Family Presence During Cardiopulmonary Resuscitation

Corporate Policy & Procedures Manual

Number: VII-B-365
Date Approved December 16, 2014
Date Effective January 9, 2015
Next Review (3 years from Effective Date) January 2018

Approved by:

Vice President and Chief Medical Officer; and
Vice President Mission, Ethics and Spirituality

Purpose

To facilitate the presence of family members during resuscitative efforts of their loved ones whenever possible as per recommendations and best practice standards set forth by Accreditation Canada and the American Heart Association.

Policy Statement

In keeping with our mission, values and ethical framework (Appendix A), as well as our palliative and end-of-life strategy, Covenant Health supports the presence of family members during resuscitative efforts of their loved ones. This presence will be facilitated by:

- An invitation to family members to be present whenever possible during a resuscitation;
- A clearly identified supportive individual (Family Presence Facilitator) to provide necessary guidance during resuscitation;
- An ongoing assessment of family members and their needs during resuscitation;
- Consideration of withdrawal of family if they so choose to leave or if healthcare professionals recommend they leave.

Applicability

This policy and procedure applies to Covenant Health facilities that have a Family Presence Facilitator and appropriate supports in place to make it possible for staff, members of the medical staff, volunteers, students and any other persons acting on behalf of Covenant Health to align with the requirements outlined in this policy. This policy does not apply to operating rooms.

Responsibility

Resuscitation Team:

1. Primary Code Team Physician:
   - Provides direction to the resuscitation team;
   - Support family presence to occur during resuscitation efforts when possible.

2. Code Team Nurse:
   - Assist and carry out resuscitative measures within their scope of practice according to protocol and code team leader;
   - Encourage and aide in the facilitation of family presence during resuscitation.

3. Respiratory Therapist:
   - Assist and carry out resuscitative measures within their scope of practice according to protocol and code team leader;
   - Encourage and aide in the facilitation of family presence during resuscitation.
Family Presence Facilitator (FP Facilitator):
- Aides in the facilitation of family presence during resuscitation when the situation is both appropriate and reasonable;
- Is a designated Covenant Health staff member who is exclusively assigned to the family of a patient to provide psycho-social-spiritual support (ie. Chaplain);
- Ensures the safety of family members present during resuscitation efforts. Aides family members in observing universal precautions when needed;
- Determines family’s wishes and continuously evaluates family’s desire to be present during the resuscitation of their loved one.

Unit Staff:
- Support resuscitation team;
- Identify family wishes regarding presence during resuscitation;
- Introduce family to designated FP Facilitator.

Family:
- The family’s primary role is to provide comfort, support and reassurance to the patient/resident¹ and not hinder the resuscitation effort;
- The family will provide information based on the patient’s/family’s wishes to the resuscitation team regarding continuation or termination of resuscitation efforts.

Principles
The literature demonstrates the positive value that family presence can bring, and thereby the importance of developing policy and educational programs to ensure integration occurs in everyday practice (See Appendix A & Appendix B). Family presence during resuscitation is fully aligned with the principle of respect for the dignity of every person, as well as the calls to foster trust and justice as described in the Health Ethics Guide (2012, 14-16). Moreover, facilitating the presence of family during resuscitative attempts models Covenant Health’s values of compassion, respect, collaboration and integrity and provides another tangible way in which we fulfill our strategic direction to “live our mission and values in all we do.”

Procedure
1. Identify the FP Facilitator.

2. Patient Resuscitation Effort and Family Assessment
   2.1 Assess each situation to determine 1) patient’s current condition, 2) physical constraints to family presence, and 3) resuscitation team’s willingness for family presence.

   2.2 Ask the primary care provider directing the resuscitation whether he or she is in agreement with the family being present, and understand that based on reasonable grounds, he or she may request the family to be escorted from the room at anytime.

   2.3 Assess the family before the option of family presence is offered to understand the family’s level of emotional coping, and ensure absence of combative or threatening behaviors and behaviors which may suggest

¹ Hereafter, all references to 'patients' includes residents and clients.
altered mental status due to recent alcohol and/or drug use. If appropriate, the family’s need, wishes and desire to be present during resuscitation efforts should be explored by the FP facilitator.

