AACN Practice Alert

Facilitating Family Presence During Resuscitation and Invasive Procedures Throughout the Life Span

Scope of the Problem

To be competent in acute care, nurses must possess the knowledge, skills, and abilities to manage rapidly changing patient events.[1] Family presence (FP) is a recognized autonomous nursing intervention,[2] whereby nurses facilitate the attendance of family members during resuscitation or an invasive procedure in a patient care location that affords visual or physical contact with the patient. Family presence is an option guided by the patient- and family-centered care model. It is beneficial to patients and families[3] and historically has not interfered with care.[4] The COVID-19 pandemic dictated widespread visitation restrictions that banned families from acute care units, with their absence quickly becoming the norm.[5-7] However, the COVID-19 public health emergency ended in May 2023. The pandemic-era FP guidance should not be considered the new standard of care. Family presence should be reestablished to reflect a culture of patient- and family-centered care and safety for all those in need of family support during vulnerable health events. Nurse leaders support FP through collaboration with the clinical team, education, and policy development and modification as contemporary societal issues arise.

Expected Practice

1. Establish whom the patient identifies as "family" and ask whether FP during resuscitation or procedures is desired. [level C/D/E]
2. Assess the family for safety concerns and appropriateness for being present during resuscitation or procedures. [level B/C/D/E]

AACN Levels of Evidence

Level A Meta-analysis of quantitative studies or metasynthesis of qualitative studies with results that consistently support a specific action, intervention, or treatment (including systematic review of randomized controlled trials)

Level B Well-designed, controlled studies with results that consistently support a specific action, intervention, or treatment

Level C Qualitative studies, descriptive or correlational studies, integrative reviews, systematic reviews, or randomized controlled trials with inconsistent results

Level D Peer-reviewed professional and organizational standards with the support of clinical study recommendations

Level E Multiple case reports, theory-based evidence from expert opinions, or peer-reviewed professional organizational standards without clinical studies to support recommendations

Level M Manufacturer's recommendations only

3. Explain the responsibilities of the health care team to the patient and family and what to expect during procedures, including potential noises, smells, and sounds. Provide a safe space for the family that will not interrupt care and, if possible, include a staff person (eg, social worker, chaplain) who will act as an FP facilitator (FPF).
4. Reevaluate patient wishes throughout the hospitalization along with safety for staff and family members.
5. Facilitate FP at the bedside for patients undergoing resuscitation or invasive procedures when congruent with patient and family preferences. [level A]

Before the Event

1. Upon hospital admission, assess whom the patient identifies as "family" and determine the patient's wishes for FP during resuscitation or invasive procedures should they occur. [level C/D/E]

AACN PracticeAlert™

doi:https://doi.org/10.4037/ccn2023733

a. *If the patient is nonverbal on admission:* Follow hospital protocols for family identification and have your social worker, case manager, chaplain, or house supervisor help determine who should be designated as family.
b. *If families want to be present:* Speak with the family as soon as possible and assess the family for appropriate behavior and level of coping to ensure uninterrupted care. [level C/D]
   - Contraindications for FP include combative or violent behaviors, uncontrolled emotional outbursts or extreme emotional instability, or behaviors consistent with an altered mental state due to use of behavior-modifying substances. [level B/C/D]
   - Use existing visitor policies and chain of command to promote safe clinical practice environments; offer FP as an option (not an expectation) to the family if aligned with patient preferences and acceptable to the health care provider (HCP) team. Explain that uninterrupted patient care is the priority and FP must not interfere with patient care. [level B/C/D/E]

2. Throughout the patient's admission, reassess appropriateness for FP by assessing the family for suitable behavior and level of coping to ensure uninterrupted patient care. [level B/C/D/E]
3. Consult with the HCP team about FP before the event to establish consensus for proceeding with FP. [level C/D/E]
4. *For families who will be present:* Prepare the family for being at the bedside, including the status of the patient, interventions and procedures in progress, appropriate personal protective equipment needed, sights and sounds they can expect to encounter, number of family members who can be in the room, why they may be asked to leave the room, and assurance that they can step out and reenter the room at any time. [level D/E]
5. *For families who will not be present:* Identify which staff member will support them and provide regular updates about the patient. [level B/C/D]

During the Event

6. Inform the team of family arrival in the patient's room. If possible, identify an FPF to assist with FP. Support and prepare the family throughout the event. [level D/E]
7. Explain procedures, interventions, and medical jargon.
   a. Encourage the family to ask questions and relay important patient health information as needed. Interpret the patient's clinical status, response to interventions, and possible expected outcomes. [level B/C/D/E]
   b. Provide opportunities for the family to see, touch, or speak to the patient as appropriate. [level C]
   c. Continue to reassess the family's response to the event and level of coping and watch for signs of untoward reactions. Terminate FP if appropriate upon HCP request or because of family member interference with care. [level C/E]

After the Event

8. Escort the family to a comfortable area and address psychosocial needs and concerns, provide comfort measures, and debrief the family.
   a. Ensure opportunities for the family to see and speak to the patient.
   b. If death occurs, use understandable language, explain the care provided, prepare the family for what to expect, facilitate viewing of the body, and initiate a family bereavement follow-up program. [level D]
   c. Document the FP event and debrief with the team.

Supporting Evidence

Before the Event

As part of the admission process, assess whom the patient identifies as "family," and determine their wishes for FP during an invasive procedure or

resuscitation should it occur.[8] The family should be assessed for FP appropriateness by observing for suitable behavior and level of coping to ensure uninterrupted patient care.[9-17] Contraindications for FP include emotional instability, combativeness, and violent behaviors as well as behaviors reflecting altered mental states due to use of drugs or alcohol.[4,9-12,14-19]

If FP is assessed as appropriate, consult with the HCP team before proceeding.[10,11] If it is acceptable to the team, offer FP as an option to the family when aligned with patient preferences.[10-12,14-17,19-25] For families who choose not to be present, identify who on the team will support them by providing regular status updates.[4,11,17,26]

If families want to be present, reassess family coping and behavior for appropriateness to ensure uninterrupted care.[11,23,27] Prepare the family for being at the bedside, including the current status of their loved one, interventions and procedures in progress, sights and sounds they can expect to encounter, number of family members who can be in the room,[4,10,11] why they may be asked to leave the room, and assurance that they can step out and reenter the room at any time.[11] Use understandable language and offer supportive comfort measures.

During the Event

Inform the team when the family arrives in the patient's room.[28] Remain with the family at all times,[10,11] providing continued support.[9,11,12,14-18,23,26,27,29-32] Explain procedures, interventions, and medical jargon to the family, and interpret the patient's clinical status, response to interventions, and possible expected outcomes.[10,11] Provide opportunities for the family to see, touch, or speak to the patient as appropriate.[13] Encourage the family to ask questions and relay important information as needed. Continue to reassess the family's response to the event and level of coping and watch for signs of untoward reactions.[27] Terminate FP if appropriate upon HCP request or because of interference with care, for example, violent or disruptive behavior, uncontrolled outbursts, extreme emotional distress.[10,25,33,34]

After the Event

Escort the family to a comfortable area. Address psychosocial needs and concerns, provide comfort measures, and debrief the family. Ensure opportunities for the family to see and speak with the patient. If death occurs, use understandable language, explain the care provided, prepare the family for what to expect, facilitate viewing of the body, and initiate a family bereavement follow-up program.[11] Document the FP event and debrief with the team.

