

Increasing Nurses' Knowledge of and Self-confidence With Family Presence During Pediatric Resuscitation

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BACKGROUND Family presence during resuscitation is becoming more common, and pediatric critical care nurses regularly facilitate this process. However, most hospitals lack policies and education to support nurses in this practice.

OBJECTIVE To increase pediatric intensive care unit nurses' knowledge and self-confidence with family presence during resuscitation through an educational intervention.

METHODS The project used a pre-post intervention study design with anonymous online cross-sectional surveying. Participant demographic data were collected along with participants' responses to 2 instruments measuring perceived risks and benefits of family presence during resuscitation and participant self-confidence with the process. The educational session consisted of a 2-hour structured session incorporating content presentation, discussion, simulation videos, and parental testimony.

RESULTS Thirty-six nurses participated in this project. Overall mean scores of both tools and scores of almost every item within each tool significantly increased after the intervention.

CONCLUSION Formalized and structured education on family presence during resuscitation appears to promote pediatric intensive care unit nurses' knowledge, increase their perception of benefits outweighing risks, and enhance their self-confidence in supporting family members. Providing information about family presence during resuscitation and how best to facilitate this practice should be a priority and included as part of standard educational support for pediatric intensive care unit nurses. (*Critical Care Nurse*. 2022; 42[4]:27-37)

Over the last 3 decades, published studies have recognized the benefits of family presence during resuscitation (FPDR).¹⁻⁴ Family members commonly want to be present during the resuscitation of their loved one, and research demonstrates that being present enables family members to be more accepting of the resuscitative process, even if a negative outcome ultimately occurs.^{1,3-7} The COVID-19 pandemic has further heightened family desire to be at the bedside during hospitalization. However, despite recommendations from national organizations such as the Emergency Nurses Association⁸ and the American Association of Critical-Care Nurses⁹ to endorse FPDR,¹⁰⁻¹² many



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hospitals lack policies, guidelines, and educational training for nurses to support and facilitate this practice. Furthermore, nurses may resist FPDR because of a lack of self-confidence and formalized education to support them in the process.¹³⁻¹⁵

Relevance to Critical Care Nurses

Of all health care team members, nurses spend the most time at the bedside providing care for patients and supporting family members. During this time, trust and rapport are formed between the nurse, the patient, and the family, making it natural that families approach nurses during resuscitations. As many as two-thirds of nurses have been consulted by family members desiring presence during resuscitation.¹⁶ Other health care team members often look upon critical care nurses to drive this practice, but to do this successfully, nurses must confidently bridge the gap between family observation and resuscitation efforts.^{11,12}

A resuscitation event involves a rapidly evolving patient situation as well as many tasks and procedures occurring in quick succession. Rarely does the nurse have time to multitask resuscitation efforts while also

considering ways to best support the patient's family. In the pediatric care setting, resuscitations

are especially traumatic and heart-wrenching for families,²⁻⁴ making it imperative that pediatric critical care nurses have a sound understanding of and confidence with best practices related to FPDR. This quality improvement (QI) project aimed to increase pediatric

Overall, the review revealed that nurses are often willing to support FPDR but frequently lack the knowledge and self-confidence necessary to implement it effectively.

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intensive care unit nurses' self-confidence and perceptions of benefits versus risks of FPDR by using a formalized educational intervention.

Literature Review

To gain a comprehensive understanding of current knowledge about the subject, we conducted an integrative review of the literature focused on FPDR with pediatric and adult patients. We used PubMed and CINAHL online databases and evaluated each article selected for review using Melnyk and Fineout-Overholt's levels of evidence.¹⁷ The review included 20 articles, complete details of which are described in a separate manuscript. According to Grading of Recommendations Assessment, Development, and Evaluation principles, the literature provided a moderate level of strength and quality of evidence, reflective of varying study designs, study limitations such as potential bias and convenience sampling, and challenges related to generalizability. Overall, the review revealed that nurses are often willing to support FPDR but frequently lack the knowledge and self-confidence necessary to implement it effectively. Lack of education,^{16,18} lack of self-confidence,^{15,19,20} and lack of formal policies were all cited as major barriers to implementing FPDR.^{18,21} The review also demonstrated that educational interventions improve nurses' perceptions of the benefits of FPDR,^{18,22,23} can increase nurses' self-confidence in the implementation of FPDR,^{18,24} and can help nurses manage the emotional stress of FPDR.¹⁹

