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UNDERSTANDING THE KNOWLEDGE, PERCEPTIONS, AND ADVOCACY OF FAMILY PRESENCE DURING RESUSCITATION BY EMERGENCY DEPARTMENT REGISTERED NURSES

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UNDERSTANDING THE KNOWLEDGE, PERCEPTIONS, AND ADVOCACY OF FAMILY PRESENCE DURING RESUSCITATION BY EMERGENCY DEPARTMENT REGISTERED NURSES

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An Abstract of the Scholarly Project by
Myranda Prather

Although recommended by current evidence-based literature, family presence during resuscitation (FPDR) continues to be inconsistently implemented in healthcare facilities. This study aimed to assess and understand nurses' knowledge, perceptions, and advocacy of family presence during resuscitation in the emergency department. For this cross-sectional descriptive study, an anonymous electronic survey was administered via email to all nurses employed in the emergency department at a local healthcare facility. Hard copies of the survey were also distributed in-person. Data collection occurred over a three week period. The data were coded and entered into a computer software statistics program for analysis. Descriptive statistics were obtained for the demographic and perceptual data. Pearson's correlational coefficients were computed to assess relationships between the demographic, knowledge, perceptions, and advocacy of FPDR variable. The findings of this study revealed that most nurses understand FPDR, have positive perceptions surrounding FPDR, and have advocated or would advocate for the practice. However, there were barriers found to FPDR implementation. Resuscitations in the emergency department evolve quickly and require attention to multiple concurrent tasks. Understanding the perceived barriers to and benefits of implementing family presence during resuscitation in this setting is essential to ensure holistic nursing care is being provided during this critical time.

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Chapter I

Introduction

Family presence during resuscitation (FPDR) is an important aspect of patient care during cardiopulmonary resuscitation. Although endorsed by many organizations, FPDR is not regularly implemented in healthcare institutions. Healthcare providers are at the root of many of the reasons behind inconsistent implementation. Current research describes the barriers to and benefits of FPDR and how to implement this practice. The following chapter includes a description of the clinical problem, the significance of the problem and how it relates to nursing and the purpose of a project on FPDR. Also included is the theoretical framework that is the foundation of the project, the research questions for the project, definition of key terms, and a logic model outlining how the process of the project will flow.

Description of Clinical Problem

FPDR involves the presence of one or more family members during the cardiopulmonary resuscitation of a patient. Although FPDR has been supported by the Emergency Nurses Association (ENA), American Heart Association (AHA), American Association of Critical Care Nurses (AACN), American College of Emergency Physicians (ACEP), and American Academy of Pediatrics (AAP), the practice is inconsistently implemented in healthcare facilities (AACN, 2016; ACEP, 2018; AHA,

2015; Dudley, Ackerman, Brown, & Snow, 2015; ENA, 2012). There are several reasons why FPDR remains inconsistent despite current practice recommendations, many of which are related to perceived barriers by healthcare providers resulting in the lack of the option of FPDR provided to family members. Some of the barriers include fear of interference by the patient's family, fear of the resuscitation being too traumatic for the family, lack of a designated person to support the family, and resuscitation performance anxiety (Powers, 2017; Tudor, Berger, Polivka, Chlebowy, & Thomas, 2014).

Much of the current literature proves the aforementioned barriers incorrect and provides valuable insight on the benefits of FPDR. In fact, nurses report that FPDR has allowed them to forge a connection with the family, engage the family as active participants in the care, and experience with FPDR allowed the nurses to overcome their fears of the practice (Miller & Styles, 2009). In 2017, a study revealed that 52.1% of patients agreed that FPDR was important (Bradley, Keithline, Petrocelli, Scanlon, & Parkosewich, 2017). Family members present during resuscitation have experienced an emotionally protective effect including reductions in post-traumatic stress disorder (PTSD)-related symptoms, depression symptoms, and complicated grief symptoms one year after experiencing FPDR (De Stefano et al., 2016; Jabre et al., 2014). Multiple studies have also shown that FPDR does not interfere with patient care (Basol, Ohman, Simones, & Skillings, 2009; Dudley et al., 2015).

There are recommendations made in the literature to assist facilitation of FPDR. Among these is the recommendation for a written policy on FPDR in healthcare facilities to act as a guide for implementation, as healthcare providers often perceive the lack of a written policy as a barrier (AACN, 2016; Basol et al., 2009; Powers, 2017). Studies also

recommend the appointment and training of a family-support person to communicate with family members about the resuscitation process and provide support throughout the process (Mureau-Haines et al., 2017; Powers, 2017). Family-support persons should be trained to assess who is appropriate to be present during resuscitation, to provide explanation of the resuscitation process, and to deal with a distressed family member.

Due to variable implementation of FPDR, it is important to understand the individualized knowledge and perceptions of FPDR of healthcare providers in particular settings. The current literature provides examples of the benefits of this practice and how to execute FPDR within facilities. With the correct techniques, education, and policies, FPDR can be employed as it has a positive impact on healthcare providers and families and does not interfere with the resuscitation process.

Significance

The importance of patient- and family-centered care has long been an important aspect of nursing practice. The practice of FPDR was first brought to light in 1987 when a study was conducted where family members were asked if they wanted to be present by a nurse or chaplain and if so, were accompanied by a family support person (FSP) into the resuscitation room (Doyle et al., 1987). This study showed that family presence did not have an effect on the care provided during resuscitation and actually provided facilitated the grieving process for many of the family members. In 1992, a follow-up study performed at the same facility revealed family members present during resuscitation of patients in the emergency department (ED) continued to have positive experiences with the practice (Hanson & Strawser, 1992). Since these two studies, research has continued on FPDR to ensure that holistic care remains at the forefront of

nursing. This research has assessed the benefits for families, perceptions of healthcare workers, use of family support persons, and institutional policies regarding the practice.

Purpose/Specific Aims

The purpose of this scholarly project is to address the problem of inconsistent implementation of FPDR in the ED. To change healthcare practice, it must first be understood why healthcare workers are or are not employing that particular practice. There are multiple ways that this can be investigated. This project will utilize a survey to understand the perceptions of, knowledge about, and advocacy for FPDR of nurses who work in the ED at a local hospital. This survey will allow the researcher to understand the specific concerns and current practices regarding FPDR.

The first aim of this project is to assess and understand nurses' perceptions of FPDR in the ED. The second is to evaluate and target the current level of knowledge surrounding FPDR by nurses in the ED. Finally, the third aim is to evaluate the advocacy of FPDR by nurses in the ED.

