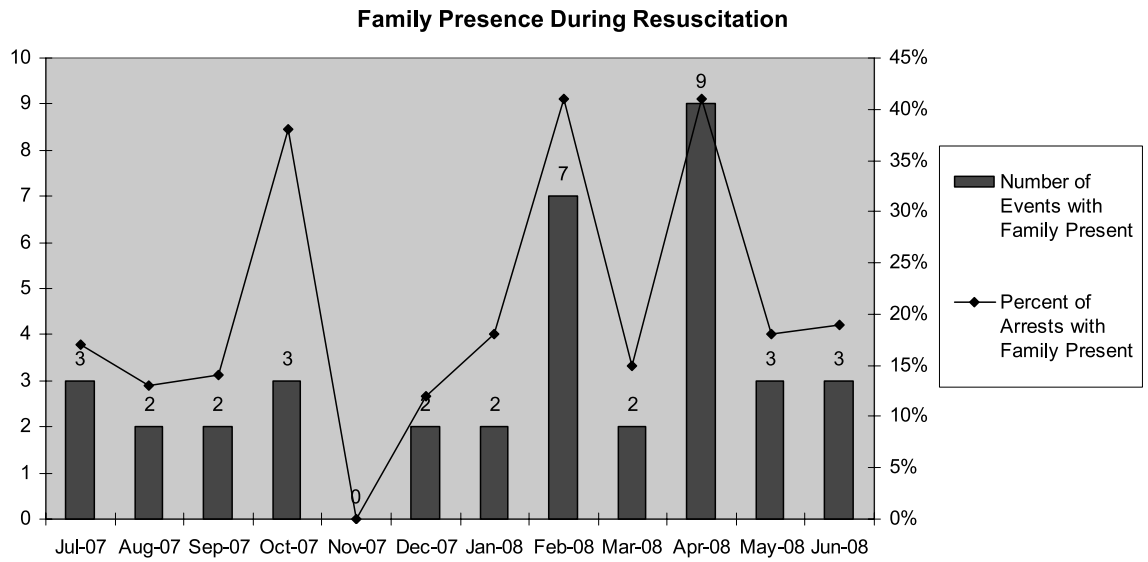
10. If death has occurred, the family support person/registered nurse will:
   A. Inform the family about what to expect
   B. Provide support for the family during the viewing of the body
   C. Offer the family time they may need including alone time
   D. Offer Spiritual Care (if not present)
   E. Assist the family with decisions concerning the disposition of the body.

11. The bereavement package will be offered to the family.

Figure 1. (continued).

and addresses staff concerns is a necessity in promoting change from traditional view.[26] Multidisciplinary team education should address issues of discomfort, risks, benefits, physical and psychological concerns, and fears expressed by staff. It should also include evidence-based practice supporting family presence.

Table 5 **Family Presence During Resuscitation**



Findings support implications for practice changes by introducing a hospital-wide policy giving families the option to be present during invasive bedside procedures and resuscitation. Currently, many nurses receive requests from patients' families to be present during invasive bedside procedures and resuscitation, and because most often, nurses facilitate this communication, units need to collaborate, educate, and promote the use of a hospital-wide policy.[1] A policy that details the responsibilities of nurses during family presence would be beneficial, providing structure and uniformity to the entire facility regarding family presence.

Recommendations for further research include revision of the instrument statements and questions to reduce the variety of responses that are produced by open-ended questions. Statistical analysis was difficult to capture with multiple open-ended questions. Creating a policy in which family presence is an option provides an opportunity for reluctant healthcare team members to refuse their presence. It also provides an opportunity for those who support family presence to welcome the family. If a hospital is going to create a policy, staff input and education are essential.

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