Nurses' Perceptions of Family Presence During Resuscitation

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Background Although strong evidence indicates that the presence of a patient's family during resuscitation has a positive effect on the family, the practice is still controversial and is not consistently implemented.
Objectives To explore nurses' experience with resuscitation, perceptions of the benefits and risks of having a patient's family members present, and self-confidence in having family presence at their workplace. Differences in demographic characteristics and relationships between nurses' perceptions of self-confidence and perceived risks and benefits of family presence were evaluated.
Methods The study was descriptive, with a cross-sectional survey design. A convenience sample of 154 nurses working in inpatient and outpatient units at an urban hospital were surveyed. The 63-item survey included 2 previously validated scales, demographic questions, and opinion questions.
Results Nurses' self-confidence and perceived benefit of family presence were significantly related ($r = 0.54$; $P < .001$). Self-confidence was significantly greater in nurses who had completed training in Advanced Cardiac Life Support, had experienced 10 or more resuscitation events, were specialty certified, or were members of nurses' professional organizations. Barriers to family presence included fear of interference by the patient's family, lack of space, lack of support for the family members, fear of trauma to family members, and performance anxiety.
Conclusions Changing the practice of family presence will require strengthening current policy, identifying a team member to attend to the patient's family during resuscitation, and requiring nurses to complete education on evidence that supports family presence and changes in clinical practice. (*American Journal of Critical Care.* 2014;23:e88-e96)

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Patient- and family-centered care has gained attention as a mechanism for transforming health care. *Crossing the Quality Chasm: A New Health System for the 21st Century*[1] called for health care professionals to "guarantee [to patients] physical comfort, emotional support and the involvement of family and friends." A patient's family members play an important and varied role in the patient's health care experience, ranging from emotional support to surrogate decision making. Providing services that make it easier for a patient's family members to participate in the care process results in the best possible care for the hospitalized patient.[2]

Involving patients' families in routine patient care can improve patient safety and satisfaction and is accepted as common practice. When emergencies occur, however, controversy exists among health care providers about family presence during resuscitation (FPDR). A position statement[3] of the Emergency Nurses Association on family presence during invasive procedures and resuscitation in the emergency department states that FPDR should be offered to appropriate family members as an option and should be based on institutional policy.

Doolin et al[4] reviewed 38 articles on attitudes and beliefs of health care providers, patients' families, and patients regarding FPDR. The findings revealed that FPDR does not adversely affect communication between members of the health care team, does not interfere with decision making or care, promotes a more professional atmosphere, and upholds the dignity of the patient. In addition, FPDR helps a patient's family members understand that everything possible was done for their loved one. The review[4] indicated that families thought that FPDR was their right and that they were more at ease when able to view resuscitation efforts firsthand. Family members reported that FPDR provided closure and helped in the grieving process. Patients who survived resuscitation and had FPDR were relieved that their family members were able to act as advocates during resuscitation. Health care providers stressed the importance of having a designated support person to remain with the patient's family at all times.

Although published articles support FPDR, barriers to implementation of the practice exist. These barriers include fear that a patient's family might interfere with the patient's care, care providers' performance anxiety, lack of support for family members, fear of emotional trauma to family members, and fear of lawsuits.[4-6] Nurses have acknowledged that caring for patients' families during and after resuscitation events is part of a nurse's duty, but the event was emotionally challenging and the nurses felt unprepared.[7]

Like the Emergency Nurses Association, the American Association of Critical-Care Nurses recommends that health care organizations have an approved written policy for presenting the option of FPDR, although only 5% of nurses surveyed reported having such written policies.[8] In one study,[9] staff in the emergency department evaluated the benefits of a new FPDR protocol. Results after implementation of the protocol indicated that the experiences were positive. In some instances, the duration of futile resuscitation efforts was decreased by family members' request. Nurses reported that they appreciated having the option within the policy to screen patients' families before offering an invitation to be present during resuscitation events and to not invite families as appropriate. Results also indicated that the input of health care personnel who provided direct care to patients requiring resuscitation was essential to the development of a FPDR protocol.