Theoretical Framework

Kolcaba's Theory of Comfort (Petiprin, 2016) is the foundational theory guiding this project of family presence during resuscitation. This middle-range theory focuses on holistic nursing care and the desired outcome of comfort. Katharine Kolcaba specializes in end of life and long-term care interventions, comfort studies, and nursing theory ("Comfort Theory," 2011). Kolcaba developed this theory after formulating a concept analysis of comfort (Petiprin, 2016). From this concept analysis, Kolcaba introduced the three forms of comfort and four contexts of holistic human experience ("Comfort Theory," 2011). Then, she constructed a model to guide the implementation of these

concepts in comfort as they relate to the nursing process. Her theory discusses the nurses' role of assessing the patient's comfort needs, implementing appropriate interventions to achieve comfort, and reassessing comfort after the interventions have been implemented ("Comfort Theory," 2011).

A foundational assumption of Kolcaba's theory is that comfort for patients is a desired outcome of nursing care and a product of holistic nursing (Petiprin, 2016). Patients are defined as "individuals, families, institutions, or communities in need of health care" (Petiprin, 2016). Her comfort theory describes comfort as existing in three forms: ease, relief, and transcendence (Petiprin, 2016). The theory states that comfort can be achieved in four different contexts: physical, psychospiritual, environmental, and sociocultural (Petiprin, 2016). The nursing role in facilitating the patient's comfort is to assess the patient's comfort needs, develop a plan to address those needs, and reevaluate the level of comfort after the plan is carried out.

The statements and assumption of the Theory of Comfort can all be applied to this scholarly project. The statement in this theory that declares the patient includes the family is applicable, as this project focuses on families. Having family present during resuscitation and explaining what is happening through effective communication can enhance the family's comfort during this critical time. Comfort could be provided in the form of ease, by easing the family's anxiety about what is happening to their family member; relief, by knowing that all is being done to resuscitate their family member; and transcendence, by facilitating the grieving process if their family member passes away after failed resuscitation. Comfort can be provided to the family in the physical context, by allowing them to be present during the resuscitation; the psychospiritual context, by

relieving their fears and uncertainties regarding resuscitation; the environmental context, by having a health care provider present to communicate with the family about the resuscitation; and the sociocultural context, by allowing the patient's family to decide whether to be present, which may have a cultural basis. Nurses have the ability to be advocates for FPDR, invite families to be present during their loved one's resuscitation, and provide support to family members throughout the process.

Research Questions

The research questions for this project are as follows:

1. What are the perceptions surrounding FPDR by nurses in the ED?
2. What is the level of knowledge regarding FPDR by nurses in the ED?
3. Do ED nurses advocate for FPDR?
4. Is there a relationship between demographic variables and perceptions, knowledge, and advocacy of FPDR?

Definition of Key Terms

Family member: Significant others or relatives that share a significant relationship with the family (AACN, 2016)

Family presence: The presence of parents for a minor or the presence of family members for adult patients (ENA, 2012)

Family support person: A member of the healthcare team that provides support to, communicates with, and explains aspects of care to the family of patients undergoing resuscitation (Jabre et al., 2014)

Knowledge: The sum of information and facts that a person has obtained through education and experience (Knowledge, 2019)

Perception: The attitudes and beliefs around a certain phenomenon; the way in which a phenomenon is regarded (Perception, 2018)

Cardiopulmonary resuscitation: The procedure occurring after cardiac arrest that involves measures of providing artificial respirations and intermittent pressure on the chest in an effort to restore normal cardiac and pulmonary function (Cardiopulmonary resuscitation, 2019)

Logic Model

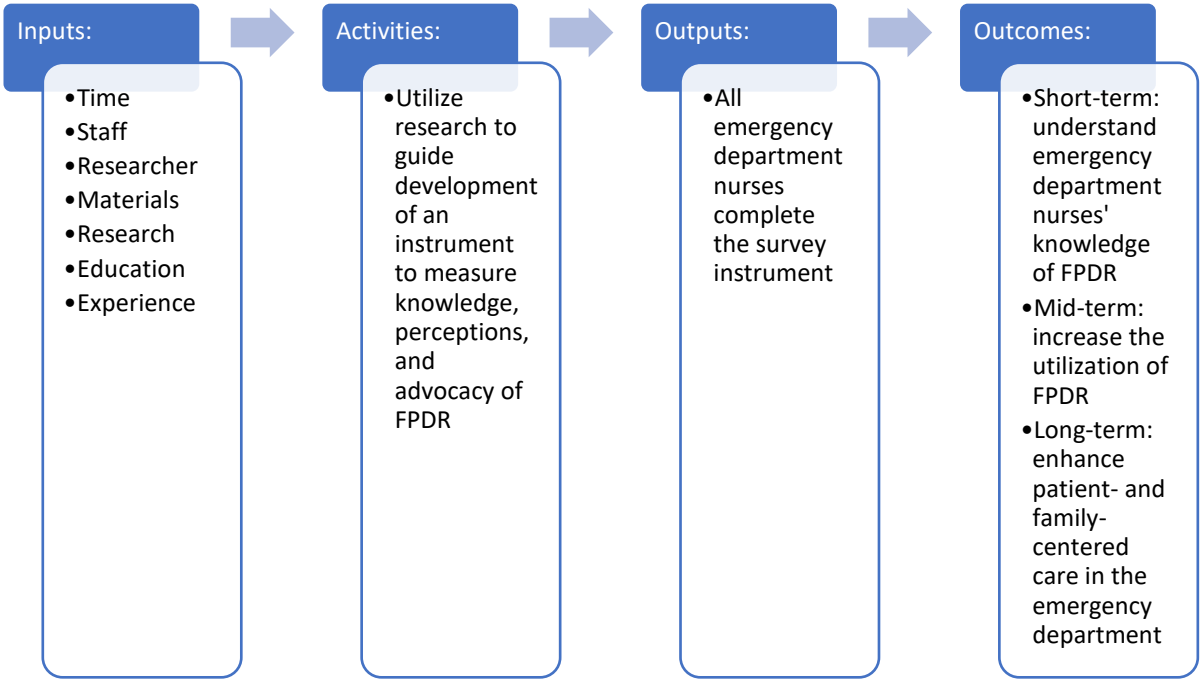

Figure 1. Logic model of FPDR project. This figure demonstrates the sequence of inputs, activities, outputs, and outcomes involved in the project.

Summary

This scholarly project will focus on understanding nurses' knowledge, perceptions, and advocacy for FPDR by utilizing a survey instrument. The framework for

the project is Kolcaba's Theory of Comfort, which focuses on nursing actions to increase comfort provided to patient and families. With the use of current literature and Kolcaba's theory, three research questions are formed and conceptual definitions of perception, knowledge, family member, family presence, and resuscitation are delineated. Finally, a logic model is constructed to guide the development and implementation of the proposed project's process.