The integrative review revealed limited research specific to FPDR in pediatric settings. An important finding specific to pediatrics was that pediatric nurses who have personal experience with FPDR are more likely facilitate the practice.¹ Furthermore, implementation of educational sessions improved nurses' self-confidence with FPDR and resulted in more positive perceptions of the benefits versus the risks.^{25,26} Unfortunately, a lack of policies and guidelines providing direction and support for FPDR continues to be a major challenge for nurses practicing in pediatric settings.^{1,11}

Local Problem

Despite the perception that FPDR is a nurse-driven responsibility in the unit, the pediatric intensive care unit (PICU) within our large academic medical center in the southeastern United States lacked policies or guidelines directing the practice of FPDR. No educational

resources or classes related to FPDR existed for these nurses in spite of the emphasis on family-centered care in the PICU.²⁷ Stress levels related to FPDR among nurses in the unit were high—a phenomenon personally witnessed and experienced by the primary author (R.N.B.), who had worked in this setting for several years before this project.

Purpose and Ethical Considerations

The purpose of this QI project was to improve staff nurses' self-confidence with FPDR in a PICU through the implementation of an educational intervention. In addition, this project aimed to enhance PICU nurses' perceptions of the benefits of FPDR as compared with the perceived risks.

The institutional review board and the Nursing Research Council at the medical center where this project took place granted approval before the project commenced. Throughout the entirety of the project, all protocols designated by the institutional review board and Nursing Research Council were maintained.

Methods

Design, Setting, and Sample

This QI project used a pre-post intervention study design. An anonymous cross-sectional survey administered with an online survey tool (Qualtrics) was used to collect demographic information and participant responses to 2 instruments. Data were gathered before and immediately after the educational intervention and analyzed using SPSS software, version 23 (IBM).

The project took place in a 20-bed level I pediatric trauma center PICU within a 950-bed Magnet-designated public academic medical center in the southeastern United States. A convenience sample of 36 PICU nurses, representing 51% of the 71 nurses eligible to participate, participated in the project. Three additional PICU nurses participated but did not complete both surveys and thus were not included in the final report. Participation was voluntary and not associated with employee performance measures. For this project, a PICU nurse was defined as any nurse who had completed all required training, including a preceptorship, and was independently providing bedside care for pediatric critical care patients. All participants worked in the PICU at the time of the project and held a current and unencumbered in-state nursing license.

Procedures

Each participant was provided a link via email to anonymous pre- and postintervention surveys. The link took the participants to an online survey to be completed within 1 week before attending the educational sessions. This process was reiterated following the educational sessions, directing participants to complete the same survey a second time within 1 week after the educational intervention. The first section of the survey gathered demographic data including age, sex, race/ethnicity, highest education level, national nursing organization membership, and national certifications currently held. The second section consisted of a 22-item instrument called the Family Presence Risk-Benefit Scale (FPR-BS; Table 1).¹⁵ This instrument assesses nurse perceptions of

benefits and risks of FPDR. The third section of

The educational intervention was offered at a variety of times to allow for flexibility and maximize the availability of nurses who could attend.

the survey consisted of a 17-item instrument known as the Family Presence Self-confidence Scale (FPS-CS), which assesses nurse confidence with facilitating FPDR (Table 2).¹⁵ Both instruments incorporate self-reporting using a 5-point Likert scale, ranging from 1 (strongly disagree) to 5 (strongly agree) for the FPR-BS and from 1 (not at all confident) to 5 (very confident) for the FPS-CS. Both instruments also had strong reliability and validity measurements when used in other studies.^{15,28-34} We obtained written permission from the author of the instruments before using them in this project.

The educational intervention consisted of a 2-hour face-to-face class session addressing FPDR in the PICU. For the purposes of this project, FPDR was defined as the presence of a parent, guardian, or loved one within eyesight of a patient receiving resuscitative care including but not limited to administration of rescue breaths via the bag-mask method, emergency intubation, chest compressions, administration of epinephrine boluses, placement of central catheters, and fluid resuscitation.

Each session was held in person in a large conference room on the hospital campus. Participation by nurses was voluntary. Nurse managers approved education pay for nurses who attended, stipulating that they attend outside of their regularly scheduled shifts.