Organizational Support Systems for Facilitating FP

Unit Leadership

1. Clinical leadership is essential to supporting bedside nurses and facilitating FP. Nurse leaders can foster a clinical environment that supports FP by developing FP champions, educational opportunities, FPFs, and policies that empower nurses at the bedside to be prepared and confident to provide FP. Nurse leaders can facilitate FP skills of new-to-practice nurses through mentorship with more experienced nurses. They can also guide new nurses to connect families with appropriate FP resources, such as hospital social workers, chaplains, or other support systems.
2. Create an interprofessional FP champion team from a variety of disciplines and management composed of people who have the passion, knowledge, and commitment to initiate, motivate, and sustain change. Early involvement of the interprofessional team is essential to establish an FP program.[11]
    a. Identify who should be invited to be part of the champion team (eg, bedside care providers, clinical leaders, physicians, clinical educators, social workers, pastoral care providers, respiratory care providers, child-life specialists, and patient/family advisors).[11]
    b. Review the science on FP's effect on patient outcomes and intervention outcomes with the FP champions. Namely, FP is associated with improved communication with patients' family members, medical decision-making, and patient care.[15,16] Multiple studies on

Table 1 Professional organization support for family presence during resuscitation and invasive procedures

Professional organization	Family presence document
American Academy of Pediatrics, American College of Emergency Physicians, and Emergency Nurses Association	Joint policy statement: Guidelines for care of children in the emergency department[51]
American Association of Critical-Care Nurses	AACN Practice Alert: Family presence during resuscitation and invasive procedures[52]
American College of Critical Care Medicine	Clinical practice guideline: Guidelines for family-centered care in the neonatal, pediatric, and adult ICU[21]
American College of Emergency Physicians	Policy statement: Patient- and family-centered care and the role of the emergency physician providing care to a child in the emergency department[53]
American Heart Association	Clinical practice guideline: Part 4: Pediatric basic and advanced life support[25] Scientific statement: Engaging families in adult cardiovascular care: a scientific statement from the American Heart Association[54]
Canadian Association of Critical Care Nurses	Position statement: Family presence during resuscitation[55]
Canadian Critical Care Society	Position statement: Family presence during resuscitation: a Canadian Critical Care Society position paper[4]
Emergency Nurses Association	Clinical practice guidelines: family presence[56] *Presenting the Option for Family Presence*[11]
European Nursing Organizations	Joint position statement: European nursing organizations stand up for family presence during cardiopulmonary resuscitation: a joint position statement[31]
European Resuscitation Council	Guidelines on ethics and resuscitation and end-of-life decisions: European Resuscitation Council Guidelines 2021: ethics of resuscitation and end-of-life decisons[57]
National Association of Emergency Medical Technicians	Clinical practice tips: Guidelines for providing family-centered prehospital care[58]
National Association of Social Workers	Clinical practice guidelines: Bereavement practice guidelines for health care professionals in the emergency department[59]
National Pediatric Family Presence During Resuscitation Consensus	Consensus recommendations from 18 national organizations: Report of the national consensus conference on family presence during pediatric resuscitation and procedures[19]

FP intervention outcomes also consistently demonstrate that FP does not increase

- Patient care disruptions[4,12,14-16,22,35-37]
- Time to key components or frequency of a trauma evaluation, and time to completion of primary and secondary trauma evaluation survey tasks[16,22]
- Workflow interruptions or interference with procedures[22,38]
- Stress or other negative impact on team performance[22,38]
- Negative outcomes during FP events[14-16,22,35,39-49]
- Duration of resuscitation or resuscitation interventions[4,22,40,49,50]
- Mortality[4,22,40,49,50]

3. Review professional organizations supporting implementation of FP in acute care units with FP champions. Consensus conferences, position and policy statements, and clinical practice guidelines (CPGs) are shown in Table 1.
4. Although the COVID-19 public health emergency ended in May 2023, it ushered in some changes that remain useful, such as innovations related to allowing family to be present through videoconferencing ("nonphysical family presence").[60,61] Some examples of guidance for FP during a pandemic issued by professional organizations include
    a. American Academy of Pediatrics – "Family presence policies for pediatric inpatient settings during the COVID-19 pandemic"[62]

b. Planetree – "Person-centered guidelines for preserving family presence in challenging times"[63]

5. Explore HCPs' concerns via assessment of staff attitudes, beliefs, and individual FP practices.[11,13] Not only can identifying such concerns at your hospital help raise awareness, but suggestions can also be incorporated into your FP program.[64] A number of validated tools are available to assess HCP attitudes, beliefs, and self-confidence in your population and organization (Table 2).[65-69]
6. Regularly review and update visitation policies that may impact FP.

Table 2 Family presence–validated tools for health care providers

Population	Tool
Pediatric	Health Professionals' Beliefs About Family Presence During Invasive Procedures[65]
	Beliefs of Health Professionals About Family Presence in CPR[65]
Adult	ED Clinicians' Attitudes Toward Family Presence During Acute Deterioration of Adults[66]
	Family Presence Risk-Benefit Scale[67,68]
	Family Presence Self-confidence Scale[68]
	Physicians' Family Presence Risk-Benefit Scale[69]
	Physicians' Family Presence Self-confidence Scale[69]

Abbreviations: CPR, cardiopulmonary resuscitation; ED, emergency department.

Education

1. Conduct an educational needs assessment[11] to determine FP knowledge needs of each discipline, as well as the whole interprofessional team.
2. Key topics recommended for educational content include
   a. Principles of patient- and family-centered care
   b. Grief and loss responses
   c. Documented patient and clinical interventions outcomes associated with FP
   d. HCP concerns about implementing FP for patients and family members
   e. Consensus conferences, position and policy statements, or CPGs from professional organizations in support of FP during resuscitation and invasive procedures
   f. Evidence of the benefits of FP for patients, family members, and HCPs

Patient Benefits and Concerns.

Research and public opinion polls indicate that most patients and families believe that family members should be offered the opportunity to be present during invasive procedures and at the time of their loved one's death.[22-24,47,52,70-81]

Specifically, patients believe that FP is beneficial and is their right.[82-84] Almost all children want their parents present.[41,85] The majority of adult patients want family members to be present during emergency procedures[8,83] and are helped and comforted by having them there.[8,46,72,74,75,82] Patients believe that FP humanizes patients in the eyes of HCPs, is a shared experience with family, and maintains patient-family connectedness.[82] Patients also believe that FP allows family members to see that everything possible was done, receive timely information, cope better, and experience closure.[24,33,83,86] Patients, however, also believe that they should be the decision-maker regarding who is present and give consent before the event, if possible.[8] Moreover, they have voiced concern about potential family distress[82] and distraction for providers.[8,83]

Family Member Benefits and Concerns.

More research has focused on the experiences of family members during FP than on those of patients. Robust evidence demonstrates that most, but not all, families want to be present for their loved one's invasive procedures and resuscitation. Additionally, most research demonstrates that FP is beneficial for families.[22,34,56,87,88] If given the option of FP, most family members would choose to be there[56,89,90] and experience high satisfaction with their ability to decide whether to be present.[89] Also, most family members believe that being present is their right, duty, and obligation and the appropriate thing to do.[14,15,22-24,56,88-92]

Families relate that their presence enables them to understand the severity of their loved one's condition and helps remove doubt about the patient's condition by witnessing that everything possible is being done.[14,15,36,39,42,43,46,47,56,90-95] Being there meets the families' need to be together and have the opportunity to advocate for, comfort, and protect their loved one.[14,15,35,36,43,44,56,92,96] Families believe that FP is helpful to the patient and themselves[14,15,35,79,90,91] and allows them to experience a sense of closure and facilitates the grieving process should death occur.[39,43,46,47,72,73,92,95,96]

Although family members demonstrate a range of distress related to emergency procedures, being present decreases family members' fear and distress about what is happening and provides a means to communicate essential patient health information to the health care team.[14,24,33,41,86,90,93,96-98] Moreover, no adverse psychological effects are reported among family members who participate in FP compared with families who do not.[14,15,33,36,44,46,92,94,99-101] In a Cochrane review of the effects of FP on posttraumatic stress and other psychological outcomes of family members, in which 3 randomized controlled trials were evaluated, the authors reported that there was not enough evidence to formulate conclusions about the effects on any of the outcomes evaluated.[102] However, several studies have demonstrated positive family outcomes resulting from FP. Some have shown that families who are present have significantly reduced stress, anxiety, and depression[79] and greater well-being regarding the care provided compared with families who are not present.[38] Others have shown a lower frequency of signs and symptoms of posttraumatic stress syndrome, depression, and traumatic grief in families present during resuscitation at both 3 months and 1 year after the event, with no lawsuits regarding the care provided filed in this group.[44,100] One compelling finding was that 94% to 100% of families would choose to be present again in the future.[14,15,26,33,35,36,39,72,90,96]

Nurse and HCP Benefits and Concerns.