Resuscitation is a critical, sometimes chaotic, event that occurs in healthcare facilities. Even in this stressful time, holistic care is essential for the patient and family. To ensure the highest level of care, all aspects of care must be incorporated including the emotional and social elements. Inviting family to be present is one way nurses can provide compassion and comfort during a tragic time to patients and families. The current literature on FPDR demonstrates no negative impact on the care being provided, no adverse emotional effects on the family, and no undesirable consequences for the healthcare team. In fact, family presence has been found to provide positive emotional benefits to families and healthcare workers involved in the resuscitative process.

Resuscitations in the emergency department evolve quickly and require attention to multiple concurrent tasks. However, patient- and family-centered care should not be withheld during this busy time. This project may provide valuable insight into ED nurses current knowledge of FPDR and why nurses may or may not utilize the practice. Understanding the perceived barriers to and benefits of FPDR in the fast-paced environment of the emergency department has the potential to be an important addition to the current body of literature.

Chapter II

Review of the Literature

Current literature was reviewed to collect the most up-to-date information pertaining to FPDR. The literature review was conducted utilizing the online database, ProQuest Nursing & Allied Health Source, along with Pittsburg State University's Axe Library's search engine, Summon. Key phrases that were utilized in the search included: "family presence during resuscitation," "family presence guidelines," "family presence during invasive procedures," "family presence during cardiopulmonary resuscitation," "cardiopulmonary resuscitation guidelines," and "perception of family presence during resuscitation". The search was limited to peer-reviewed research published within the past ten years. The search resulted in a total of twenty-two articles that were pertinent to this study, and two landmark studies from 1987 and 1992 were also included. The following literature review includes common themes that were extracted from the literature including support by professional organizations, benefits of FPDR, perceived barriers to FPDR, facilitating FPDR, and the clinical practice guidelines (CPGs) for FPDR from both the ENA and AACN.

Support for FPDR Among Professional Organizations

The literature includes a vast amount of support for FPDR, including support from professional organizations. The AACN published a practice alert in 2016

recommending that family members be present during resuscitation and invasive procedures. The practice alert includes a brief set of CPGs with the level of recommendation, supporting evidence, and future actions for healthcare providers. According to the AACN (2016), meeting patient's and family's psychosocial needs during critical times is a key factor in providing patient- and family-centered care. In addition to the recommendation of FPDR, the AACN emphasizes the importance of facility policies and procedures supporting FPDR developed by an interdisciplinary task force, proficiency standards for staff regarding FPDR, and developing documentation standards (AACN, 2016).

The ACEP (2018) published a policy statement outlining their recommendations for patient- and family-centered care. Included in the recommendations was support for family presence during all aspects of emergency department (ED) care, information provided to the family about the patient's care regardless of their choice to be present, and the development of institutional policies that advocate for patient- and family-centered care (ACEP, 2018). This policy statement is specific to the care of the child while in the ED. The same support for family presence is reflected by the AAP (Dudley et al., 2015) recommendations with an extension on the importance of communication.

AHA (2015) cardiopulmonary resuscitation guidelines include support for FPDR, despite the fact that studies of FPDR have had mixed results regarding the impact of family presence on resuscitation efforts (Fernandez, Compton, Jones, & Velilla, 2009; Goldberger et al, 2015). Fernandez et al. (2009) found that FPDR resulted in a longer time to defibrillation and fewer defibrillations, during simulated resuscitations.

In contrast, Goldberger et al. (2015) found that having a facility policy in place that supports FPDR has not been shown to have any effect on the resuscitation process or survival. Despite these somewhat mixed results, the AHA continues to support FPDR as the benefits to the family have shown to outweigh the minimal risk to the resuscitation effort (AHA, 2015).

Finally, the ENA (2012) has shown their support for FPDR and invasive procedures by their published CPG. The recommendations include offering the option of family presence during invasive procedures and resuscitation on an individual basis as long as family presence does not delay procedures or inhibit resuscitative efforts (ENA, 2012). The ENA also provides support for institutional policies addressing the implementation of family presence during resuscitation and invasive procedures, and the needs of families during such critical times (ENA, 2012).

Benefits of FPDR

Benefits for patients. It is difficult to ascertain with certainty whether FPDR has any effect on the patient being resuscitated. However, in a study conducted where inpatients were surveyed on their thoughts regarding FPDR, it was conveyed that the idea of FPDR comforts them knowing that they would not alone during the process and believe their family member's presence would be helpful (Bradley et al., 2017). In this same study, patients reported that they want to be asked about their wishes regarding FPDR and who they would like to be present. Patients have also communicated their support for FPDR because the family member could be witness to everything that was done to save them (Bradley et al., 2017; ENA, 2012). Patients have stated that they

believe their family members presence could facilitate coping with their death if the resuscitation ended in a poor outcome (Bradley et al., 2017).

From the perspective of family members who have been present during their child's resuscitation, they believe that their presence was comforting to the patient (Dudley et al., 2015). A study performed by Mangurten et al. (2007) found 100% of parents believed that their presence during the resuscitation of their child allowed them to emotionally support the child, 86% were able to provide vital health information to healthcare providers at the bedside, and the parents felt that their presence in the room provided comfort and fear reduction for their child.

Benefits for family members. The first documented study of FPDR demonstrates the benefits to family members (Doyle et al., 1987). This three-year study of family members who were offered the option to be present during resuscitation found that all respondents reported that being present allowed them to visualize that everything possible had been done for their family member, 76% reported that FPDR facilitated an easier grieving process, and 64% believed their presence was beneficial for their family member being resuscitated (Doyle et al., 1987). A follow-up study conducted at the same facility in 1992 confirmed these findings after nine years of experience with FPDR (Hanson & Strawser, 1992). Since these two breakthrough studies, research on FPDR has continued to prove beneficial.

Studies that have surveyed family members after their presence during resuscitation have shown the numerous benefits regarding the practice. Several studies report that FPDR allows family members to visualize that everything was done for their family member during the resuscitation process (Drewe, 2017; Shaw, Ritchie, & Adams,

2011; Tudor et al., 2014). Family members have also reported that being present helped them move toward closure and overcome the death of their family member if the outcome was poor (Drewe, 2017; Shaw et al., 2011; Tudor et al., 2014). Parents of children reported that being present during their child's resuscitation effort reduced feelings of uncertainty, chaos and distress and 100% of parents in the study said they would be involved in FPDR again (Shaw et al., 2011). When asked their opinion, nurses state that they believe FPDR allows families to understand the reality and seriousness of the situation (Drewe, 2017; Miller & Stiles, 2009).

Multiple studies have assessed the impact of FPDR on family members after being present during a resuscitation. According to Leske, McAndrew, Brasel, and Feetham (2017), family members that witnessed resuscitation after a trauma had lower anxiety related to the resuscitation seventy-two hours later, than did family members who were not present. Further, FPDR has lowered the frequency of PTSD-related symptoms, anxiety, and depression in family members who witnessed resuscitation compared to family members who did not (ENA, 2012; Jabre et al., 2013; Mottillo & Delaney, 2014). After one year, these same benefits of reduced PTSD-related symptoms, depression, and complicated grief still exist for family members present during resuscitation (Jabre et al., 2014). Finally, FPDR has fostered family reports of well-being (Leske et al., 2017).