Family presence promotes and upholds the dignity of the patient.

Nurses' perceptions of their self-confidence and of the benefits and risks of FPDR were explored by Twibell et al,[10] who developed 2 tools: 1 to measure nurses' perceptions of the risk and benefits of FPDR and 1 to measure nurses' self-confidence for managing resuscitation while patients' families were present. Two-thirds of the 375 participants had never invited a patient's family to be present during the resuscitation.

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Nurses who perceived more benefits and fewer risks perceived more self-confidence in their ability to manage family presence. Certified nurses and members of professional organizations perceived greater self-confidence in their ability to manage FPDR. Years of experience and age were not significantly related to risks and benefits or to self-confidence. More than half of the nurses thought it is a family's right to be present during resuscitation. Twibell et al did not obtain information on nurses' experiences with resuscitation.

Chapman et al[11] replicated the study of Twibell et al in Australia and found that most nurse and physician participants considered FPDR a basic right of patients and the patients' families, and almost one-fourth of the respondents had invited patients' family members to be present during resuscitation on more than 5 occasions. Unlike Twibell et al, Chapman et al found that older, more clinically experienced participants had significantly greater self-confidence in their ability to manage FPDR than did their younger, less experienced colleagues.

Data were collected via survey packets placed on nursing units and an on-line survey.

Much research on family presence has focused on nurses in the emergency department, and researchers have used a variety of instruments to gather information, making comparisons across studies difficult. Using the tool developed by Twibell et al, we examined the knowledge, attitudes, and beliefs of registered nurses throughout Norton Hospital, an urban hospital in Louisville, Kentucky, regarding FPDR. We explored nurses' perceptions of the benefits and risks of FPDR and their self-confidence in having FPDR at their workplace. We also examined similarities and differences in the perceptions of nurses who work in divergent specialty areas and have different backgrounds.

Methods

The study, a cross-sectional survey, was approved by the appropriate institutional review board.

Setting and Sample

The hospital where the study was done employs approximately 800 registered nurses. To be included, participants had to be at least 18 years old and employed in the hospital as a registered nurse.

Measures

The instrument used was a 63-item survey consisting of demographic questions, opinion questions, and 2 scales previously validated by Twibell et al.[10] The author of the survey provided written permission to use the tool. The Family Presence Risk-Benefit Scale (FPR-BS) is a 22-item scale used to measure nurses' perceptions of the risks and benefits of family presence to the patient's family, the patient, and members of the resuscitation team (Cronbach α reliability = 0.96). Response options range from strongly disagree (1) to strongly agree (5). The Family Presence Self-Confidence Scale (FPS-CS) is a 17-item scale used to measure nurses' self-confidence with having patients' family members present during resuscitation (Cronbach α reliability = 0.95). Response options for the FPS-CS range from not at all confident (1) to very confident (5). A higher score on the FPS-CS indicates greater self-confidence in having patients' families present during resuscitation, and a higher score on the FPR-BS indicates perceiving more benefits than risks associated with FPDR. Additional questions addressed participants' demographics, each nurse's opinion about wanting his or her family members present during his or her own resuscitation, who should make the decision about allowing a patient's family to be present, and whether the decision should be part of an advance directive. Open-ended questions allowed respondents to state why they would or would not invite a patient's family to be present during resuscitation, barriers to FPDR, and other comments.

Procedures

Data were collected anonymously via 2 methods: survey packets placed on nursing units in congregate areas frequented by nurses, such as break rooms, and an online survey. The hard-copy and online surveys were available for completion during the same 14-day period and took about 10 to 15 minutes to complete. Participants were recruited by using a scripted e-mail, verbal messages, and flyers placed in nonpatient areas. A follow-up e-mail was sent 1 week after the first e-mail message.