3. Possible Constraints

3.1 FP facilitator must remain present with family members at all times. Family members who exhibit uncontrolled emotional behavior, or impede the resuscitation will be removed from the environment by the facilitator.

3.2 Environmental Constraints:

3.2.1 Limit the number of healthcare personnel present to the minimum required; remove all non-essential personnel from the room.

3.2.2 Remove all non-essential equipment from room (ie. night stand, bedside tables and chairs).

3.2.3 If resuscitation effort is located in a semi-private room or ward room, remove any additional patients to accommodate for the space needed.

4. Preparation for Family Presence:

4.1 The FP Facilitator will provide information to the family about the resuscitation before they enter the room. Information will include:

4.1.1 The FP facilitator will remain present with the family members in the room throughout the resuscitation effort and will not be given any other task.

4.1.2 Patient’s current medical status, including explanation of possible procedures completed prior to the family entering the room (i.e. endotracheal intubation or central line placement).

4.1.3 Explanation of interventions being performed during the resuscitation effort, and of patient’s response to such interventions.

4.1.4 They will limit the number of family members present to 1-2 people (at the FP Facilitator’s discretion) allowed in at one time, where they will stand in the room and when it is appropriate to move closer to the bedside of the patient.

4.1.5 Provides an explanation of why they might be asked to leave the room and ensures family can leave the resuscitation room at any time.

5. Roles and Responsibilities of Designated FP Facilitator (Modified from Emergency Nurses Association; Presenting the Option for Family Presence, 3rd edition)
5.1 Introduce yourself to the staff treating the patient and family.

5.2 Obtain information about the patient’s status, response to treatment, identified needs.

5.3 Communicate known information concerning the patient’s status to the family.

5.4 Evaluate the patient’s and the family’s bio-psycho-social-spiritual support needs and initiate measures to meet those needs.

5.5 Offer and provide comfort measures.

5.6 Determine patient’s and family’s preference for family presence.

5.7 Prepare the patient and family for the family presence experience.

5.8 Accompany the family to the treatment or resuscitation area.

5.9 Introduce yourself and other members of the support team to the family and patient.

5.10 Determines the best placement of family within the resuscitation environment.

5.11 When providing support for the family at the patient’s bedside, ensure the following is provided:

- Explanation of the interventions;
- Provide information about the patient’s response to treatment/expected outcomes;
- Opportunity to see, touch and speak to the patient prior to intra or inter-hospital transfer;
- Clarify any misconceptions;
- Reassess patient’s and family’s bio-psycho-social-spiritual support needs and initiates supportive interventions;
- Continuous presence with family members at the bedside during resuscitation.

5.12 If death occurs:

5.12.1 Ensure the family has been informed about what to expect, what they will see and hear. Facilitate the family’s viewing of the body.

5.12.2 Provide as much time as the family needs and offer the family time alone with their loved one. Be observant of cultural/religious norms when it is practical and reasonable as possible.

5.12.3 Provide family information concerning the disposition of the body, contact person and phone numbers if they have questions later.
5.13 Assist in identifying need for critical incident stress debriefing, individual diffusing of events, etc.

5.14 Bring any feedback from family members back to the resuscitation team to enhance patient care in the future.

Definitions

*Family* means one or more individuals identified by the patient as an important support, and who the patient wishes to be included in any encounters with the health care system, including, but not limited to, family members, legal guardians, friends and informal caregivers.

*Resuscitation* means an emergent situation in which advanced medical interventions are utilized (i.e. measures to support blood pressure or respiratory efforts); or cardiopulmonary resuscitation (CPR) techniques are required in an attempt to restore spontaneous circulation, in which the outcome of the situation is unknown. This does not include the usual routine care or initial resuscitative efforts that occur at the time of intensive care unit admission.

*Family Presence Facilitator* (FP Facilitator) means a Covenant Health staff member who is exclusively assigned to the family of a patient to provide psycho-social-spiritual support. The staff member has no other assigned responsibilities but guiding the family through the experience. The staff members that may act as a FP facilitator may include: Members of Spiritual care team and/or an experienced nurse who has past experience with both resuscitation and family members.