Table 1 Family Presence Risk-Benefit Scale

1. Family members should be given the option to be present when a loved one is being resuscitated.
2. Family members will panic if they witness a resuscitation effort.
3. Family members will have difficulty adjusting to the long-term emotional impact of watching a resuscitation effort.
4. The resuscitation team may develop a close relationship with family members who witness the efforts, as compared with family members who do not witness the efforts.
5. If my loved one were being resuscitated, I would want to be present in the room.
6. Patients do not want family members present during a resuscitation attempt.
7. Family members who witness unsuccessful resuscitation efforts will have a better grieving process.
8. Family members will become disruptive if they witness resuscitation efforts.
9. Family members who witness resuscitation efforts are more likely to sue.
10. The resuscitation team will not function as well if family members are present in the room.
11. Family members on the unit where I work prefer to be present in the room during resuscitation efforts.
12. The presence of family members during resuscitation is beneficial to patients.
13. Family presence during resuscitation is beneficial to families.
14. Family presence during resuscitation is beneficial to nurses.
15. Family presence during resuscitation is beneficial to physicians.
16. Family presence during resuscitation should be a component of family-centered care.
17. Family presence during resuscitation will have a positive effect on patient ratings of satisfaction with hospital care.
18. Family presence during resuscitation will have positive effect on family ratings of satisfaction with hospital care.
19. Family presence during resuscitation will have a positive effect on nurse ratings of satisfaction in providing optimal patient and family care.
20. Family presence during resuscitation will have a positive effect on physician ratings of satisfaction in providing optimal patient and family care.
21. Family presence during resuscitation is a right that all patients should have.
22. Family presence during resuscitation is a right that all family members should have.

Adapted with permission from Twibell et al.¹⁵

Table 2 Family Presence Self-confidence Scale

1. I could communicate about the resuscitation effort to family members who are present.
2. I could administer drug therapies during resuscitation efforts with family members present.
3. I could perform electrical therapies during resuscitation efforts with family members present.
4. I could deliver chest compressions during resuscitation efforts with family members present.
5. I could communicate effectively with other health care team members during resuscitation efforts with family members present.
6. I could maintain dignity of the patient during resuscitation efforts with family members present.
7. I could identify family members who display appropriate coping behaviors to be present during resuscitation efforts.
8. I could prepare family members to enter the area of resuscitation of their family member.
9. I could enlist support from attending physicians for family presence during resuscitation efforts.
10. I could escort family members into the room during resuscitation of their family member.
11. I could announce family members' presence to resuscitation team during resuscitation efforts of their family member.
12. I could provide comfort measures to family members witnessing resuscitation efforts of their family member.
13. I could identify spiritual and emotional needs of family members witnessing resuscitation efforts of their family member.
14. I could encourage family members to talk to their family member during resuscitation efforts.
15. I could delegate tasks to other nurses in order to support family members during resuscitation efforts of their family member.
16. I could debrief family after resuscitation of their family member.
17. I could coordinate bereavement follow-up with family members after resuscitation efforts of their family member, if required.

Adapted with permission from Twibell et al.¹⁵

Table 3 Qualifications and responsibilities of the family support team member

Qualifications

PICU RN who is not the primary nurse for patient being resuscitated
RN who has attended the 2-hour FPDR education session (literature identifies the nurse as optimal person for role as identified by family members)

Responsibilities

Determine whether family is present or needs to be notified.
Introduce self and briefly describe family support provider role to family members.
Prepare family members before entering resuscitation room.
Set clear ground rules to ensure the family member's presence does not negatively impact the resuscitation attempt.
Determine family member's desire to be present.
Screen for factors that would rule out an invitation to be present.
Ascertain family's religious or cultural preferences relative to end-of-life concerns.
Announce family's arrival to the resuscitation team when applicable.
Offer emotional support for family members.
Provide updates for family regarding team's actions and efforts.
Offer physical comfort: chair, water, tissues, etc.
Encourage family members to position themselves where physical contact is easy to achieve (head or foot of bed).
Remain with family member and monitor their well-being while answering all questions.
Maintain awareness of family's reactions while providing a compassionate presence; escort family out when appropriate.
Assist family to be closer to patient in the event of inevitable death.
Provide grief support.

What does this look like?