Analysis

Data were analyzed by using SPSS, version 22 (IBM SPSS Statistics). A total of 5 designated items on the FPR-BS were reverse scored.[10] Items in the 2 subscales (FPR-BS and FPS-CS) were summed, and the mean of the total ratings was calculated for all scale items, resulting in scores ranging from 1 to 5.[10] Quantitative data were analyzed descriptively. The Pearson r correlation was used to compare FPR-BS and FPS-CS scores. Comparisons between groups were assessed by using t tests and analysis of variance. A priori, $\alpha = .05$ was considered significant. Responses to open-ended questions were transcribed and

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categorized as representing either a reason to offer FPDR (82 comments) or a perceived barrier (221 comments). Within these 2 categories, themes and subthemes were identified; responses were coded to these themes and subthemes and then verified independently by 2 members of the research team.

Results

The survey was completed by 154 participants, most of whom were white and female (Table 1). More than half were between 25 and 55 years old (73.5%) and had more than 6 years of experience (68.2%) as a registered nurse. Work units of the participants varied, but the most prevalent was the transitional care unit (27.2%). More than three-fourths were trained in Advanced Cardiac Life Support and had participated in a mock code. More than half (54.5%) had been involved in more than 10 resuscitation events, but only 38.4% had ever invited a patient's family member to be present during resuscitation. A total of 25.0% indicated they would want a member of their family present during their own resuscitation, and 16.2% had been present when a member of their own family was being resuscitated. When asked who should make the decision about FPDR, most participants indicated that the patient, the patient's family, the patient's physician, and the patient's nurse should all be involved in the decision and that the decision should be a component of the advanced directive authorized by the patient.

Nurses' Perceptions of Self-confidence and Risks vs Benefits Related to FPDR

The mean score on the FPS-CS was 3.6 (SD, 0.07; range, 1.0-5.0). Participants indicated that they were quite or very confident for 15 of the 17 items on the FPS-CS scale (Table 2). The 2 items in which participants were less confident addressed enlisting physicians' support for FPDR and encouraging a patient's family members to talk to the patient during resuscitation.

The mean score on the FPR-BS was 2.9 (SD, 0.06; range, 1.2-4.8). Of the 22 items on the FPR-BS scale, participants were neutral on 15. Participants neither agreed nor disagreed with items about the disruption of having FPDR, the benefits to the patient, the grieving process, and satisfaction ratings by patients and patients' family members as a result of FPDR.

The Pearson r correlation between FPS-CS and FPR-BS was significant ($r = 0.54$, $P < .001$). This result indicates that nurses who were more self-confident in their ability to include patients' family members during resuscitation also perceived more benefits to FPDR.

Table 1
Participants' characteristics

Characteristic[a]	No. (%) of participants[b]
Ethnicity (n = 150)	
African American	9 (6.0)
Asian	4 (2.7)
White	135 (90.0)
Other	2 (1.3)
Sex (n = 152)	
Male	18 (11.8)
Female	134 (88.2)
Age, y (n = 151)	
18-24	11 (7.3)
25-39	51 (33.8)
40-55	60 (39.7)
≥56	29 (19.2)
Years of experience (n = 154)	
≤ 5	49 (31.8)
6-10	25 (16.2)
11-20	26 (16.9)
≥ 20	54 (35.1)
Work unit (n = 151)	
Intensive care	30 (19.9)
Transitional care	41 (27.2)
Medical/surgical	20 (13.2)
Other	60 (39.7)
Member of a professional organization (n = 148)	57 (38.5)
Specialty certification (n = 152)	59 (38.8)
Advanced Cardiac Life Support training (n = 146)	110 (75.3)
Mock code experience (n = 145)	112 (77.2)
Times involved with resuscitation (n = 154)	
0	10 (6.5)
1-2	23 (14.9)
3-5	24 (15.6)
6-10	13 (8.4)
>10	84 (54.5)
Want own family present if being resuscitated (n = 152)	38 (25.0)
Ever present in room when own family member resuscitated (n = 154)	25 (16.2)
Ever invited family member to be present during resuscitation (n = 151)	58 (38.4)
Who should make decision about family presence during resuscitation efforts	
Patient (beforehand) (n = 134)	114 (85.1)
Patient's family (n = 135)	103 (76.3)
Physician (n = 132)	102 (77.3)
Nurse (n = 136)	87 (69.0)
Decision about family presence during resuscitation should be part of advanced directive (n = 152)	100 (65.8)

[a]Sample sizes vary because of missing data.
[b]Because of rounding, not all percentages total 100.