Related Documents

Appendix A: Ethics Framework
Appendix B: Background

References

American Heart Association. Circulation; 2010; [Suppl.3]: Ethics, 02 November 2010.


http://www.nationalconsensusproject.org

Family Presence During Code Blue in ICU; Misericordia Intensive Care Unit, April 2003

Chronological Revision Date(s)  N/A
Appendix A: Ethics Framework

Family Presence during Cardiopulmonary Resuscitation

The ethical justification for supporting family presence during CPR starts with the fundamental premise that the family is an extension of the patient. The Health Ethics Guide recognizes the importance of a person’s emotional, familial and cultural ties which must be respected and fostered. “These relationships create rights and duties for both the person receiving services and for those providing care.” While a patient should not be treated as a means to an end for the benefit of family, the needs of family cannot be simply disregarded as irrelevant either. Catholic moral tradition affirms the interrelatedness of every human being, in which we are connected to the social communities where we live and have been formed, including our connection to the most basic social community - the family. Therefore, institutional practices that automatically and indiscriminately exclude family from the person receiving care apart from basic concerns for privacy, propriety, safety or any legal restrictions without a proportionate reason are not in keeping with the moral tradition to which Covenant Health ascribes.

The literature demonstrates the value of having family present during crisis interventions like CPR and shows its benefit to patient, family and health care team alike. Shifts in policy must evolve to take into account the clinical evidence and perceived pastoral benefits, even if it poses some logistical challenges in accommodating family during resuscitation efforts. Much as health care norms have shifted to accommodate fathers in birthing suites despite risks of disruption to the safe delivery of the baby or the father’s own well-being, so must Covenant Health demonstrate leadership in helping shift attitudes and dispelling myths to support similar accommodations for family presence during CPR despite the known risks.

Rather than resisting a change in practice because of concern of families members collapsing or inadvertently disrupting the resuscitation efforts, a problem-solving approach must be taken to anticipate such risks, and attempt to minimize their occurrence.

This problem-solving precedent in accommodating families being present in their loved one’s care has been long established in other routine hospital settings. Parents of young children are almost always expected to be involved in their loved one’s care in which the health care team simply works around their presence. Families are often called upon to help calm an agitated or frightened loved one during a procedure, assist in feeding or other activities of daily living, or serving to interpret when language and cultural barriers exist. Yet despite these norms, family presence during CPR of adult patients is still not widely encouraged, especially when the outcome is poor.

Ethically, the presumption should be in favour of family presence, in which inviting family to be with their loved one in the room during resuscitation is the norm, rather the exception. However, at the same time, family should not be required to be present if it will pose too great an emotional burden on them, or risk psychologically traumatizing the family member given the graphic nature of what is seen, heard and experienced during a resuscitation event. Careful assessment must be made of the family member’s emotional capacity to be present. In some cases, it may be that one person is present at the bedside while other family members remain in a waiting room. Nor should a choice be deemed irrevocable. A person can certainly choose to leave the room if they are finding it becoming too much, or ask to be present if they later...
feel able and desire to be present. Ultimately, a collaborative problem-solving approach that respects the family’s needs should be employed at the outset as much as practically possible to identify who can and cannot be present, and to take every practical step to ensure those who are present in the room where CPR is taking place are not neglected. Here the role of the experienced nurse (ie. charge nurse) or chaplain is critically important to help support the family member and explain what is happening.

Given the short time frame in which a Code Blue is called, resuscitation begins, and a patient is pronounced if CPR is unsuccessful, it is reasonable and understandable that little time may be possible to make a thorough assessment and a prudential judgment may be required. We may not always assess correctly a family member’s willingness to be present under such circumstances, and it reasonable to expect that errors will occur. This should not detract from the overall presumption in favour of family and the spirit of the policy that seeks to tailor the most compassionate and supportive health care experience possible for patient and family, especially at the end of life.