Know the name and sex of the child.
Introduce yourself to the parents and family members present.
Prepare the parent with what is about to happen; what will they see?
Ask the parent if they want to come closer to the bed.
Explain step-by-step in laymen's terms what the team is doing and how the patient is responding.
Prepare parent if death appears imminent.
Assure parents that there is nothing they could have done to prevent this.
Place the child in the parents' arms or prepare the patient so they can be close to the bed.
Offer therapeutic touch/hug if appropriate.
Sit down.
Listen and tolerate silence. Answer their questions.
Explain to them what happens next.

Abbreviations: FPDR, family presence during resuscitation; PICU, pediatric intensive care unit; RN, registered nurse.

Educational techniques included a slide presentation (PowerPoint, Microsoft), active discussion, and short videos. The slide presentation contained current evidence and trends related to FPDR, its history, common myths and barriers, steps in supporting families through this difficult time, and FPDR best practice. Specifically, the primary author (R.N.B.) provided a definition of FPDR and family-centered care to participants and discussed how FPDR has evolved over time, including organizational support for the practice. Next, a series of questions regarding myths and barriers were posed and discussed with participants. Evidence from the literature identifying barriers to FPDR implementation was then described. R.N.B. provided a definition of the family support team member during resuscitation. Responsibilities of this individual were described in detail (Table 3). In addition, explanations of how to

best fulfill the responsibilities of the family support team member during resuscitation were offered.

Next, the participants watched and discussed three 5-minute simulation videos. The videos were originally created by Washington State University College of Nursing for a project intended to train nursing students to facilitate FPDR.²² We obtained permission from the creators and authors of that study to use the videos in the educational session and to cite them in this manuscript. The simulation videos depicted recreations of actual cases. The videos addressed a postpartum event (<http://vimeo.com/14864959>), a pediatric event (<http://vimeo.com/14864545>), and an adult trauma event (<http://vimeo.com/14865388>),²² chosen to reflect the full span of pediatric patient age groups treated in the PICU. A real-life case study involving a child resuscitation in a PICU was then presented; participants discussed what

Table 4 Demographic characteristics of participants (N = 36)

Characteristic	No. (%) of participants
Age, y	
18-24	2 (6)
25-39	19 (53)
40-55	14 (39)
>55	1 (3)
Sex	
Male	1 (3)
Female	35 (97)
Race/ethnicity	
Black	1 (3)
Asian	3 (8)
White	29 (81)
Hispanic/Latino	3 (8)
Nursing experience, y	
<1	2 (6)
1-5	9 (25)
6-10	11 (31)
11-20	4 (11)
>20	10 (28)
Highest nursing degree	
Nursing diploma	1 (3)
Associate's	4 (11)
Bachelor's	25 (69)
Master's	6 (17)
Professional organization membership	
Yes	24 (67)
No	12 (33)
Specialty certification	
Yes	17 (47)
No	19 (53)
Experience with a mock cardiac arrest event	
Yes	35 (97)
No	1 (3)
No. of total experiences with pediatric cardiac arrest events	
1-2	4 (11)
3-5	4 (11)
6-10	8 (22)
>10	20 (56)

went well, what did not, and how they would now handle the situation after receiving the training. Next, participants viewed a video testimony of 2 parents who had been present during the resuscitation of their child in a PICU. The family had created the video for use during an annual PICU conference and had provided consent to have it used for this project. Finally, a discussion addressing any unanswered participant questions or concerns took place.

The educational intervention was offered at a variety of times to allow for flexibility and maximize the availability of nurses who could attend. In total, 10 educational interventions were completed over a 5-week period in 2020. One session was recorded for future use by the nursing unit. To promote intervention fidelity, R.N.B. facilitated all educational sessions. The material and format of each session was identical to ensure consistency; however, discussions varied somewhat depending on participant questions and input.

Results

Demographic Findings

Thirty-six PICU nurses participated in the project. Demographic data analysis revealed that although the participant group lacked diversity with respect to sex (97% female) and race/ethnicity (81% White/non-Hispanic), it was consistent with current nursing workforce demographics.³⁵ The vast majority of participants (92%) were in the age range of 25 to 55 years, and the sample reflected a relatively even spread of number of years of PICU experience. Most participants (69%) held a bachelor's degree. Most (67%) were members of a professional nursing organization and almost half (47%) had obtained a specialty nursing certification. Almost every participant (97%) had participated in mock cardiac arrest events, every participant had been involved with a pediatric cardiac arrest event, and over half (56%) had participated in more than 10 cardiac arrest events. Complete details of the demographic analysis are shown in Table 4.