Nurses' Perceptions of FPDR by Demographic Factors

Participants who were members of a professional nursing organization, had a specialty certification, had

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Table 2
Participants' responses to items on Family Presence Risk-Benefit Scale and Family-Presence Self-Confidence Scale (N = 154)

Risk-Benefits Scale, scale items	No. (%) of participants[a]		
	Strongly agree/agree	Neutral	Disagree/strongly disagree
1. Family members should be given the option to be present when a loved one is being resuscitated.	77 (50.0)	40 (26.0)	37 (24.0)
2. Family members will panic if they witness a resuscitation effort.	93 (60.4)	43 (27.9)	18 (11.7)
3. Family members will have difficulty adjusting to the long-term emotional impact of watching a resuscitation effort.	90 (58.4)	39 (25.3)	25 (16.2)
4. The resuscitation team may develop a close relationship to family members who witness the efforts, compared with family members who do not witness the efforts.	46 (29.9)	60 (39.0)	48 (31.2)
5. If my loved one were being coded, I would want to be present in the room.	65 (42.2)	18 (11.7)	71 (46.1)
6. Patients do not want family members present during a resuscitation attempt.	38 (24.7)	83 (53.9)	33 (21.4)
7. Family members who witness unsuccessful resuscitation efforts will have a better grieving process.	41 (26.6)	62 (40.3)	51 (33.1)
8. Family members will become disruptive if they witness resuscitation efforts.	52 (33.8)	73 (47.4)	29 (18.8)
9. Family members who witness resuscitation efforts are more likely to sue.	24 (15.6)	61 (39.6)	69 (44.8)
10. The resuscitation team will not function as well if family members are present in the room.	40 (26.0)	32 (20.8)	82 (53.2)
11. Family members on the unit I work prefer to be present in the room during resuscitation efforts.	17 (11.0)	98 (63.6)	39 (25.3)
The presence of FPDR efforts is			
12. ...beneficial to patients	28 (18.2)	60 (39.0)	66 (42.9)
13. ...beneficial to families	52 (33.8)	52 (33.8)	50 (32.5)
14. ...beneficial to nurses	26 (16.9)	41 (26.6)	87 (56.5)
15. ...beneficial to physicians	26 (16.9)	38 (24.7)	90 (58.4)
16. ...should be part of family-centered care	60 (39.0)	49 (31.8)	45 (29.2)
The presence of FPDR efforts will have a positive effect on			
17. ...patient ratings of satisfaction with hospital care	23 (14.9)	64 (41.6)	67 (43.5)
18. ...family ratings of satisfaction with hospital care	29 (18.8)	63 (40.9)	62 (40.3)
19. ...nurse ratings of satisfaction in providing optimal patient-family care	32 (20.8)	55 (35.7)	67 (43.5)
20. ...physician ratings of satisfaction in providing optimal patient-family care	28 (18.2)	61 (39.6)	65 (42.2)
21. The presence of FPDR efforts is a right that all patients should have.	104 (67.5)	29 (18.8)	21 (13.6)
22. The presence of FPDR effort is a right that all family members should have.	75 (48.7)	37 (24.0)	42 (27.3)

Self-Confidence Scale, scale items	No. (%) of participants[a]		
	Not at all/not very confident	Somewhat confident	Quite/very confident
I could			
1. ...communicate about resuscitation efforts to family members who are present	26 (16.9)	38 (24.7)	90 (58.4)
2. ...administer drug therapies during resuscitation efforts with family members present	15 (9.7)	30 (19.5)	109 (70.8)
3. ...perform electrical therapies during resuscitation efforts with family members present	27 (17.5)	24 (15.6)	103 (66.9)
4. ...deliver chest compressions during resuscitation efforts with family members present	14 (9.1)	21 (13.6)	119 (77.3)
5. ...communicate effectively with other health team members during resuscitation efforts with family members present	18 (11.7)	33 (21.4)	103 (66.9)
6. ...maintain dignity of the patient during resuscitation efforts with family members present	27 (17.5)	46 (29.9)	81 (52.6)