Thus the ethical justification for family presence during CPR is contingent upon 1) family choice; 2) not abandoning the family if they do choose to be present,and; 3) and on-going reassessment of family needs.

Finally, having family present during CPR may introduce added emotional stress for the health care team. While the literature indicates that care for the patient with family present is more reverential and respectful, it also can be emotionally demanding nonetheless. Just as family should be supported if they chose to be present, staff should also be appropriately supported, if not possible during the CPR event, then certainly afterwards. For very emotionally charged CPR events, staff resources such as Critical Incident Stress Management, Spiritual Care, or the Employee Family Assistance Program should be made available. Covenant Health must also be present to the needs of their staff. The Family Presence during Cardiopulmonary Resuscitation policy reflects a multi-level concern for the needs of the family and staff, and the patient who is at the centre of everything we do.
Family Presence During Cardiopulmonary Resuscitation

Appendix B

Background

Family Presence (FP) during cardiopulmonary resuscitation (CPR) is a controversial issue which healthcare professionals may have had prior experience with or may come across in their future practice. Family presence is occurring throughout the world, including in Edmonton and area hospitals. A survey completed by Kosowan & Jensen (2011) reported that 51.5% of the Edmonton and area cardiac health professionals surveyed have past experience with FP during CPR.

Benefits

Reported within the literature, healthcare professionals and family often recognize the similar benefits of FP during CPR. The benefits of FP include: providing emotional and spiritual support to the patient; allowing families to see that everything was being done for their loved one; providing information to the healthcare team; providing opportunities for families to be able to spend their last moments together; and aiding in the grieving process (Fullbrook et al., 2005; Grice et al., 2003; Mcmahon-Parkes et al., 2009; Meyers et al., 2000; Miller & Stiles, 2009). Family members who were not given the choice to be present during CPR of their loved one often reported higher levels of depression and anxiety (Jarbre et al., 2013). In addition, healthcare professionals felt by having family present during CPR they could advocate for the patient’s wishes and aide in the decision making process (Kosowan & Jensen, 2011). It was also thought that FP often would promote open communication between the family and staff members (Ellison, 2003; Mcmahon-Parkes et al., 2009; Miller & Silles; 2009; Sanford, Pugh, & Warren, 2002).

Barriers

Healthcare professionals often feel that FP would cause emotional trauma and distress to the family members (Ellison, 2003; Grice et al., 2003; Meyers et al., 2000, Miller & Stilles, 2009; Redley & Hood, 1996), though Robinson (1998) reported that there were no adverse affects among family members who witnessed a resuscitation effort of a loved one. Furthermore, Robinson (1998) showed that family members who did remain present had decreased symptoms of grief and intrusive imagery compared to those who were not present when surveyed after three months.

Within the literature the lack of physical space and lack of adequate staff to support the family members is often a concern to healthcare professionals which could decrease the frequency of FP occurrences (Ellison, 2003). The lack of support for the family members was the greatest barrier perceived by Edmonton cardiac healthcare professionals (Kosowan & Jensen, 2011). Furthermore Kosowan & Jensen (2011) report the respondents often felt that family would interfere during CPR, which is also a common theme within the literature (Helmer et al., 2000; Meyers et al., 2000). Tsai (2002) stated that family rarely interfered with CPR and when the rare occurrence happened it occurred in institutions which did not have a policy and procedure in place.

Policy and Procedure

Fallis, McClement, and Pereira (2008) found that only eight percent of Canadian critical care nurses have access to policy and procedures regarding family presence. Kosowan & Jensen (2011) found that 82.9% of cardiac healthcare workers were in support of a family presence policy and procedure. Through the development of policy and procedure and educational programs family presence became an everyday practice (Carter & Lester, 2008; Mian et al, 2007). The American Heart Association states “Offering select family
members the opportunity to be present during a resuscitation is reasonable and desirable” (AHA Guidelines, 2010). The literature also suggests that hospitals in which policies and procedures for family presence are in place, promote holistic family centered care environment (Baumhover & Huhes; 2009).

References:

American Heart Association. Circulation; 2010; [Suppl.3]: Ethics, 02 November 2010.