Benefits for healthcare providers. FPDR has demonstrated positive effects not only for the family, but for the healthcare providers involved. According to the ENA (2012), healthcare providers believe that family members should be present during resuscitation and invasive procedures because it is good for the patient and the family. Nurses have reported having a positive experience during FPDR as it allowed them to

forge a connection with the family, promote the needs of the family, and promote the needs of the patient (Miller & Stiles, 2009). Healthcare providers maintain that FPDR improves communication and enables family education during the process (Basol et al. 2009). Finally, healthcare providers express that FPDR supports patient dignity and allows them to humanize the patient (Basol et al., 2009).

Perceived Barriers to Implementation of FPDR

Despite support from an immense amount of literature and multiple professional organizations, FPDR continues to be inconsistently implemented. The reason for the inconsistency in implementation is attributed to several factors. One perceived barrier that is frequently present in the literature is the worry by healthcare providers that family members would disrupt or interfere with the resuscitative efforts (Basol et al., 2009; Carroll, 2014; Miller & Stiles, 2009; Powers, 2017; Tudor et al., 2014). However, it has been documented that this perceived barrier should be overcome because FPDR has been shown to have no impact on the resuscitative efforts (Basol et al., 2009; Dudley et al., 2015; Jabre et al., 2013; Mottillo & Delaney, 2014). Nurses also report that they fear FPDR would increase the stress levels for the healthcare providers (Drewe, 2017; Jabre et al., 2013; Mottillo & Delaney, 2014; Tudor et al., 2014). Again, this concern has been disproven by multiple studies that have demonstrated no increase in healthcare providers stress levels during FPDR compared to no family present (Jabre et al., 2013; Mottillo & Delaney, 2014; Tudor et al., 2014).

Another frequent concern and barrier to offering FPDR is the fear of an increased number of lawsuits (Drewe, 2017; Tudor et al., 2014). Nevertheless, studies continue to provide results that negate this fear. In the study performed by Jabre et al. (2013), no

lawsuits were encountered with the implementation of FPDR. This is confirmed by another study that also had no experience with lawsuits related to FPDR (Mottillo & Delaney, 2014). Fear that FPDR might be too traumatic for the family member to witness is another frequently reported barrier to offering FPDR (Miller & Stiles, 2009; Powers, 2017; Tudor et al., 2014). Yet, family members continue to report positive experiences with FPDR (ENA, 2012; Jabre et al., 2013; Leske et al., 2017; Mottillo & Delaney, 2014; Shaw et al., 2011).

Nurses also convey that they are concerned about being unaware of patient's wishes regarding FPDR (Tudor et al., 2014). They are concerned that family members may be present when the patient did not wish for this to occur. The lack of a written, formal, facility policy has a negative impact on the willingness of healthcare providers to offer FPDR (Basol et al., 2009; Leske et al., 2017; Powers, 2017) Finally, another barrier noted in the literature is lack of a designated person to communicate with the family and support them during the resuscitation (Powers, 2017; Tudor et al., 2014). The lack of an FSP is detrimental to the practice of FPDR.

Recommendations for Facilitating FPDR

The first recommendation made in the literature to assist in facilitating FPDR is a written facility policy that would act as a guide for implementation (AACN, 2016; Basol et al., 2009; Powers, 2017). Healthcare professionals state that the lack of a formal policy is a barrier to offering FPDR and believe it would be beneficial (ENA, 2012). Healthcare professionals recommend that the policy be written so that it facilitates improved communication and provides consistent guidelines (Basol et al., 2009). Although some facilities have a FPDR policy, healthcare professionals are not always aware of it (ENA,

2012). Therefore, it is important to educate staff on the presence of the policy. Having a formal policy for nurses and other healthcare professionals to follow, along with educating staff about the policy, would be beneficial to improve the implementation of FPDR.

Another common recommendation among the literature is the use of an FSP to accompany the family into the resuscitation (Jabre et al., 2013; Leske et al., 2017; Mureau-Haines et al., 2017; Powers, 2017; Tudor et al., 2014). The role of FSP is to assess when family presence is appropriate, educate the family on what to expect during the resuscitation, provide explanations of medical procedures and jargon, and continually assess appropriateness of family presence throughout the resuscitation (Jabre et al., 2014; James, Cottle, & Hodge, 2010; Leske et al., 2017; Powers, 2017). Leske et al. (2017) and Shaw et al. (2011) emphasize the importance of an FSP for facilitation of FPDR and that adequate training, knowledge, and support is necessary to fulfill this role. It has been stressed that the FSP be someone that is not involved in the actual resuscitative effort in order to meet the family member's needs entirely (Drewe, 2017; Leske et al., 2017). The FSP can be vital in helping the family members come to terms with the death of their loved ones, should the resuscitation outcome be poor (James et al., 2017).

Clinical Practice Guidelines Regarding FPDR

The search for clinical practice guidelines (CPGs) regarding FPDR revealed no results from the large databases of Cochrane or National Guidelines Clearinghouse. From there, the search was moved to professional organizations where two sets of CPGs were found. The Emergency Nurses Association (ENA, 2012) has a set of CPGs and the

American Association of Critical Care Nurses (AACN, 2016) has a published practice alert regarding FPDR including guidelines for clinical practice.

CPG published by the ENA. There are five guidelines in this set, outlined in Table 1, which support the practice of family presence during resuscitation, but also the implementation of a written institution policy to facilitate this practice. The first recommendation which states that FPDR and invasive procedures is appropriate and should be offered based on written institutional policies is based on Level A evidence, reflecting a high degree of clinical certainty (ENA, 2012). The remaining four recommendations include: concerns that FPDR may be detrimental to the patient, family, or healthcare provider are not supported by the literature, family presence acceptance may have a cultural basis, healthcare professionals support having a family support person, and educating staff members about policies regarding FPDR provides support and structure (ENA, 2012). It is important to note that these last four recommendations are all Level B recommendations which means a moderate recommendation or that there are minor inconsistencies in the quality of evidence, but they are relevant and applicable to emergency nursing practice (ENA, 2012). Although these guidelines are focused on emergency nursing, the guidelines could be applied in any resuscitation event.

Table 1.

ENA's CPG Recommendations and Level of Supporting Evidence

Recommendation	Level of Evidence
Family member presence during invasive procedures or resuscitation should be offered as an option to family members and should be based on written institution policies	A
Concerns that family presence is detrimental to the patient, the family, or the healthcare team are not supported by the evidence	B
Acceptance of family presence may have some cultural basis	B
Healthcare professionals support the presence of a designated healthcare professional assigned to family members present to provide explanation and comfort	B
Educating staff in the development, implementation, and evaluation of policy regarding family member presence provides structure and support to healthcare professionals involved in this practice	B

Note. Recommendations and level of evidence from ENA (2012).