Continued

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Table 2
Continued

Self-Confidence Scale, scale items	No. (%) of participants[a]		
	Not at all/not very confident	Somewhat confident	Quite/very confident
I could			
7. ...identify family members who display appropriate coping behaviors to be present during resuscitation efforts	23 (14.9)	39 (25.3)	92 (59.7)
8. ...prepare family members to enter the area of resuscitation of their family member	26 (16.9)	35 (22.7)	93 (60.4)
9. ...enlist support from attending physicians for family presence during resuscitation efforts	33 (21.4)	49 (31.8)	72 (46.8)
10. ...escort family members into the room during resuscitation of their family member	22 (14.3)	32 (20.8)	100 (64.9)
11. ...announce family member's presence to resuscitation team during resuscitation efforts of their family member	30 (19.5)	31 (20.1)	93 (60.4)
12. ...provide comfort measures to family members witnessing resuscitation efforts of their family member	23 (14.9)	30 (19.5)	101 (65.6)
13. ...identify spiritual and emotional needs of family members witnessing resuscitation efforts of their family member	26 (16.9)	37 (24.0)	91 (59.1)
14. ...encourage family members to talk to their family member during resuscitation efforts	43 (27.9)	43 (27.9)	68 (44.2)
15. ...delegate tasks to other nurses in order to support family members during resuscitation efforts of their family member	27 (17.5)	32 (20.8)	95 (61.7)
16. ...debrief family after resuscitation of their family member	19 (12.3)	32 (20.8)	103 (66.9)
17. ...coordinate bereavement follow-up with family members after resuscitation efforts on their family member, if required	20 (13.0)	35 (22.7)	99 (64.3)

Abbreviation: FPDR, family presence during resuscitation.
[a] Because of rounding, not all percentages total 100.

ever invited a patient's family member to be present during a resuscitation, and would want a member of their own family present if they were being resuscitated reported significantly greater benefits compared with risks for FPDR and were significantly more self-confident in their ability to include patients' family members in resuscitation events (Table 3). In addition, participants with 11 to 20 years of experience as a registered nurse reported significantly greater benefits compared with risks for FPDR. Participants who worked in an intensive care unit, had been involved in more than 10 resuscitation events, were trained in Advanced Cardiac Life Support, and had participated in a mock code reported significantly more self-confidence with FPDR. Differences on either scale were not significant for race/ethnicity, sex, age, having personally been present when the nurse's own family member was being resuscitated, or having FPDR as a component of an advanced directive.

Nurses' Comments on Benefits of and Barriers to FPDR

Table 4 displays the common themes among the written comments on perceived benefits of and barriers to FPDR. Nurses perceived that the greatest benefit was reassurance for a patient's family members that everything possible was done to help the family's loved one. Some nurses thought FPDR may help provide closure for the family if a patient's outcome was poor. As one nurse said, "When families step back and let us work, this seems to work well and families see first-hand that we have tried everything to save their loved one."

Several barriers were identified. The most common one was the perception that a patient's family members might interfere with the resuscitation, either because of their disruptive emotional and/or behavioral response to the situation or because of overcrowding in the room. One nurse said he or she would not allow a patient's family in the room "if the family is so upset that they are getting in the way of the code." Another stated, "There are so many people involved in the code already. Those that are there are involved in the efforts to save the patient's life. The family would just be in the way." Many nurses were concerned about psychological trauma the family might experience from watching the event, stating that resuscitations can be "brutal"

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Table 3
Significant differences by participant characteristics in family presence during resuscitation Risk-Benefit Scale and Self-Confidence Scale[a]