Health care providers agree that family members should be supported to be present if they so desire.[3,103,104] They believe that FP helps families understand the extent of care provided and that everything possible was done for the patient, as well as assists families with the grieving process and achieving a sense of closure in case of death.[3,103] They also believe that physicians should not be solely responsible for deciding if family members should be present.[3]

Sociocultural, environmental, and individual factors affect perceptions of FP among HCPs.[34,105] Greater confidence in and more support for FP have been documented in providers with higher levels of education and certification in their specialty, greater clinical and intensive care unit experience or mock code training, and experience with FP, FP policies, and FP education, as well as among those who have previously invited families to be present.[56,79,106-109]

Health care providers have concerns about FP. Some HCPs are concerned that FP might interfere with patient care or affect the team's concentration during resuscitation,[3,56,103,108,110] delay interventions, or prolong the resuscitation.[110] Some fear potential litigation because of family misunderstandings during emergent procedures.[3,56] Moreover, HCPs are concerned that FP may be a traumatic experience for families[3,22,103] and cause distress for both families and HCPs.[56,103,110] Health care providers also worry about not respecting the patient's wishes if FP was not previously discussed with them, as well as not meeting

family needs in terms of their education level, culture, and religion.[3,110]

Barriers to FP voiced by HCPs include the lack of physical room for the family,[103,108,109,111] a clear FP policy,[20,103,108,109] a designated FPF,[3,20,33,103,110] and support from both leadership and other members of the resuscitation team.[109,110]

3. Educate all interprofessional team members who will be involved with FP.[18,20,26,29,31,32,56,72,91,112-114] In preparing educational opportunities, recognize how environmental and sociocultural factors and HCP opinions and attitudes toward FP will affect acceptance and implementation success.[34,105] For instance, some HCPs may be hesitant to embrace FP to protect families from what they perceive as potential psychological trauma, as well as because of the potential for distractions and concerns that families will not understand what is occurring.[22] Awareness of these factors is crucial for launching a successful educational campaign.
4. Use an array of educational strategies to heighten awareness, influence attitudes, and build FP knowledge among HCPs. Nurses report a desire for a variety of educational approaches to learn about FP.[115] Furthermore, until more robust FP research[22,24,110,113] illuminates which interprofessional educational approaches are most effective in promoting positive FP attitudes, beliefs, and practices, incorporate a variety of modalities, including
    a. Just-in-time learning platforms, QR codes, huddle discussions, unit meeting in-service programs
    b. Posting educational information in secure staff common areas with an opportunity for team members to ask questions and address ongoing educational needs
    c. Lecture and discussion
    d. Guest speakers
        - Patients and family members who can share their FP stories[116]
        - Leaders from other organizations with successful FP programs
    e. Self-paced modules and articles
    f. Online education, which shows promise in improving nurses' perceptions of and confidence regarding FP and thus has potential in assisting widespread adoption[117]
    g. Personal values clarification exercises
    h. Education and training videos
    i. Role-playing exercises or use of simulation in which staff members assume the roles of patient and family member during a critical event[113,114,116]
    j. Resuscitation and invasive procedure simulations
    k. Case reviews
5. Embed FP education into orientation and establish competency standards[52] for all staff members involved in FP to ensure patient, family, and staff safety. During the initial implementation of an FP program in your institution, develop competency statements for each member of the interprofessional team who may play a role in FP during resuscitation or invasive procedures. Staff members can also be assigned annual competency review of the FP policy and specific roles of the interprofessional team and FPF to ensure that all team members have refresher education about their important roles in supporting patients and families.
6. Create additional opportunities for formal and informal discussions to assist the team in sharing evidence, experiences, perspectives, and opposing viewpoints that can ready the culture for FP during resuscitation and invasive procedures. Such conversations help identify staff and team sentiments, potential roadblocks, additional educational needs, and issues to incorporate into FP guidelines and implementation plans. These formal and informal opportunities might include
    a. Unit huddles
    b. Evidence-based practice rounds
    c. Staff meetings
    d. In-service programs
    e. Journal clubs
    f. Ethics conferences
    g. Shared governance council meetings
    h. Open team forums

7. Host grand rounds on FP during resuscitation and invasive procedures. Invite the interprofessional team to hear experts summarize the current state of the science, as well as discuss case studies of successful FP events and patient/family testimonials.
8. Post current patient- and family-centered care and FP research articles on unit bulletin boards and websites and in the nurse's station and team rooms on a regular basis.

Family Presence Facilitators

1. Best practice suggests that FPFs play a pivotal role in protecting the safety of the patient, family, and HCPs and facilitating patient and clinical intervention outcomes during FP. Most importantly, FPFs safeguard the guiding principle of FP by ensuring that no disruptions or interference with patient care will occur. Thus, when resources are available, educate a team of FPFs to ensure that resuscitation efforts are viewed as successful by the family and health care team, whether the patient survives or not.[23,115]
2. The FPF should be a core member of the resuscitation team[21,33,34] and needs to be identified as early as possible during an emergency event.[22,33] Team members who serve as the FPF have an additional specialized role. Ideally, the FPF should not directly participate in the resuscitation but instead should be designated to support families during such events. A training session for educating the FPF has been described, including FPF roles and responsibilities, curricular content, an FPF flow chart, and a documentation template.[118] Significant increases in all rated aspects of knowledge of the family support role and self-care strategies were reported. Teach FPFs how to assess, communicate with, prepare, and support family members who may choose to be present during an invasive procedure or resuscitation event, as well as approaches to dealing with families who are in distress.[27,118,119] Use a variety of educational methods to develop FPF skills, such as self-paced study, lecture and discussion, role playing, and simulation of case studies.

   The FP policy or CPG should delineate who can serve in this role, although no evidence exists to indicate which HCPs are best qualified to do so.[23,120] A cadre of team members—such as bedside care providers, nurse leaders/managers/supervisors, clinical nurse specialists, social workers, physicians, chaplains, child-life specialists, respiratory care practitioners, family therapists, or nursing students—should be trained in the FPF role.[4,9,11,17,23,26,30,120-123] The American Heart Association recommends that FP be permitted during pediatric resuscitation even if an FPF is not available.[25] Others recommend that FP not be offered without an FPF,[4] although FP rarely begins in hospitals with a formal program, education, policies, and trained family support facilitators.
3. Acute care nurses report that the FPF role is difficult but rewarding. The complex, multifaceted role involves being fully present and compassionately attentive to families in addition to continuously assessing family members; coordinating the first moments during the FP event; explaining resuscitation activities in simple, tailored terminology; and providing emotional and psychological support.[27]