CPG published by the AACN. The AACN guideline includes two recommendations similar to the set from the ENA that support the practice of family presence in resuscitation and invasive procedures along with a written policy at the institution to facilitate this practice. The first guideline in this CPG recommends that family members of all patients be offered presence during invasive procedures and resuscitation (AACN, 2016). This recommendation is a Level B, which according to the

AACN's level of evidence, means that this recommendation is supported by "well-designed, controlled studies with results that consistently support a specific action, intervention, or treatment" (AACN, 2016). The second recommendation states that all patient-care units should have an approved policy for offering FPDR and invasive bedside procedures. This recommendation is a Level D which means "peer-reviewed professional and organizational standards with the support of clinical study recommendations" (AACN, 2016). According to these levels of evidence, this CPG contains moderate to weak levels of evidence and should be utilized with caution.

Summary

This literature summary was performed to review all relevant literature to date on the subject of FPDR. The literature review demonstrates support of FPDR by multiple professional organizations including the AACN, ACEP, AHA, and ENA . The multiple benefits of FPDR for families, healthcare providers, and patients are well documented. Perceived barriers to FPDR implementation include worry from healthcare providers that FPDR will interfere with the resuscitative efforts, will increase the stress levels for the healthcare providers, and will increase the number of lawsuits. Recommendations made in the literature to improve implementation and overcome perceived barriers consist of having a written facility policy on FPDR, educating staff on the presence of the policy, and the use of an FSP. Finally, CPGs published by the ENA and AACN support FPDR. Information provided by the current literature concludes that FPDR can and should be implemented by healthcare organizations based on a facility policy or protocol that includes the use of an FSP.

Chapter III

Methods

Project Design

For this research project, a cross-sectional descriptive design was used. An anonymous survey distributed electronically was sent to all emergency department (ED) staff nurses in a large metropolitan-area hospital, including charge nurses, over a two week period. After two weeks, the number of survey responses was low. To recruit more participants, this researcher presented to the department during the morning and night shift huddles to encourage participation. This survey included twenty statements that were rated on a Likert-type scale to assess the perceptions, knowledge, and advocacy of family presence during resuscitation (FPDR) by ED nurses. The information collected was used to provide insight into why ED nurses do or do not utilize the practice of FPDR.

Target Population

The target population for this study was registered nurses (RNs) employed in the ED at a local hospital. The hospital is a 502-bed facility in a large metropolitan area with a 40-bed emergency department. The roles of the RNs included ED staff nurses and charge nurses. These RNs were targeted over a two week period in November 2019. The nurses were targeted by electronic communication initially. After noting the low response

rates, the nurses were targeted by in-person communication at the morning and night shift daily shift huddles.

Target population recruitment. Convenience sampling was utilized for this project. The ED RNs were easily accessible via e-mail and at the daily shift huddles. No compensation was provided for participation.

Inclusion and exclusion criteria. Inclusion criteria for this study included RNs with an active license and current employment in the ED. Persons not fulfilling these criteria were excluded from the study.

Protection of human subjects. Approval from Pittsburg State University's (PSU) institutional review board (IRB) was obtained (see Appendix C). The application for approval was submitted under the exempt category after proposal to the researcher's committee members. After IRB approval was obtained from PSU, an abstract was sent to the facility in which data collection occurred. This facility expedited the project through their own informal IRB and was approved. The survey utilized was anonymous and data were kept securely in electronic form. Completed paper copies of the survey were kept with the researcher in a folder at a secure location. All participation was voluntary with the ability to withdraw from the study at any time. There were no vulnerable populations or participants under the age of eighteen included in the study.

Instrument

This study measured ED nurses' knowledge, perceptions, and advocacy of FPDR. The instrument that was utilized to measure each of these domains was a survey (see Appendix B). The survey was developed by the researcher to answer the research questions. Evidence-based clinical practice guidelines and current literature was utilized

in the creation of the survey. After development, the instrument was sent to three registered nurses that work in the ED for an evaluation of content and face validity. The committee for this DNP project also evaluated the tool and provided suggestions to improve the validity

The survey instrument was administered electronically through Google Docs. Emails for the ED nurses were obtained from the director of emergency services. There was a two week period for participants to complete the survey. Reminders were sent out via email after 7 days and 12 days of data collection to encourage participation. Despite this encouragement, there were still minimal responses. The deadline for participation was extended one week and the researcher brought surveys on pen and paper to the morning and night shift huddles to encourage participation of the ED nurses.

The survey included five demographic questions (see Appendix A) where the participant was asked to free text their answer. These demographic questions collected data on the participants age, years of experience, gender, ethnicity, and highest degree earned in nursing. The remaining twenty statements gathered information on the nurses' knowledge, perceptions, and advocacy of FPDR. These statements were all formatted with Likert-type scales with a measure of 1 (strongly disagree) to 4 (strongly agree). This tool was formulated with the review of the literature in mind.

Procedure

Data collection occurred over a three week period in November 2019 electronically and in-person at the morning and night daily shift huddles. The survey instrument collecting information on nurses' knowledge, perceptions, and advocacy of FPDR was disbursed via e-mail using an electronic survey. Instructions for the survey

and an explanation of the project was provided in the e-mail communication. Consent for participation was implied by the return of the survey. As stated above, the response rates were low electronically, so the researcher presented to the ED morning and night daily shift huddles to recruit further participants for the study. In this case, the survey was administered on pen and paper. Instructions for the survey and explanation of the project was provided prior to data collection. Questions were answered, and nurses were given the opportunity to opt out of the research. Consent was implied by the return of the survey. After data collection, all of the data were entered into a statistical database for analysis.

Evaluation Plan

The data collected was statistically analyzed using a computer software statistics program, SPSS. Descriptive statistics were computed for the demographic and perceptual data. Pearson's correlation coefficients (*r*) were calculated to assess the relationships between the variables of demographic, knowledge, perceptions, and advocacy of FPDR.

To answer the research questions: *What are the perceptions surrounding FPDR by nurses in the ED?, What is the level of knowledge regarding FPDR by nurses in the ED?, and Do ED nurses advocate for FPDR?,* the data from the survey were coded and entered into the statistical software for computations using descriptive statistics. This summarized the overall perceptions, knowledge, and advocacy of FPDR by ED nurses.

To answer the research question: *Is there a relationship between demographic variables and perceptions, knowledge, and advocacy of FPDR?,* the data from the demographic questions and perceptual questions were computed using the Pearson's

correlational coefficients to determine the relationship between demographic variables and perceptions, knowledge, and advocacy of FPDR.