Characteristic	Risk-benefit, mean (SD)	*P*	Self-confidence, mean (SD)	*P*
Years of experience		.04		.29
≤5	2.8 (0.6)		3.5 (0.7)	
6-10	2.8 (0.7)		3.6 (0.8)	
11-20	**3.3 (0.9)**		3.9 (1.0)	
>20	2.9 (0.7)		3.7 (0.9)	
Work unit		.24		.05
Intensive care	3.1 (0.8)		**4.0 (0.7)**	
Transitional care	2.8 (0.7)		3.5 (0.9)	
Medical-surgical	2.8 (0.7)		3.6 (0.8)	
Other	2.9 (0.7)		3.6 (0.9)	
Member of professional organization		<.001		.01
Yes	**3.2 (0.7)**		**3.9 (0.7)**	
No	2.7 (0.7)		3.5 (0.9)	
Specialty certification		.02		.02
Yes	**3.1 (0.7)**		**3.8 (0.9)**	
No	2.8 (0.7)		3.5 (0.8)	
Trained in Advanced Cardiac Life Support		.16		.02
Yes	3.0 (0.7)		3.7 (0.8)	
No	2.7 (0.7)		3.4 (0.8)	
Mock code experience		.84		.005
Yes	2.9 (0.7)		**3.7 (0.9)**	
No	2.9 (0.6)		3.3 (0.6)	
Times involved with resuscitation		.29		.02
0 (n = 10)	2.8 (0.4)		3.1 (0.7)	
1-2 (n = 23)	3.0 (0.6)		3.4 (0.8)	
3-5 (n = 24)	2.6 (0.7)		3.5 (0.7)	
6-10 (n = 13)	2.9 (0.6)		3.4 (0.8)	
>10 (n = 84)	3.0 (0.8)		**3.8 (0.9)**	
Want own family present if being resuscitated		<.001		<.001
Yes	**3.6 (0.6)**		**4.1 (0.7)**	
No	2.7 (0.6)		3.5 (0.8)	
Ever invited a patient's family member to be present during resuscitation		<.001		<.001
Yes	**3.3 (0.6)**		**4.0 (0.8)**	
No	2.6 (0.6)		3.4 (0.8)	

[a] Bold indicates value significantly greater.

and "messy," and that unlike in codes in television programs, the patient may be totally exposed. One nurse expressed this sentiment as follows:

> This is not PG TV. We remove gowns and perform CPR sometimes in the bed with the patient, especially the very large person, to effectively perform chest compressions. Every code is never so "clean" as to only expose a chest, place "paddles," and "shock" as in the movies. The process itself is barbaric and could traumatize the family members—they could think we are hurting the patient instead of helping the patient.

Several nurses stated that their primary concern was the patient being resuscitated, not the patient's family, and that someone on the team must be assigned to care for the family members if they are allowed to be present. Two responses illustrate this sentiment. One nurse said, "Sometimes family members are emotional and need someone to care for their needs during a code. I do not think it is the nurse's responsibility to resuscitate a patient and try to care for the family at the same time." Another said, "As the team is calling off orders and directions using 'nonlayman' terms [patients' family members] may become confused, fearful, and agitated because they don't understand what is being said or done. If they are in the room, there should be a nurse along with a chaplain explaining the process to the family using language and terms they understand."

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Additional comments made by nurses included reluctance of physicians to allow patients' families to be in the room and that every case is different and should be handled according to the nurse's judgment. For example, one nurse said, "I do not have a problem with family members being present during a code; they should have the choice. BUT it is a privilege, NOT a right. A right would mean that staff would not have the authority to ask an obstructive family member to leave; we cannot interfere with a right. Again it should be a privilege and not a right."