FPR-BS Instrument

A paired *t* test was used to compare the overall mean scores of the FPR-BS before the intervention (mean score, 3.74) and after the intervention (mean score, 4.32). The difference in mean scores was significant ($P \leq .001$), suggesting that the educational intervention had a significant positive influence on the nurses' perception of the benefits versus the risks of FPDR.

Paired *t* testing was also used to compare mean scores of each item in the FPR-BS instrument before and after the intervention. Items 2, 3, 6, 8, 9, and 10 were reverse-scoring items, meaning that an increase in the mean scores of these items after the intervention reflected a more negative rating or disagreement with these items. An example of one such item was "family members will panic if they witness a resuscitation effort." As seen in

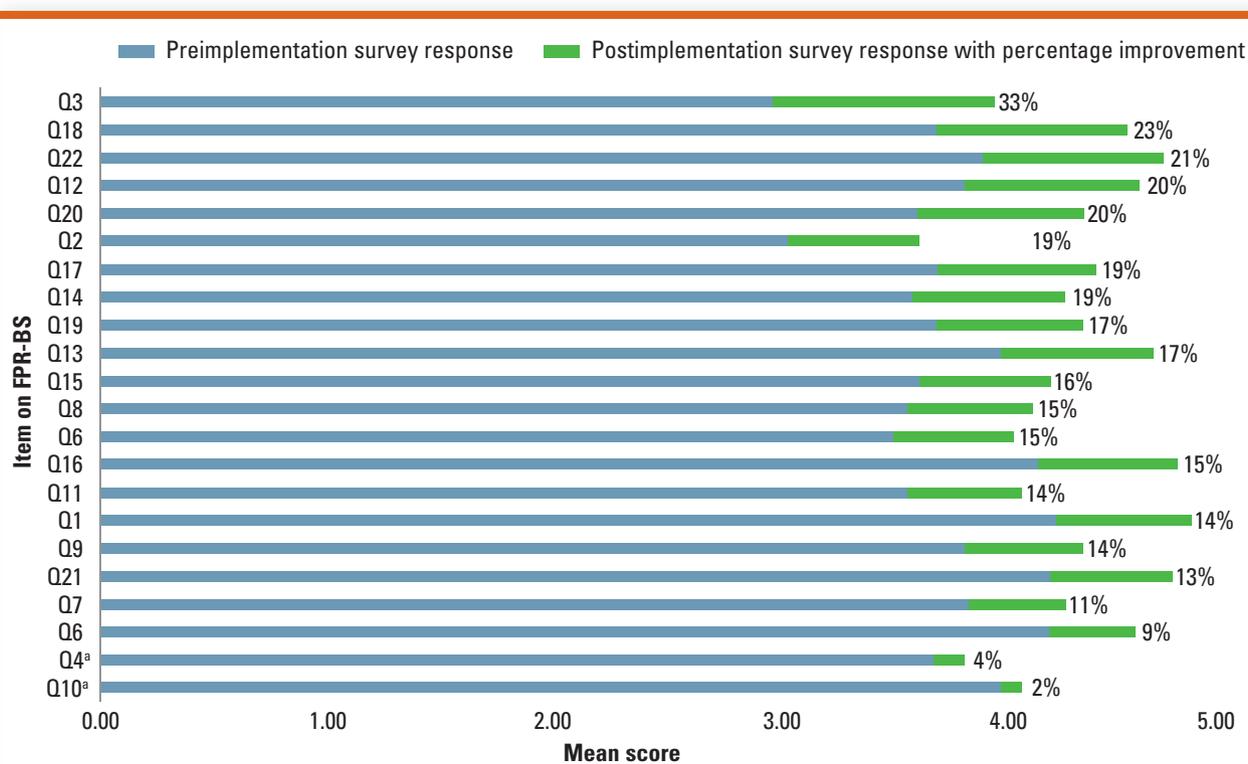


Figure 1 Family Presence Risk-Benefit Scale (FPR-BS) responses (sorted in descending order by percentage improvement).

^a Postimplementation survey improvement not significant.

Figure 1, the scores for all items in the FPR-BS except items 4 and 10 showed a statistically significant increase in nurses' perceptions of benefits and reduction in nurses' perceptions of risks associated with FPDR after participation in the educational intervention.

FPS-CS Instrument

A paired *t* test was conducted to compare overall mean scores of the FPS-CS before and after the intervention (mean scores, 4.05 and 4.46, respectively). The difference in scores was significant ($P \leq .001$), suggesting that the educational intervention had a significant positive influence on nurses' self-confidence with facilitating FPDR.