Plan for Sustainability

Providing holistic care is one of the foundational elements of nursing practice. In critical times, like resuscitation, it is important to remember that the family of the patient needs care as well. To provide care that parallels current evidence-based guidelines, FPDR should be considered an option. To understand why a phenomenon is or is not being implemented, the knowledge and perceptions of that practice must be understood. This information can be utilized to develop education regarding the practice. Facilities participating in resuscitation attempts should have a written policy promoting the option of FPDR, including details about the role of a family support person, and provide education to staff members, particularly nurses, to enhance advocacy of the practice. Doing so will promote nursing practice that aligns with current evidence-based guidelines and encourage superior nursing care.

Chapter IV

Evaluation Results

The overall purpose of this project was to determine the attitudes, knowledge, and perceptions of family presence during resuscitation (FPDR) by registered nurses (RNs) in the emergency department (ED). FPDR is inconsistently implemented in healthcare facilities and this project was designed to help begin to understand why. Understanding why or why not a phenomenon is utilized is important, to determine if practice changes are needed. The research questions evaluated in this project include:

1. What are the perceptions surrounding FPDR by nurses in the ED?
2. What is the level of knowledge regarding FPDR by nurses in the ED?
3. Do ED nurses advocate for FPDR?
4. Is there a relationship between demographic variables and perceptions, knowledge, and advocacy of FPDR?

Description of Population

The total number of participants in the study was 60. Demographic characteristics were collected on the participants concerning their age, years of experience as a registered nurse, gender, highest degree achieved in nursing, and ethnicity. The format of the questions was open-ended to allow participants to free-text their answers. Demographic data were computed using frequencies.

Sixty, forty-eight female and twelve male, RNs from an ED participated in this research. The age of the participants ranged from 22 to 61 years old, with the mean age being 35.03. Participants' years of experience as a registered nurse ranged from 1 to 40, with an average of 10.73 years overall. Out of the sixty participants, forty-seven had a Bachelor's degree in nursing (78.3%), seven had an Associate's degree in nursing (11.7%), and six had a Master's degree in nursing (10%). For ethnicity, fifty-seven participants declared their ethnicity as Caucasian or White (94.9%) with three participants stating either Filipino, Hispanic, or Human (5.1%). All of the participants (100%) have been involved in a resuscitative effort of a patient and fifty-five participants (91.7%) have been involved in the resuscitative effort of a patient while family was present.

Description of Variables

The data collected from this study were computed using the computer statistics program, SPSS. In this correlational study, both of the variables are considered dependent. The first group of variables included the participants age, gender, ethnicity, highest degree achieved in nursing, and years of experience as a registered nurse. These variables were measured using one question relating to each variable in which the participant could free-text their answer. The other group of dependent variables included the knowledge, perceptions, and advocacy of FPDR. These variables were measured by asking participants to rate statements on a Likert-type scale from 1 (strongly disagree) to 4 (strongly agree). Each of the statements pertained to either knowledge of, perceptions surrounding, or advocacy for FPDR.

Analyses of Research Questions

1. What are the perceptions surrounding FPDR by nurses in the ED?

To answer this research question, participants were asked to rate fourteen different statements according to their level of agreement or disagreement utilizing a four-point Likert-type scale where one means strongly disagree and four means strongly agree. Higher mean scores indicate agreement with the statement or positive perceptions and lower mean scores indicate disagreement with the statement or negative perceptions. Descriptive statistics were obtained from analyses of the data. The four statements that reflect negative perceptions of FPDR were reversed scored and mean scores fell between 1.15 and 2.22 (see Table 2). These mean scores indicate the participants' overall disagreement that FPDR may have negative consequences, with the exception of agreement with the statement indicating that FPDR would be too traumatic for the family. For most statements that reflect positive perceptions of FPDR, mean scores fell between 2.6 and 3.43, demonstrating that participants agreed with these statements (see Table 2). For the statement stating a family support person should be present during FPDR, the mean score was 3.83, demonstrating that participants strongly agree with this statement (see Table 2). Overall, only two items were below 2 and three items were below 2.5, demonstrating the overwhelming positive perceptions of FPDR.

Table 2.

Mean Scores and Standard Deviations for Participant Perceptions of FPDR

	Mean	Std. Deviation
3. There should be a family support person when family is present during resuscitation	3.83	.46
4. Family should be invited to be present during resuscitation of their loved one	3.43	.81
11. Family presence during resuscitation helps the family see that everything was done for their loved one	3.38	.69
12. … reduces feelings of uncertainty for the family	3.22	.74
18. I have had a positive experience with family presence during resuscitation	3.18	.79
5. I would want to be present if my family member was being resuscitated	3.17	.98
10. Family presence during resuscitation facilitates the grieving process for the family	3.10	.68
15. … improves communication between the healthcare providers and family members	3.08	.70
14. … facilitates a connection between the healthcare providers and the family members	2.97	.80
13. Family presence during resuscitation is beneficial for the healthcare providers involved	2.60	.87
8. Family presence will increase the stress of the healthcare providers performing the resuscitation*	2.55	.83
9. Family presence during resuscitation will increase the number of lawsuits against healthcare providers*	2.22	.80
7. Family presence will cause a disruption to the resuscitation process*	1.82	.85
6. Being present during resuscitation of their loved one is a traumatic experience for the family*	1.15	.82

Note. *. Item has been reversed scored. Bolded items indicate mean scores greater than 2.5. All items were placed in descending order to demonstrate overwhelming positive perceptions.

2. What is the level of knowledge regarding FPDR by nurses in the ED?

To answer this research question, participants were asked to rate two different statements according to their level of agreement utilizing a four-point Likert-type scale where 1 means strongly disagree and 4 means strongly agree. Higher mean scores reflect knowledge and lower mean scores reflect no knowledge. Descriptive statistics were

obtained through analyses of the data. For the statement reflecting knowledge of clinical practice guidelines, the mean score was 2.98. This demonstrates that on average, participants agreed with the statement (see Table 3). In other words, 76.7% of participants answered this question correctly, as there are published clinical practice guidelines on FPDR. In contrast, the mean score of the statement reflecting knowledge of a facility written policy was 2.35. This demonstrates that on average, participants disagreed with the statement (see Table 3). In other words, only 36.6% of participants answered this question correctly, as there is a written policy regarding FPDR at the facility the participants work in.

Table 3.