Table 4
Comment themes related to perceived benefits and barriers to presence of a patient's family members during resuscitation

Benefits	Barriers
Help family members see that everything possible is being done for their loved one	Families might interfere with the resuscitation Emotional and behavioral response of family member disruptive Lack of space in the room
Accommodate patient and family wishes	Traumatic to family Lack of public knowledge of what to expect (blood, chaos, tubes, etc)
Relieve any doubt about patient's prognosis; families may rethink code status	Unable to care for patient and family at the same time; resuscitation is first priority Someone on team needs to be assigned to care for the family
Help family achieve a sense of closure if outcome is poor	Performance anxiety or lack of confidence

Discussion

Although FPDR has been studied, it remains a controversial issue among nurses and other health care providers. Investigators in many of the previous studies used different instruments to determine nurses' perceptions of FPDR, making comparisons between studies difficult. We built on the previous findings,[10,11] enabling comparisons across studies. Similar to findings in the previous studies, our results indicated that most nurses had never invited a patient's family member to be present during resuscitation, yet participants had fairly high self-confidence in having family members present, and those who had higher self-confidence also perceived greater benefits of FPDR. However, participants in our study had lower FPR-BS mean scores compared with the participants in the studies by Twibell et al[10] and Chapman et al.[11] This difference may be associated with the high number of neutral responses to the FPR-BS items. Because of their lack of experience with FPDR, participants may not have known if they agreed or disagreed with the statements on the FPR-BS. The lack of experience with FPDR may have also been reflected in the lower percentage of nurses in our study who agreed with providing families with the option of being present during resuscitation compared with the percentage in other studies.[6,12]

Consistent with findings in previous studies,[10,11] membership in a professional nursing organization and board certification were associated with higher perceived benefits and self-confidence. Additionally, participants with training in Advanced Cardiac Life Support and experience with mock codes had higher self-confidence in their performance during FPDR. These findings indicate that nurses who are more engaged in professional development may be more likely than other nurses to see greater benefits and be more self-confident with FPDR.

Our findings were presented to the nursing research council, the patient care council, the code committee, and the medical executive committee at our hospital. Survey results and guidelines provided by the American Association of Critical-Care Nurses were considered in updating existing policy on FPDR within the health care system. A primary barrier to FPDR, identified in our study, and in other research,[4-6] was fear of interference by a family member during resuscitation and a need for someone to attend to the family. Although chaplains already responded to codes and were able to tend to and be responsible for a patient's family members during resuscitation events, chaplains were not always available, especially at night. In order to address this issue, the policy was amended to include assignment of a designated family facilitator for each resuscitation event. If no chaplain is available, the designated family facilitator is appointed by the code team leader. Education encompassing the practice change and communication of expectations was provided to nurses by adding FPDR to the required competency modules, incorporating FPDR into mock code scenarios, and adding FPDR content in the system's life support classes. In order to evaluate the effectiveness of the policy change, the designated family facilitator completes an audit tool after each resuscitation event that is reviewed by the code committee. In addition, the FPR-BS and FPS-CS will be repeated approximately 1 year after implementation of the practice change.

Most nurses had never invited a patient's family member to be present during resuscitation.

In our survey, participants, many of whom had never invited a patient's family member to be present during a resuscitation, often expressed concern for the patient's well-being, privacy, and dignity if FPDR was allowed and thus were reluctant to support such

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an option. Several participants commented that they would like to see FPDR added to the advanced directive so the patient's preference would be known in advance. With education related to the benefits of FPDR, more experience with FPDR, and appointment of a designated family facilitator to attend to the patient's family, nurses may be more likely than they are now to see FPDR as a right of both patients and the patients' families.

Limitations

Our findings cannot be generalized beyond the respondents to the survey. Although other health care professionals such as physicians and respiratory therapists are critical to resuscitation efforts, they were not included in our study. Future studies should include a diverse group of participants. Because the respondents in our study could complete the survey either on hard copy or online, a choice that increased the participation rate, a participant could have completed the survey more than once. Future studies should consider adding an item to determine if participants completed more than one form of the survey.

Conclusion

Our organization needed to change practice and policy related to FPDR to align with professional practice guidelines. Our findings provided valuable insight into the self-confidence of nurses, the perceived risks and benefits of FPDR, and the concerns that would need to be addressed through education and resource allocation.

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