Paired *t* testing was conducted to compare the mean scores of each item within the FPS-CS instrument before and after the intervention (Figure 2). Differences in scores were significant for every item except items 1, 4, and 15.

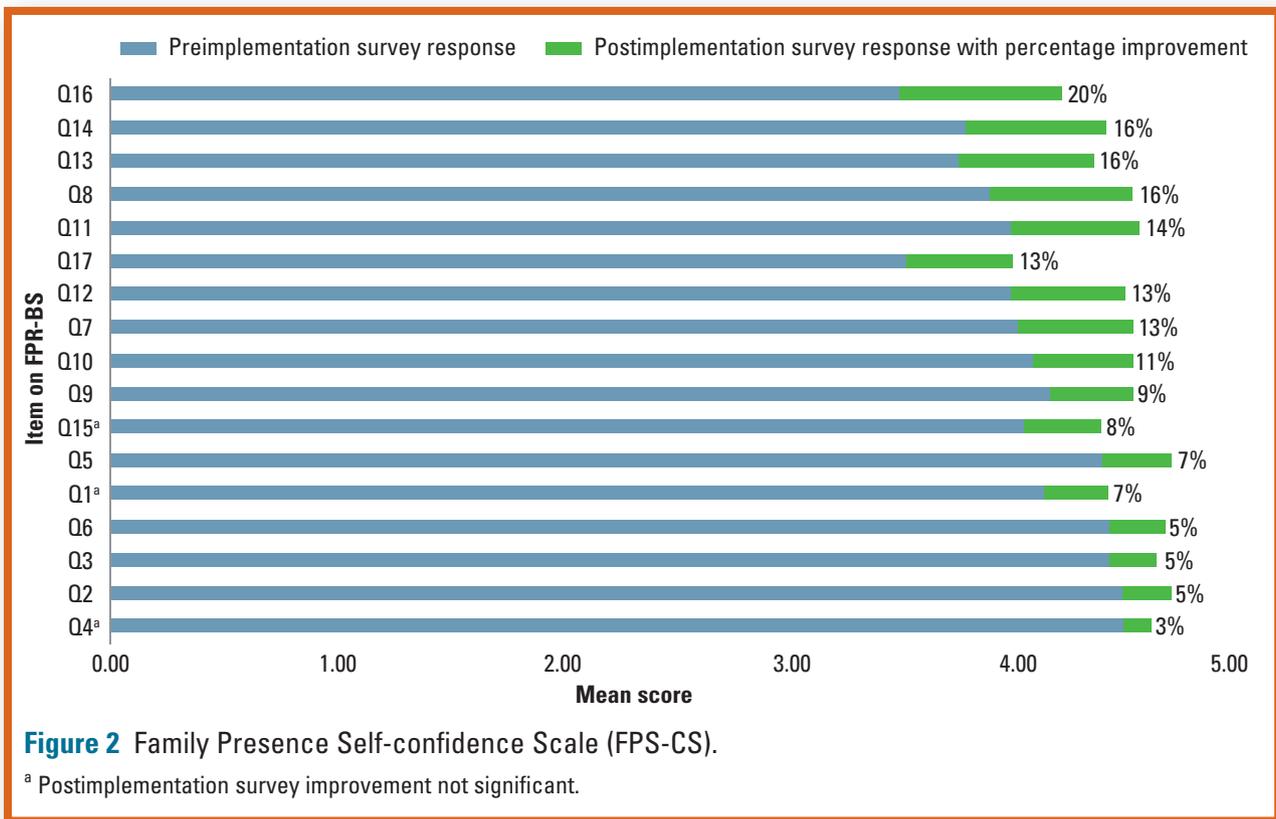
Validity and Reliability of Instruments

The validity of the FPR-BS and FPS-CS has been previously tested using maximum likelihood exploratory factor analysis with varimax rotation and reported by

the original author.¹⁵ Both instruments have been used in multiple other studies^{15,22,28-34} and were used in this project in an unaltered format. Item-to-total correlations and Cronbach α reliability have been previously measured, indicating a high level of internal consistency and reliability. For this project, the Cronbach α reliability was 0.90 and 0.94 for the FPR-BS pre- and postintervention measures, respectively, and was 0.92 and 0.95 for the FPS-CS pre- and postintervention measures, respectively. These results suggest that both instruments were highly reliable with the project sample.