Mean Scores and Standard Deviations for Participant Knowledge of FPDR

	Mean	Std. Deviation
1. There are evidence-based clinical practice guidelines published for family presence during resuscitation	2.98	1.00
2. The facility that I work in has a written policy on family presence during resuscitation	2.35	.90

3. Do ED nurses advocate for FPDR?

To answer this research question, participants were asked to rate two different statements according to their level of agreement based on a four-point Likert-type scale where 1 means strongly disagree and 4 means strongly agree. Descriptive statistics were obtained from analyses of the data. For the statement reflecting that the participant has offered family to be present during resuscitation, the mean score was 2.93. This demonstrates that on average, participants agreed with the statement (see Table 4). For the statement reflecting that the participant would offer family to be present if given the chance, the mean score was 3.35, demonstrating that on average, participants agreed with

the statement (see Table 4). In other words, 66.7% of participants have advocated for FPDR and 90% of participants would advocate for FPDR if given the chance.

Table 4.

Mean Scores and Standard Deviations for Participant Advocacy of FPDR

	Mean	Std. Deviation
19. I have offered family to be present during resuscitation of their loved one	2.93	1.07
20. If given the chance, I would offer family to be present during resuscitation of their loved one	3.35	.80

4. Is there a relationship between demographic variables and perceptions, knowledge, and advocacy of FPDR?

For this research question, Pearson's correlation coefficients were computed to determine if a relationship existed between demographic variables and perceptions, knowledge, and advocacy of FPDR. For the variables of gender, ethnicity, and highest degree completed in nursing, the responses were particularly homogenous, so Pearson's correlational coefficients were not computed for these variables. The computations for the other two variables yielded correlations between demographic variables and perceptions, knowledge, and advocacy of FPDR.

Age. Pearson's correlational coefficients were computed to determine if there was a relationship between years of age and perceptions, knowledge, and advocacy of FPDR. According to the calculations, there was no correlation between these variables (see Table 5). In other words, regardless of age, participants knowledge, perceptions, and advocacy of FPDR remains the same.

Years of experience. Pearson's correlation coefficients were computed to determine if there was a relationship between years of experience as a registered nurse

and perceptions, knowledge, and advocacy of FPDR. The results indicate that a higher number of years of experience as a registered nurse correlates with a disagreement that family presence will cause a disruption to the resuscitation process and agreement that participants have offered family to be present (see Table 5). In other words, with more years of nursing experience, there are more positive perceptions and higher advocacy for the practice.

Table 5.

Correlational Coefficients Between Demographic Variables and Knowledge, Perceptions, and Advocacy of FDR

Knowledge	Age	Years of Experience
1. There are evidence-based clinical practice guidelines published for family presence during resuscitation	.034	.183
2. The facility that I work in has a written policy on family presence during resuscitation	.068	.161
Perceptions	**Age**	**Years of Experience**
3. There should be a family support person when family is present during resuscitation	.127	.223
4. Family should be invited to be present during resuscitation of their loved one	.037	.227
5. I would want to be present if my family member was being resuscitated	.132	.196
6. Being present during resuscitation of their loved one is a traumatic experience for the family	.029	-.227
7. Family presence will cause a disruption to the resuscitation process	-.185	-.393*
8. Family presence will increase the stress of the healthcare providers performing the resuscitation	-.118	-.253
9. Family presence during resuscitation will increase the number of lawsuits against healthcare providers	-.009	-.014
10. … facilitates the grieving process for the family	.093	.181
11. … helps the family see that everything was done for their loved one	.025	.160
12. … reduces feelings of uncertainty for the family	-.033	.054
13. … is beneficial for the healthcare providers involved	.023	.101
14. … facilitates a connection between the healthcare providers and the family members	.148	.219
15. … improves communication between the healthcare providers and family members	-.085	.071
18. I have had a positive experience with family presence during resuscitation	-.003	.157
Advocacy	**Age**	**Years of Experience**
19. I have offered family to be present during resuscitation of their loved one	.202	.386*
20. If given the chance, I would offer family to be present during resuscitation of their loved one	.108	.304

Note. *. Correlation is significant at the 0.05 level (2-tailed).

Additional Statistical Analyses

Additionally, Pearson's correlational coefficients were computed to determine if there were any significant correlations between the different variables of knowledge, perceptions, and advocacy of family presence during resuscitation. The significant correlations are discussed below.

Knowledge and perceptions. Pearson's correlational coefficients were computed to determine if there was a relationship between knowledge of FPDR and perceptions of FPDR. According to the calculations, there was a positive correlation between having knowledge of the clinical practice guidelines and believing that family should be invited to be present and that family presence improves communication between the healthcare providers and family (see Table 6). There was also a negative correlation between having knowledge of clinical practice guidelines and believing that family presence will increase the stress of the healthcare providers (see Table 6). In other words, having knowledge of FPDR clinical practice guidelines correlates with positive perceptions of FDPR. Further, there is a negative correlation between having knowledge of the facility policy on FPDR and believing that family presence will cause a disruption to the resuscitation process (see Table 7). In other words, having knowledge of FPDR policy correlates with positive perceptions of FPDR.

Table 6.

Correlation Coefficients Between Knowledge of CPGs and Perceptions of FPDR

		1. There are evidence-based clinical practice guidelines published for family presence during resuscitation
4. Family should be invited to be present during resuscitation of their loved one	Pearson Correlation	.260*
8. Family presence will increase the stress of the healthcare providers performing the resuscitation	Pearson Correlation	-.256*
15. Family presence improves communication between the healthcare providers and family members	Pearson Correlation	.294*

Note. *. Correlation is significant at the 0.05 level (2-tailed).

Table 7.

Correlational Coefficients Between Knowledge of Policy and Perceptions of FPDR

		2. The facility that I work in has a written policy on family presence during resuscitation
7. Family presence will cause a disruption to the resuscitation process	Pearson Correlation	-.262*

Note. *. Correlation is significant at the 0.05 level (2-tailed).

Knowledge and advocacy. Pearson's correlational coefficients were computed to determine if there was a relationship between knowledge of FPDR and advocacy for FPDR. According to the calculations, there was a positive correlation between having knowledge of the clinical practice guidelines on FPDR and the willingness to offer family

to be present during resuscitation (see Table 8). There was also a positive correlation between having knowledge of the facility's policy on FPDR and having offered family to be present during resuscitation in the past (see Table 9).

Table 8.

Correlational Coefficients Between Knowledge of CPGs and Advocacy of FPDR

		1. There are evidence-based clinical practice guidelines published for family presence during resuscitation
20. If given the chance, I would offer family to be present during resuscitation of their loved one	Pearson Correlation	.262*

Note. *. Correlation is significant at the 0.05 level (2-tailed).

Table 9.

Correlational Coefficients Between Knowledge of Policy and Advocacy of FPDR

		2. The facility that I work in has a written policy on family presence during resuscitation
19. I have offered family to be present during resuscitation of their loved one	Pearson Correlation	.324*

Note. *. Correlation is significant at the 0.05 level (2-tailed).

Experience and perceptions. Pearson's correlational coefficients were computed to determine if there was a relationship between experience with FPDR and perceptions of FPDR. According to the calculations, there was a positive correlation between having been involved in FPDR and having a positive experience with the practice (see Table 10). There was also a negative correlation between having been involved in FPDR and

believing that family presence would cause a disruption to the resuscitation process (see Table 10).