Create an FP Practice Protocol or Policy

1. Institutional FP policies provide a sanctioned road map for facilitating FP in clinical practice. Written, approved FP policies or CPGs protect the safety of the patient, family, and health care team by ensuring that FP implementation is evidence based, supported, and accepted by the interprofessional team and offered equitably to family members of critically ill patients undergoing invasive procedures and resuscitation.
2. Family presence education and policies or CPGs are recommended by many professional organizations, consensus conferences, and joint position and policy statements.[4,11,19-21,25,31,51-53,55,56,58,59,124] Professional organizations supporting FP implementation are shown in Table 1.
   a. Institutional FP policies or CPGs are needed to guide clinical practice. In one study,

education increased HCPs' awareness of and compliance with FP policies.[64] Similarly, Powers and Reeve[107] found that FP education for nurses and an FP policy or CPG were associated with greater confidence in the FP intervention and increased invitations extended to families to be present.

b. Recent literature clearly indicates that institutional FP policies are not widespread[21] and yet FP commonly occurs in clinical practice. Health care providers have expressed concerns and hesitation about implementing FP because they lack FP policies and support from the interprofessional team.[103,109,110] Bedside care providers may not be aware that an FP policy or CPG exists in their institution.[110] In a national survey of critical care nurses in the United States (n = 395), most respondents reported either not having or not knowing of an institutional policy on FP during resuscitation, but the majority had experienced FP.[110] Another national study found that only about one-third of 252 hospitals had FP policies.[40] Other surveys of critical care nurses' practice indicate that many, if not most, patients' families have asked if they could be present during resuscitation and invasive procedures and were brought to the bedside despite the lack of formal policies.[69,125]

3. Develop institutional, evidence-based FP policies or CPGs by using or adapting existing policy guidelines as a template[4,10,11,13,19,56] to ensure that all patient care units have an approved, written practice document. The FP policy or CPG should address the following:
   a. Identify the purpose of the FP policy or CPG guided by the patient- and family-centered care model, in which care is driven by the needs of the patient and family rather than controlled by HCPs, the health care system, or the patient's disease.
   b. Define key terms, including *family, family presence, family presence facilitator, resuscitation,* and *invasive procedure*.[10,11,19]
   c. Identify the indications for FP during a medical alert, code blue, trauma resuscitation, and invasive procedure.
   d. Describe the roles and responsibilities of the FPF to support the family.[10,25,116] Describe the roles and responsibilities of other team members involved in the event in relationship to FP, including bedside care providers, resuscitation leader, physicians, and others.[10]
4. Seek agreement with and approval of the FP policy from stakeholders (administration, physicians, nurses, social workers, chaplains, child-life specialists, respiratory therapists, legal department,[19] infectious disease department, risk management, and security department as appropriate).[11,13]
5. Instruct all providers involved in FP on the step-by-step approach to follow when implementing the FP policy or CPG.
6. Create FP documentation standards,[52] including who is responsible. Suggested elements to document in a progress note in the health care record after the event include
   a. If the family was assessed as appropriate per family behavioral contraindications
   b. If the resuscitation team was consulted before FP
   c. If FP was offered to the family as an option; if not, document the reason,[19] such as combative or violent behavior, uncontrolled emotional outbursts or extreme emotional instability, and behaviors consistent with altered mental state due to use of drugs or alcohol
   d. The family's decision about being present and which family members wanted to participate
   e. Support measures offered before, during, and after the event
   f. If the family chose not to be present, support measures and updates offered to the family
   g. Family behavior and reactions during and after the FP event
   h. Patient outcome related to the invasive procedure or resuscitation

7. Plan evaluation of the FP program.[11-13]
    a. Participate in team debriefings after FP events to address emotions and potential conflict, as well as determine what went well and what could have been improved.[4,10,11,13]
    b. Debriefings can also provide recovery time for providers following a difficult procedure, resuscitation, or death.[4,10,11] Share these learnings with the larger interprofessional team to improve future FP events.
    c. Teams may find it useful to periodically assess their performance of FP using video-recordings or simulation.[126] Kassam-Adams et al[126] developed an observational checklist for assessment of team behaviors, which is freely available (Pediatric Resuscitation Observation Checklist for Patient/Family Centered and Trauma-Informed Care) at www.healthcaretoolbox.org/observation-checklist-pediatric-resuscitation.
    d. Evaluate the FP program by assessing outcomes of patients, families, and HCPs in addition to the rate of HCP compliance in offering the option of FP to families.[52] Identify target rates of compliance and delineate steps to take if compliance falls below the target; for example, reeducation of staff, inclusion in orientation and annual competency programs, and reminders via communication tools.[11,52]

Other Resources

- Review the Institute for Patient- and Family-Centered Care's website for resources on patient- and family-centered care and ways to maintain FP during a pandemic: www.ipfcc.org.
- Contact an American Association of Critical-Care Nurses clinical practice specialist for additional information: practice@aacn.org.
- Review the third edition of *Presenting the Option for Family Presence,*[11] developed and published by the Emergency Nurses Association, which offers guidelines suitable for adaptation to critical care units. These guidelines include educational slides and handouts, an FP department assessment tool, a staff assessment tool, an educational needs assessment tool, a sample FP guideline, and other supporting documents. This resource is no longer available from the Emergency Nurses Association, but nurses can borrow it through interlibrary loan at a hospital library. Consult your medical librarian.
- Consult resources for developing a protocol for FP, including defining team roles and expectations, such as the Palliative Care Network of Wisconsin's "Fast Fact #233: Implementation of a Family Presence During Resuscitation Protocol at https://www.mypcnow.org/fast-fact/implementation-of-a-family-presence-during-resuscitation-protocol.
- Access the 3 free videos "Training Parent Facilitators" developed by Martha Curley, PhD, RN, for the Cardiovascular Critical Care Nursing Program at Children's Hospital Boston. These videos role-model how to be an effective facilitator with parents at the bedside and represent a simulation-based teaching resource in training FPFs. In 2 of the simulations, staff members support parents (trained actors) whose children are undergoing resuscitation and invasive procedures. The other video includes debriefings of the simulations with the health care team and family. The videos are available at www.marthaaqcurley.com/training-parent-facilitators.html.
- Healthy Work Environment Assessment Tool. Participate in this free online assessment: https://www.aacn.org/nursing-excellence/healthy-work-environments. This tool measures the health of the work environment against the American Association of Critical-Care Nurses' Healthy Work Environment Standards. Download your team results to access valuable resources to begin transforming your work environment and influencing patient, nurse, and hospital outcomes.

Original Author: Cathie E. Guzzetta, PhD, RN
November 2004

Contributing Authors: Margo A. Halm, PhD, RN, NEA-BC, Halley Ruppel, PhD, RN, Jessica R. Sexton, MSN, RN, Cathie E. Guzzetta, PhD, RN
Fall 2023

Reviewed and approved by the Clinical Resources Task Force, 2023

Financial Disclosures

None reported.