Discussion

This QI project demonstrated that formalized education on FPDR for pediatric intensive care nurses increases their perceptions of benefits outweighing risks and enhances their self-confidence in supporting family members. The educational sessions resulted in more positive risk-benefit perceptions surrounding FPDR, reflected in an overall significant increase in mean scores of the FPR-BS. In addition, the project revealed an increase in nurses' self-confidence with FPDR, reflected by a significant increase



in the mean scores of the FPS-CS. Both of these findings are supported by existent literature^{13,15,18,21-23,25,26,36} and add to the body of knowledge measuring the impact of educational interventions on nursing perceptions of FPDR.

In terms of differences in individual items within the FPR-BS, results of this project demonstrated statistically significant improvement in every question except items 4 and 10. Item 4 assessed whether participants believed that resuscitation team members developed closer relationships with family members taking part in FPDR. In the PICU where this QI initiative took place, the health

The mean overall score of the FPS-CS reflected a statistically significant increase in nurses' reported self-confidence after attending the educational session.

care team conducts rounds twice a day for each

patient and makes a conscious effort to include families. This practice may explain the smaller increase in the mean score for item 4 because relationships between the team and families are typically strong whether or not a resuscitation event occurs. Item 10 assessed whether participants felt the resuscitative team would function

better if family members were not present, a finding not previously reported in the literature. In the PICU where this project took place, parents were often already at the bedside during resuscitation, and participants had already borne witness to the team functioning well. They may have therefore reported less of an increase in the mean score of this item after the educational session.

The mean overall score of the FPS-CS reflected a statistically significant increase in nurses' reported self-confidence after attending the educational session. This finding aligns with the results of previous studies, which have also demonstrated an increase in nurse confidence with FPDR following an educational intervention.^{15,21-23,36} Findings from this project suggested statistically significant increases in all but 3 individual items of the FPS-CS. These were item 1 (communicating with families during resuscitation), 4 (delivering chest compressions with family present), and 15 (delegating tasks to other nurses to support FPDR). These results may reflect our educational intervention focusing on facilitating FPDR and not focusing on other tasks associated with management of a cardiac arrest event. Findings in the literature are mixed in relation to these latter results. Curley et al²⁵

found that an educational program helped clinicians feel an improved sense of preparedness to implement FPDR and communicate effectively with families, but other studies found that nurses did not expect FPDR to affect their own individual performance in cardiac arrest events. Instead, nurses were more concerned with having sufficient staff to support FPDR.^{11,25} This finding emphasizes the need for a dedicated family facilitator of FPDR.

The nurses participating in this QI project were experienced overall; 69% of participants had more than 5 years of experience in the PICU setting. This finding may explain the smaller increase in the mean score for item 1 of the FPS-CS. Furthermore, although the PICU where this QI project took place had not previously offered education on FPDR for nurses, family members had been allowed to be present during resuscitations. Consequently, some participants had experience with FPDR before the educational intervention, which explains why pre- and postintervention mean scores for items 4 and 15 reflected smaller increases.

Previous studies have suggested that age, years of nursing experience, level of education, and experience with facilitating family presence may have a direct correlation with nurses' reported perceptions of risks versus benefits and self-confidence.²³ In our study, nurses' level of education and age were not correlated with either the FPR-BS score or the FPS-CS score before the intervention. The number of years of nursing experience and prior experience inviting family members to the bedside during resuscitation were not correlated with the mean overall score for the FPR-BS before the intervention. However, the number of years of nursing experience was significantly correlated with the overall mean FPS-CS score before the intervention ($r=0.588$, $P=.003$). These findings suggest that although years of nursing experience and experience with actively inviting families to the bedside appear to have little effect on nurses' perceptions of the risks and benefits of practicing FPDR, increased experience in these areas does positively affect their self-confidence in their ability to support families during a resuscitation event.

Strengths and Limitations

Several strengths were noted in this QI initiative. Survey responses were anonymous, allowing participants to reflect honestly on their perceptions of FPDR and level of self-confidence in the practice. Group sizes

for the educational intervention were small and consisted of the primary author (R.N.B.) and 6 or fewer participants, promoting substantive engagement and interaction. Sessions also incorporated a variety of educational strategies consistent with several learning styles, adding to their effectiveness.