References

1. Stahl M, Miller J, eds. *AACN's Competence Framework for Progressive and Critical Care: Initial Competency 2022.* American Association of Critical-Care Nurses; 2022. [level E]
2. Butcher H, Bulecheck G, Dochterman J, et al. *Nursing Interventions Classification (NIC).* Elsevier; 2018. [level E]
3. Gomes BD, Dowd OP, Sethares KA. Attitudes of community hospital critical care nurses toward family-witnessed resuscitation. *Am J Crit Care*. 2019;28(2):142-148. doi:10.4037/ajcc2019162 [level C]
4. Oczkowski SJ, Mazzetti I, Cupido C, Fox-Robichaud AE; Canadian Critical Care Society. Family presence during resuscitation: a Canadian Critical Care Society position paper. *Can Respir J.* 2015;22(4):201-205. doi:10.1155/2015/532721 [level D]
5. Frampton S, Agrawal S, Guastello S. Guidelines for family presence policies during the COVID-19 pandemic. *JAMA Health Forum.* 2020;1(7):e200807. doi:10.1001/jamahealthforum.2020.0807 [level D]
6. Perkins SB, Dokken DL, Johnson BH, Frederick K. Family presence during Covid-19: learning from one hospital's journey. *NEJM Catalyst Innov Care Deliv*. 2022;3(3). doi:10.1056/CAT.22.0025 [level E]
7. Marmo S, Milner KA. From open to closed: COVID-19 restrictions on previously unrestricted visitation policies in adult intensive care units. *Am J Crit Care.* 2023;32(1):31-41. doi:10.4037/ajcc2023365 [level C]
8. Bradley C, Keithline M, Petrocelli M, Scanlon M, Parkosewich J. Perceptions of adult hospitalized patients on family presence during cardiopulmonary resuscitation. *Am J Crit Care*. 2017;26(2):103-110. doi:10.4037/ajcc2017550 [level C]
9. Clark AP, Aldridge MD, Guzzetta CE, et al. Family presence during cardiopulmonary resuscitation. *Crit Care Nurs Clin North Am.* 2005;17(1):23-32. doi:10.1016/j.ccell.2004.09.004 [level E]
10. Farah MM, Thomas CA, Shaw KN; Children's Hospital of Philadelphia. Evidence-based guidelines for family presence in the resuscitation room: a step-by-step approach. *Pediatr Emerg Care*. 2007;23(8):587-591. doi:10.1097/PEC.0b013e318131e482 [level E]
11. Guzzetta CE, Clark AP, Halm M, eds. *Presenting the Option for Family Presence.* 3rd ed. Emergency Nurses Association; 2007:1-108. [level D]
12. Kingsnorth J, O'Connell K, Guzzetta CE, et al. Family presence during trauma activations and medical resuscitations in a pediatric emergency department: an evidence-based practice project. *J Emerg Nurs.* 2010;36(2):115-121. doi:10.1016/j.jen.2009.12.023 [level C]
13. Mangurten JA, Scott SH, Guzzetta CE, et al. Family presence: making room. *Am J Nurs.* 2005;105(5):40-49. doi:10.1097/00000446-200505000-00027 [level C]
14. Mangurten J, Scott SH, Guzzetta CE, et al. Effects of family presence during resuscitation and invasive procedures in a pediatric emergency department. *J Emerg Nurs*. 2006;32(3):225-233. doi:10.1016/j.jen.2006.02.012 [level C]
15. Meyers TA, Eichhorn DJ, Guzzetta CE, et al. Family presence during invasive procedures and resuscitation. *Am J Nurs.* 2000;100(2):32-43. [level C]
16. O'Connell KJ, Farah MM, Spandorfer P, Zorc JJ. Family presence during pediatric trauma team activation: an assessment of a structured program. *Pediatrics*. 2007;120(3):e565-e574. doi:10.1542/peds.2006-2914 [level B]
17. Pankop R, Chang K, Thorlton J, Spitzer T. Implemented family presence protocols: an integrative review. *J Nurs Care Qual*. 2013;28(3):281-288. doi:10.1097/NCQ.0b013e31827a472a [level C]
18. Doolin CT, Quinn LD, Bryant LG, Lyons AA, Kleinpell RM. Family presence during cardiopulmonary resuscitation: using evidence-based knowledge to guide the advanced practice nurse in developing formal policy and practice guidelines. *J Am Acad Nurse Pract*. 2011;23(1):8-14. doi:10.1111/j.1745-7599.2010.00569.x [level C]
19. Henderson DP, Knapp JF. Report of the national consensus conference on family presence during pediatric cardiopulmonary resuscitation and procedures. *J Emerg Nurs*. 2006;32(1):23-29. doi:10.1016/j.jen.2005.11.009 [level D]
20. Considine J, Eastwood KJ, Webster HS, et al. Family presence during adult resuscitation from cardiac arrest: a systematic review. *Resuscitation*. 2022;180:11-23. doi:10.1016/j.resuscitation.2022.08.021 [level C]
21. Davidson JE, Aslakson RA, Long AC, et al. Guidelines for family-centered care in the neonatal, pediatric, and adult ICU. *Crit Care Med.* 2017;45(1):103-128. doi:10.1097/CCM.0000000000002169 [level D]
22. Deacon A, O'Neill TA, Gilfoyle E. A scoping review of the impact of family presence on pediatric resuscitation team members. *Pediatr Crit Care Med*. 2020;21(12):e1140-e1147. doi:10.1097/PCC.0000000000002471 [level C]
23. Jordahl E, Hyde YM, Kautz DD. Overcoming resistance to family-witnessed resuscitation. *Dimens Crit Care Nurs.* 2015;34(6):317-320. doi:10.1097/DCC.0000000000000139 [level C]
24. Toronto CE, LaRocco SA. Family perception of and experience with family presence during cardiopulmonary resuscitation: an integrative review. *J Clin Nurs.* 2019;28(1-2):32-46. doi:10.1111/jocn.14649 [level C]
25. Topjian AA, Raymond TT, Atkins D, et al. Part 4: Pediatric basic and advanced life support: 2020 American Heart Association guidelines for cardiopulmonary resuscitation and emergency cardiovascular care. *Circulation*. 2020;142(16 suppl 2):S469-S523. doi:10.1161/CIR.0000000000000901 [level D]
26. Curley MAQ, Meyer EC, Scoppettuolo LA, et al. Parent presence during invasive procedures and resuscitation: evaluating a clinical practice change. *Am J Respir Crit Care Med*. 2012;186(11):1133-1139. doi:10.1164/rccm.201205-0915OC [level B]
27. Powers K, Duncan JM, Twibell K. Family support person role during resuscitation: a qualitative exploration. *J Clin Nurs.* 2022;32(3/4):409-421. doi:10.1111/jocn.16248 [level C]
28. Bettencourt AP, Gorman M, Mullen JE. Pediatric resuscitation. *Crit Care Nurs Clin North Am*. 2021;33(3):287-302. doi:10.1016/j.cnc.2021.05.005 [level E]
29. Fulbrook P, Latour J, Albarran J, et al. 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. *Eur J Cardiovasc Nurs*. 2007;6(4):255-258. doi:10.1016/j.ejcnurse.2007.07.003 [level D]
30. James J, Cottle E, Hodge RD. Registered nurse and health care chaplains' experiences of providing the family support person role during family witnessed resuscitation. *Intensive Crit Care Nurs*. 2011;27(1):19-26. doi:10.1016/j.iccn.2010.09.001 [level C]
31. Moons P, Norekvål TM. European nursing organizations stand up for family presence during cardiopulmonary resuscitation: a joint position statement. *Prog Cardiovasc Nurs.* 2008;23(3):136-139. doi:10.1111/j.1751-7117.2008.00004.x [level D]
32. Davidson JE, Buenavista R, Hobbs K, Kracht K. Identifying factors inhibiting or enhancing family presence during resuscitation in the emergency department. *Adv Emerg Nurs J.* 2011;33(4):336-343. doi:10.1097/TME.0b013e318234e6a0 [level C]
33. McAlvin SS, Carew-Lyons A. Family presence during resuscitation and invasive procedures in pediatric critical care: a systematic review. *Am J Crit Care*. 2014;23(6):477-485. doi:10.4037/ajcc2014922 [level C]
34. Tíscar-González V, Gea-Sánchez M, Blanco-Blanco J, Pastells-Peiró, De Ríos-Briz N, Moreno-Casbas MT. Witnessed resuscitation of adult and paediatric hospital patients: an umbrella review of the evidence. *Int J Nurs Stud*. 2021;113:103740. doi:10.1016/j.ijnurstu.2020.103740 [level C]
35. Dudley NC, Hansen KW, Furnival RA, Donaldson AE, Van Wagenen KL, Scaife ER. The effect of family presence on the efficiency of pediatric trauma resuscitations. *Ann Emerg Med.* 2009;53(6):777-784.e3. doi:10.1016/j.annemergmed.2008.10.002 [level B]
36. Pasquale MA, Pasquale MD, Baga L, Eid S, Leske J. Family presence during trauma resuscitation: ready for primetime? *J Trauma*. 2010;69(5):1092-1100. doi:10.1097/TA.0b013e3181e84222 [level C]
37. Sacchetti A, Paston C, Carraccio C. Family members do not disrupt care when present during invasive procedures. *Acad Emerg Med.* 2005;12(5):477-479. doi:10.1197/j.aem.2004.12.010 [level C]
38. Leske JS, McAndrew NS, Brasel KJ, Feetham S. Family presence during resuscitation after trauma. *J Trauma Nurs*. 2017;24(2):85-96. doi:10.1097/JTN.0000000000000271 [level C]
39. Doyle CJ, Post H, Burney RE, Maino J, Keefe M, Rhee KJ. Family participation during resuscitation: an option. *Ann Emerg Med.* 1987;16(6):673-675. doi:10.1016/s0196-0644(87)80069-0 [level E]
40. Goldberger ZD, Nallamothu BK, Nichol G, Chan PS, Curtis JR, Cooke CR. Policies allowing family presence during resuscitation and patterns of care during in-hospital cardiac arrest. *Circ Cardiovasc Qual Outcomes*. 2015;8(3):226-234. doi:10.1161/CIRCOUTCOMES.114.001272 [level C]
41. Gonzalez JC, Routh DK, Saab PG, et al. Effects of parent presence on children's reactions to injections: behavioral, physiological, and subjective aspects. *J Pediatr Psychol.* 1989;14(3):449-462. doi:10.1093/jpepsy/14.3.449 [level C]
42. Lowry E. "It's just what we do": a qualitative study of emergency nurses working with well-established family presence protocol. *J Emerg Nurs.* 2012;38(4):329-334. doi:10.1016/j.jen.2010.12.016 [level C]
43. Hanson C, Strawser D. Family presence during cardiopulmonary resuscitation: Foote Hospital emergency department's nine-year perspective. *J Emerg Nurs*. 1992;18(2):104-106. [level E]