Limitations also existed. The sample size was relatively small and consisted of a nonrandomized convenience sample of PICU nurses at a single site. Additionally, the sample reflected little diversity, so the impact of the educational intervention on critical care nurses who represent minority groups or who are male remains unknown. Additionally, since participants were volunteers, they may have already had a preexisting bias toward supporting FPDR. Those who did not participate in the project may have felt less affinity for the practice of FPDR in the PICU, may have had a lower interest in educational opportunities, or may have been experiencing burnout. The latter is an especially plausible explanation because this project took place during the COVID-19 pandemic when nursing staff burnout was high. Last, because of time limitations, there was little opportunity to reconnect with participants at a later date to determine if they were able to implement their learning in an actual resuscitation event.

Conclusion

In an era when family-centered care is leading the way in pediatrics, FPDR is a critical component of nursing practice. Education is needed and wanted by nurses who are expected to facilitate this practice. The QI project described in this article supports the idea that educational support should be a priority in PICUs where FPDR is practiced.

Furthermore, **Ongoing support and continuing education of pediatric critical care nurses with respect to FPDR seems valuable.** about FPDR

should be considered as part of the training of new PICU nurses. Doing so will allow nurses to build their own understanding of and confidence with supporting families during such a traumatic event and provide families with the support they need.

Many nurses who participated in this project wanted additional focused training on how to effectively fill the role of FPDR facilitator and debriefing sessions after resuscitation events to review what went well, what did not, and what was learned that could be applied

to future events. Ongoing support and continuing education of pediatric critical care nurses with respect to FPDR seems valuable. Unit policies or guidelines defining and supporting the practice of FPDR are also needed to provide clearer direction for pediatric critical care nurses. Clearly, FPDR is an important part of family-centered care, and for PICUs considering the practice, educational support for nurses is paramount. **CCN**

Financial Disclosures
None reported.

See also

To learn more about family presence during resuscitation, read "Attitudes of Community Hospital Critical Care Nurses Toward Family-Witnessed Resuscitation" by Gomes et al in the *American Journal of Critical Care*, 2019;28(2):142-148. Available at www.ajcconline.org.

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Increasing Nurses' Knowledge of and Self-confidence With Family Presence During Pediatric Resuscitation

Family presence during resuscitation (FPDR) is becoming more common, and pediatric critical care nurses regularly facilitate this process. However, most hospitals lack policies and education to support nurses in this practice. The authors sought to increase pediatric intensive care unit (PICU) nurses' knowledge and self-confidence with FPDR through an educational intervention

- To gain a comprehensive understanding of current knowledge about FPDR, we conducted an integrative review of the literature. Overall, the review revealed that nurses are often willing to support FPDR but frequently lack the knowledge and self-confidence necessary to implement it effectively.
- The educational intervention consisted of a 2-hour face-to-face class session addressing FPDR in the PICU and covering current evidence and trends related to FPDR, its history, common myths and barriers, steps in supporting families through this difficult time, and FPDR best practice.
- Educational techniques included a slide presentation, active discussion, and short videos.
- This project demonstrated that formalized education on FPDR for pediatric intensive care nurses increases their perceptions of benefits outweighing risks and enhances their self-confidence in supporting family members.
- Previous studies have suggested that age, years of nursing experience, level of education, and experience with facilitating family presence may have a direct correlation with nurses' reported perceptions of risks versus benefits and self-confidence.
- In our study, although years of nursing experience and experience with actively inviting families to the bedside appear to have little effect on nurses' perceptions of the risks and benefits of practicing FPDR, increased experience in these areas does positively affect their self-confidence in their ability to support families during a resuscitation event.
- In an era when family-centered care is leading the way in pediatrics, FPDR is a critical component of nursing practice. Education is needed and wanted by nurses who are expected to facilitate this practice.
- Educational sessions about FPDR should be considered as part of the training of new PICU nurses. Doing so will allow nurses to build their own understanding of and confidence with supporting families during such a traumatic event and provide families with the support they need.
- Unit policies or guidelines defining and supporting the practice of FPDR are also needed to provide clearer direction for pediatric critical care nurses. Clearly, FPDR is an important part of family-centered care, and for PICUs considering the practice, educational support for nurses is paramount. **CCN**

Bush RN, Woodley L. Increasing nurses' knowledge of and self-confidence with family presence during pediatric resuscitation. *Critical Care Nurse*. 2022;42(4):27-37.