44. Jabre P, Belpomme V, Azoulay E, et al. Family presence during cardiopulmonary resuscitation. *N Engl J Med*. 2013;368(11):1008-1018. doi:10.1056/NEJMoa1203366 [level B]
45. Ringer T, Moller D, Mutsaers A. Distress in caregivers accompanying patients to an emergency department: a scoping review. *J Emerg Med*. 2017;53(4):493-508. doi:10.1016/j.jemermed.2017.03.028 [level C]
46. Robinson SM, Mackenzie-Ross S, Campbell Hewson GL, Egleston CV, Prevost AT. Psychological effect of witnessed resuscitation on bereaved relatives. *Lancet*. 1998;352(9128):614-617. doi:10.1016/s0140-6736(97)12179-1 [level B]
47. Tinsley C, Hill JB, Shah J, et al. Experience of families during cardiopulmonary resuscitation in a pediatric intensive care unit. *Pediatrics*. 2008; 122(4):e799-e804. doi:10.1542/peds.2007-3650 [level C]
48. Vardanjani AE, Golitaleb M, Abdi K, et al. The effect of family presence during resuscitation and invasive procedures on patients and families: an umbrella review. *J Emerg Nurs*. 2021;47(5):752-760. doi:10.1016/j.jen.2021.04.007 [level C]
49. Waldemar A, Bremer A, Holm A, Strömberg A, Thylén I. In-hospital family-witnessed resuscitation with a focus on the prevalence, processes, and outcomes of resuscitation: a retrospective observational cohort study. *Resuscitation*. 2021;165:23-30. [level C]
50. Krochmal RL, Blenko JW, Afshar M, et al. Family presence at first cardiopulmonary resuscitation and subsequent limitations on care in the medical intensive care unit. *Am J Crit Care*. 2017;26(3):221-228. doi:10.4037/ajcc2017510 [level C]
51. American Academy of Pediatrics, Committee on Pediatric Emergency Medicine; American College of Emergency Physicians, Pediatric Committee; Emergency Nurses Association, Pediatric Committee. Joint policy statement—guidelines for care of children in the emergency department. *J Emerg Nurs*. 2013;39(2):116-131. doi:10.1016/j.jen.2013.01.003 [level D]
52. Guzzetta CE. AACN Practice alert. Family presence during resuscitation and invasive procedures. *Crit Care Nurse*. 2016;36(1):e11-e14. doi:10.4037/ccn2016980 [level D]
53. American College of Emergency Physicians. Patient- and family-centered care and the role of the emergency physician providing care to a child in the emergency department. Updated October 2020. Accessed January 24, 2022. https://www.acep.org/globalassets/new-pdfs/policy-statements/patient--and-family-centered-care-and-the-role-of-the-ep-providing-care-to-a-child-in-the-ed.pdf [level D]
54. Goldfarb MJ, Bechtel C, Capers Q, et al. Engaging families in adult cardiovascular care: a scientific statement from the American Heart Association. *J Am Heart Assoc*. 2022;11(10):e025859. doi:10.1161/JAHA.122.025859 [level D]
55. Canadian Association of Critical Care Nurses. Position statement: Family presence during resuscitation. *Dynamics*. 2005;16(4):8. [level D]
56. Vanhoy MA, Horigan A, Stapleton SJ, et al; 2017 ENA Clinical Practice Guideline Committee. Clinical practice guideline: family presence. *J Emerg Nurs*. 2019;45(1):76.e1-76.e29. doi:10.1016/j.jen.2018.11.012 [level D]
57. Mentzelopoulos SD, Couper K, Van de Voorde P, et al. European Resuscitation Council Guidelines 2021: ethics of resuscitation and end of life decisions. *Resuscitation*. 2021;161:408-432. [level D]
58. National Association of Emergency Medical Technicians. Guidelines for providing family-centered prehospital care. Published July 2000. Accessed October 26, 2015. https://paemsc.org/wp-content/uploads/2017/02/guidelines-for-providing-family-centered-care-NAEMT.pdf [level D]
59. Lipton H, Coleman M. Bereavement practice guidelines for health care professionals in the emergency department. *Int J Emerg Ment Health*. 2000;2(1):19-31. [level D]
60. Hart JL, Taylor SP. Family presence for critically ill patients during a pandemic. *Chest*. 2021;160(2):549-557. doi:10.1016/j.chest.2021.05.003 [level E]
61. Lederman Z. Family presence during cardiopulmonary resuscitation in the Covid-19 era. *Resuscitation*. 2020;151:137-138. doi:10.1016/j.resuscitation.2020.04.028 [level E]
62. American Academy of Pediatrics. Family presence policies for pediatric inpatient settings during the COVID-19 pandemic. Accessed September 21, 2023. https://www.aap.org/en/pages/2019-novel-coronavirus-covid-19-infections/clinical-guidance/family-presence-policies-for-pediatric-inpatient-settings-during-the-covid-19-pandemic [level E]
63. Planetree. Person-centered guidelines for preserving family presence in challenging times. Accessed September 21, 2023. https://planetree.org/wp-content/uploads/2020/08/Published-Guidelines-on-Family-Presence-During-a-Pandemic-Final-8.13.20v5.pdf [level D]
64. Ferrara G, Ramponi D, Cline TW. Evaluation of physicians' and nurses' knowledge, attitudes, and compliance with family presence during resuscitation in an emergency department setting after an educational intervention. *Adv Emerg Nurs J*. 2016;38(1):32-42. doi:10.1097/TME.0000000000000086 [level C]
65. Ferreira CAG, Balbino FS, Balieiro MMFG, Mandetta MA. Validation of instruments about family presence on invasive procedures and cardiopulmonary resuscitation in pediatrics. *Rev Lat Am Enfermagem*. 2018;26:e3046. doi:10.1590/1518-8345.2368.3046 [level C]
66. Youngson MJ, Considine J, Currey J. Development, reliability and validity of a tool, to measure emergency department clinicians' attitudes towards family presence (FP) during acute deterioration in adult patients. *Australas Emerg Nurs J*. 2015;18(2):106-114. doi:10.1016/j.aenj.2014.12.002 [level C]
67. Parial LL, Torres GC, Macindo JR. Family presence during resuscitation benefits-risks scale (FPDR-BRS): instrument development and psychometric validation. *J Emerg Nurs*. 2016;42(3):213-223. doi:10.1016/j.jen.2015.08.018 [level C]
68. de Mingo-Fernández E, Belzunegui-Eraso Á, Jiménez-Herrera M. Family presence during resuscitation: adaptation and validation into Spanish of the Family Presence Risk-Benefit scale and the Self-Confidence scale instrument. *BMC Health Serv Res*. 2021;21(1):1-12. doi:10.1186/s12913-021-06180-2 [level C]
69. Twibell RS, Siela D, Neal A, Riwitis C, Beane H. Family presence during resuscitation: physicians' perceptions of risk, benefit, and self-confidence. *Dimens Crit Care Nurs*. 2018;37(3):167-179. doi:10.1097/DCC.0000000000000297 [level C]
70. Barratt F, Wallis DN. Relatives in the resuscitation room: their point of view. *J Accid Emerg Med*. 1998;15(2):109-111. doi:10.1136/emj.15.2.109 [level C]
71. Bauchner H, Waring C, Vinci R. Parental presence during procedures in an emergency room: results from 50 observations. *Pediatrics*. 1991;87(4):544-548. [level C]
72. Belanger MA, Reed S. A rural community hospital's experience with family-witnessed resuscitation. *J Emerg Nurs*. 1997;23(3):238-239. doi:10.1016/s0099-1767(97)90015-5 [level C]
73. Boie ET, Moore GP, Brummett C, Nelson DR. Do parents want to be present during invasive procedures performed on their children in the emergency department? a survey of 400 parents. *Ann Emerg Med*. 1999;34(1):70-74. doi:10.1016/s0196-0644(99)70274-x [level C]
74. Benjamin M, Holger J, Carr M. Personal preferences regarding family member presence during resuscitation. *Acad Emerg Med*. 2004;11(7):750-753. doi:10.1197/j.aem.2004.01.008 [level C]
75. McMahon-Parkes K, Moule P, Benger J, Albarran JW. The views and preferences of resuscitated and non-resuscitated patients towards family-witnessed resuscitation: a qualitative study. *Int J Nurs Stud*. 2009;46(2):220-229. [level C]
76. Mazer MA, Cox LA, Capon JA. The public's attitude and perception concerning witnessed cardiopulmonary resuscitation. *Crit Care Med*. 2006;34(12):2925-2928. doi:10.1097/01.CCM.0000247720.99299.77 [level C]
77. Meyers TA, Eichhorn DJ, Guzzetta CE. Do families want to be present during CPR? a retrospective survey. *J Emerg Nurs*. 1998;24(5):400-405. doi:10.1016/s0099-1767(98)70005-4 [level C]
78. Sacchetti A, Lichenstein R, Carraccio CA, Harris RH. Family member presence during pediatric emergency department procedures. *Pediatr Emerg Care*. 1996;12(4):268-271. doi:10.1097/00006565-199608000-00008 [level C]
79. Oczkowski SJ, Mazzetti I, Cupido C, Fox-Robichaud AE. The offering of family presence during resuscitation: a systematic review and meta-analysis. *J Intensive Care*. 2015;3:41. doi:10.1186/s40560-015-0107-2 [level A]
80. Tudor K, Berger J, Polivka BJ, et al. Nurses' perceptions of family presence duringresuscitation. *Am J Crit Care*. 2014;23(6):e88-e96. doi:10.4037/ajcc2014484 [level C]
81. Mortelmans LJM, Van Broeckhoven V, Van Boxstael S, et al. Patients' and relatives' view on witnessed resuscitation in the emergency department: a prospective study. *Eur J Emerg Med*. 2010;17(4):203-207. doi:10.1097/MEJ.0b013e328331477e [level C]
82. Eichhorn DJ, Meyers TA, Guzzetta CE, et al. During invasive procedures and resuscitation: hearing the voice of the patient. *Am J Nurs*. 2001;101(5):48-55. doi:10.1097/00000446-200105000-00020 [level C]
83. Twibell RS, Craig S, Siela D, Simmonds S, Thomas C. Being there: inpatients' perceptions of family presence during resuscitation and invasive cardiac procedures. *Am J Crit Care*. 2015;24(6):e108-e115. doi:10.4037/ajcc2015470 [level C]
84. Wolfram RW, Turner ED. Effects of parental presence during children's venipuncture. *Acad Emerg Med*. 1996;3(1):58-64. doi:10.1111/j.1553-2712.1996.tb03305.x [level B]
85. Fiorentini SE. Evaluation of a new program: pediatric parental visitation in the post anesthesia care unit. *J Post Anesth Nurs*. 1993;8(4):249-256. [level E]

86. Mark K. Family presence during paediatric resuscitation and invasive procedures: the parental experience: an integrative review. *Scand J Caring Sci*. 2021;35(1):20-36. doi:10.1111/scs.12829 [level C]
87. Dainty KN, Atkins DL, Breckwoldt J, et al. Family presence during resuscitation in paediatric and neonatal cardiac arrest: a systematic review. *Resuscitation*. 2021;162:20-34. doi:10.1016/j.resuscitation.2021.01.017 [level C]
88. Stewart SA. Parents' experience during a child's resuscitation: getting through it. *J Pediatr Nurs*. 2019;47:58-67. doi:10.1016/j.pedn.2019.04.019 [level C]
89. Zhang A, Yocum RM, Repplinger MD, Broman AT, Kim MK. Factors affecting family presence during fracture reduction in the pediatric emergency department. *West J Emerg Med*. 2018;19(6):970-976. doi:10.5811/westjem.2018.9.38379. [level C]
90. O'Connell K, Fritzeen J, Guzzetta CE, et al. Family presence during trauma resuscitation: family members' attitudes, behaviors, and experiences. *Am J Crit Care*. 2017;26(3):229-239. doi:10.4037/ajcc2017503 [level B]
91. Holzhauser K, Finucane J, De Vries SM. Family presence during resuscitation: a randomised controlled trial of the impact of family presence. *Australas Emerg Nurs J*. 2006;8(4):139-147. doi:10.1016/j.aenj.2005.10.003 [level B]
92. McGahey-Oakland PR, Lieder HS, Young A, Jefferson LS. Family experiences during resuscitation at a children's hospital emergency department. *J Pediatr Health Care*. 2007;21(4):217-225. doi:10.1016/j.pedhc.2006.12.001 [level C]
93. Leske JS, McAndrew NS, Brasel KJ. Experiences of families when present during resuscitation in the emergency department after trauma. *J Trauma Nurs.* 2013;20(2):77-85. doi:10.1097/JTN.0b013e31829600a8 [level C]
94. Maxton FJC. Parental presence during resuscitation in the PICU: the parents' experience. Sharing and surviving the resuscitation: a phenomenological study. *J Clin Nurs*. 2008;17(23):3168-3176. doi:10.1111/j.1365-2702.2008.02525 [level C]
95. Timmermans S. High touch in high tech: the presence of relatives and friends during resuscitative efforts. *Sch Inq Nurs Pract.* 1997;11(2):153-173. [level E]
96. Powers KS, Rubenstein JS. Family presence during invasive procedures in the pediatric intensive care unit: a prospective study. *Arch Pediatr Adolesc Med*. 1999;153(9):955-958. doi:10.1001/archpedi.153.9.955 [level C]
97. Manguy AM, Oakley E, Gordon R, Joubert L. Acute psychosocial care of families in paediatric resuscitation settings: variables associated with parent emotional response. *Australas Emerg Care*. 2021;24(3):224-229. doi:10.1016/j.auec.2020.11.001 [level C]
98. Shapira M, Tamir A. Presence of family member during upper endoscopy: what do patients and escorts think? *J Clin Gastroenterol*. 1996;22(4):272-274. doi:10.1097/00004836-199606000-00006 [level C]
99. Compton S, Levy P, Griffin M, Waselewsky D, Mango LM, Zalenski R. Family-witnessed resuscitation: bereavement outcomes in an urban environment. *J Palliat Med*. 2011;14(6):715-721. doi:10.1089/jpm.2010.0463 [level C]
100. Jabre P, Tazarourte K, Azoulay E, et al. Offering the opportunity for family to be present during cardiopulmonary resuscitation: 1-year assessment. *Intensive Care Med*. 2014;40(7):981-987. doi:10.1007/s00134-014-3337-1 [level B]
101. Leske JS, Brasel K. Effects of family-witnessed resuscitation after trauma prior to hospitalization. *J Trauma Nurs*. 2010;17(1):11-18. doi:10.1097/JTN.0b013e3181d915b0 [level C]
102. Rubin MA, Svensson TL, Herling SF, Jabre P, Møller AM. Family presence during resuscitation. *Cochrane Database Syst Rev*. 2023;5(5):CD013619. doi:10.1002/14651858.CD013619.pub2 [level A]
103. Ramage E, Porter JE, Biedermann N. Family presence during resuscitation (FPDR): a qualitative study of implementation experiences and opinions of emergency personnel. *Australas Emerg Care*. 2018;21(2):51-55. doi:10.1016/j.auec.2018.05.002 [level C]
104. Zavotsky KE, McCoy J, Bell G, et al. Resuscitation team perceptions of family presence during CPR. *Adv Emerg Nurs J.* 2014;36(4):325-334. doi:10.1097/TME.0000000000000027 [level C]
105. Barreto MDS, Peruzzo HE, Garcia-Vivar C, Marcon SS. Family presence during cardiopulmonary resuscitation and invasive procedures: a metasynthesis. *Rev Esc Enferm USP*. 2019;53:e03435. doi:10.1590/S1980-220X2018001303435 [level A]
106. McLean J, Gill FJ, Shields L. Family presence during resuscitation in a paediatric hospital: health professionals' confidence and perceptions. *J Clin Nurs*. 2016;25(7-8):1045-1052. doi:10.1111/jocn.13176 [level C]
107. Powers K, Reeve CL. Factors associated with nurses' perceptions, self-confidence, and invitations of family presence during resuscitation in the intensive care unit: a cross-sectional survey. *Int J Nurs Stud.* 2018;87:103-112. doi:10.1016/j.ijnurstu.2018.06.012 [level C]
108. Bader KW, Smith CR, Gillespie GL. Critical care nurses' attitudes about family presence during resuscitation: an integrative review. *Crit Care Nurse*. 2023;43(5):17-31. [level C]
109. Powers K, Reeve CL. Family presence during resuscitation: medical-surgical nurses' perceptions, self-confidence, and use of invitations. *Am J Nurs*. 2020;120(11):28-38. doi:10.1097/01.NAJ.0000721244.16344.ee [level C]
110. Powers KA. Barriers to family presence during resuscitation and strategies for improving nurses' invitation to families. *Appl Nurs Res.* 2017;38:22-28. doi:10.1016/j.apnr.2017.08.007 [level C]
111. Beckstrand RL, Corbett EM, Macintosh JLB, Luthy KEB, Rasmussen RJ. Emergency nurses' department design recommendations for improved end-of-life care. *J Emerg Nurs.* 2019;45(3):286-294. doi:10.1016/j.jen.2018.05.014 [level C]
112. Edwards EE, Despotopulos LD, Carroll DL. Changes in provider perceptions of family presence during resuscitation. *Clin Nurse Spec*. 2013;27(5):239-244. doi:10.1097/NUR.0b013e3182a0ba13 [level C]
113. Schafer KM, Kremer MJ. Outcomes of simulation-based experiences related to family presence during resuscitation: a systematic review. *Clin Simul Nurs.* 2022;65:62-81. doi:10.1016/j.ecns.2022.01.002 [level C]
114. Bordessoule A, Felice-Civitillo C, Grazioli S, et al. In situ simulation training for parental presence during critical situations in PICU: an observational study. *Eur J Pediatr.* 2022;181(6):2409-2414. doi:10.1007/s00431-022-04425-8 [level C]
115. Powers KA. Family presence during resuscitation: the education needs of critical care nurses. *Dimens Crit Care Nurs*. 2018;37(4):210-216. doi:10.1097/DCC.0000000000000304 [level C]
116. Bush RN, Woodley L. Increasing nurses' knowledge of and self-confidence with family presence during pediatric resuscitation. *Crit Care Nurse*. 2022;42(4):27-37. [level C]
117. Powers KA, Candela L. Family presence during resuscitation: impact of online learning on nurses' perception and self-confidence. *Am J Crit Care*. 2016;25(4):302-309. doi:10.4037/ajcc2016814 [level C]
118. Mureau-Haines RM, Boes-Rossi M, Casperson SC, et al. Family support during resuscitation: a quality improvement initiative. *Crit Care Nurse*. 2017;37(6):14-23. doi:10.4037/ccn2017347 [level C]
119. Ghavi A, Hassankhani H, Powers K, Arshadi-Bostanabad M, Namdar-Areshtanab H, Heidarzadeh M. Parental support needs during pediatric resuscitation: a systematic review. *Int Emerg Nurs*. 2022;63:101173. doi:10.1016/j.ienj.2022.101173 [level C]
120. Timmins F, Pujol N. The role of healthcare chaplains in resuscitation: a rapid literature review. *J Relig Health.* 2018;57(3):1183-1195. doi:10.1007/s10943-018-0604-4 [level C]
121. Clark AP, Calvin AO, Meyers TA, Eichhorn DJ, Guzzetta CE. Family presence during cardiopulmonary resuscitation and invasive procedures: a research-based intervention. *Crit Care Nurs Clin North Am.* 2001;13(4):569-575. [level E]
122. Myers RN. *Because We Care: A Handbook for Chaplaincy in Emergency Medical Services.* Gryphon's Key Publishing; 2021. [level E]
123. Tennyson CD, Oliver JP, Jooste KR. A descriptive study of chaplains' code blue responses. *Am J Crit Care*. 2021;30(6):419-425. doi:10.4037/ajcc2021854 [level C]
124. Egging D, Crowley M, Arruda T, et al. Emergency nursing resource: family presence during invasive procedures and resuscitation in the emergency department. *J Emerg Nurs*. 2011;37(5):469-473. doi:10.1016/j.jen.2011.04.012 [level D]
125. MacLean SL, Guzzetta CE, White C, et al. Family presence during cardiopulmonary resuscitation and invasive procedures: practices of critical care and emergency nurses. *Am J Crit Care*. 2003;12(3):246-257. [level C]
126. Kassam-Adams N, Butler L, Price J, et al. Trauma-informed and family-centered paediatric resuscitation: defining domains and practices. *Resusc Plus.* 2023;14:100374. doi:10.1016/j.resplu.2023.100374 [level C]