Table 10.

Correlational Coefficients Between FPDR Experience and Perceptions of FPDR

		17. I have been involved in the resuscitative effort of a patient while family was present
7. Family presence will cause a disruption to the resuscitation process	Pearson Correlation	-.288*
18. I have had a positive experience with family presence during resuscitation	Pearson Correlation	.396**

Note. *. Correlation is significant at the 0.05 level (2-tailed).
**. Correlation is significant at the 0.01 level (2-tailed).

Summary

On average, the participants agreed with the statements reflecting positive perceptions of FPDR. Of note, the only negative perception of FPDR by the participants was that they believed it would be too traumatic for the family. In regard to knowledge about FPDR, participants agreed that there are CPGs published on FPDR, but they disagreed that their healthcare facility had a policy relating to FPDR. Finally, the participants agreed with the statements reflecting advocacy for FPDR.

Due to the homogenous responses for the variables of gender, ethnicity, and highest degree completed in nursing, Pearson's correlational coefficients were not computed for these variables. There was no correlation found between age and knowledge, perceptions, and advocacy of FPDR indicating that it does not matter how old the participants were, they still had very positive perceptions of FPDR, and they still

advocate for the practice. There was a correlation between years of experience as a registered nurse and whether participants believed FPDR would cause a disruption to the resuscitation process. There was also a correlation between years of experience and the advocacy of FPDR.

Lastly, there were significant correlations found between the different variables of knowledge, perceptions, and advocacy. Having knowledge of FPDR, whether of CPGs or facility policy, had a correlation with positive perceptions of the practice. Further, knowledge of FPDR was correlated with advocacy for the practice. Finally, involvement in the resuscitative effort of a patient with family present was correlated with positive perceptions of FPDR.

Chapter V

Discussion

Purpose

The purpose of this study was to determine the knowledge, perceptions, and attitudes of family presence during resuscitation (FPDR) by registered nurses (RNs) who work in the emergency department (ED). This study provides insight into why nurses may or may not utilize the practice of FPDR. Understanding what nurses know and think about a practice helps determine how to increase utilization in healthcare facilities. This project could help guide healthcare facilities when implementing and educating about FPDR.

Relationship of Outcomes to Research

This study aimed to answer four different research questions. Each of the questions was answered by the study and further information was obtained through other analyses of the data. The relationship of these outcomes to current literature is discussed below.

1. What are the perceptions surrounding FPDR by nurses in the ED?

This question was evaluated through the research by asking participants to rate their level of agreement or disagreement with fourteen statements. The responses were based on a four-point Likert-type scale with responses ranging from 1 – strongly disagree

to 4 – strongly agree. The mean scores and standard deviations were noted for each of these statements.

For ten of the statements, the mean score reflected that participants either agreed or strongly agreed. These ten statements reflected support for FPDR, benefits for the family, and benefits for healthcare providers. The mean scores demonstrate that participants have positive perceptions of FPDR. This is in alignment with current research as multiple professional organizations support the practice of FPDR and have demonstrated the benefits for the family and healthcare providers, alike (AACN, 2016; ACEP, 2018; AHA, 2015; Dudley, Ackerman, Brown, & Snow, 2015; ENA, 2012).

The other four statements were reverse scored. Mean scores reflected that participants disagreed with three of the negative statements, demonstrating that they do not believe that FPDR will have negative consequences. This is consistent with current literature that states FPDR does not have an effect on patient care (Basol, Ohman, Simones, & Skillings, 2009; Dudley et al., 2015). On the contrary, participant mean scores for the statement "being present during the resuscitation of their loved one is a traumatic experience for the family", reflected that participants agreed with this statement. Current literature actually shows that FPDR can decrease symptoms of PTSD, complicated grief, and depression in family members, along with fostering a sense of well-being (De Stefano et al., 2016; Jabre et al., 2014).

2. What is the level of knowledge regarding FPDR by nurses in the ED?

This question was evaluated through the research by asking participants to rate their level of agreement or disagreement with two statements. The responses were based on a four-point Likert-type scale with responses ranging from 1 – strongly disagree to 4 –

strongly agree. The mean scores and standard deviations were noted for each of these statements.

These two statements express awareness of the current evidence-based CPGs published on FPDR and the policy regarding FPDR at the participants healthcare facility. The mean score for the statement regarding CPGs on FPDR reflected that participants agreed. The mean score for the statement regarding the healthcare facility policy reflected that participants disagreed. In other words, participants are aware of current evidence-based practice recommendations, but are not aware of a policy at their healthcare institution. Prior to completing this study, it was unknown whether participants were aware of FPDR, as the practice is inconsistently implemented in healthcare facilities. It should be mentioned that the participants' healthcare facility does not have a separate policy on FPDR, but there is a statement of support for FPDR in the facility's code blue policy.

3. Do ED nurses advocate for FPDR?

This question was evaluated through the research by asking participants to rate their level of agreement or disagreement with two statements. The responses were based on a four-point Likert-type scale with responses ranging from 1 – strongly disagree to 4 – strongly agree. The mean scores and standard deviations were noted for each of these statements.

These two statements express advocacy for FPDR. According to the mean scores, nurses at this healthcare facility agreed with these two statements. In other words, nurses have offered family to be present during resuscitation or would offer FPDR, if given the chance. Again, this is in alignment with current literature that supports and encourages

the practice of FPDR (AACN, 2016; ACEP, 2018; AHA, 2015; Dudley, Ackerman, Brown, & Snow, 2015; ENA, 2012).

4. Is there a relationship between demographic variables and perceptions, knowledge, and advocacy of FPDR?

For this research question, Pearson's correlational coefficients were calculated to determine if a relationship existed between demographic variables and perceptions, knowledge, and advocacy of FPDR. For the variables of gender, ethnicity, and highest degree completed in nursing, participant responses had very little variance, so Pearson's correlational coefficients were not calculated for these variables. The other two variables that were analyzed were age and years of nursing experience.

For the variable of age, there was no correlation found between age and knowledge, perceptions, or advocacy of FPDR which means that despite age, participants still have knowledge of FPDR, positive perceptions of FPDR, and advocate for FPDR. This agrees with findings in prior studies (Twibell et al., 2008). For the variable of years of experience, there was a correlation found between years of nursing experience and two statements on perception and advocacy. With an increase in years of experience, there was a decrease in agreement that FPDR would cause a disruption to the resuscitation process and an increase in participants who have offered family to be present. It makes sense that with more experience, nurses feel more comfortable with FPDR and have offered FPDR more than nurses with fewer years of experience. However, this correlation was not found in prior studies (Twibell et al., 2008). The explanation for this difference in findings could be due to the small sample size in this study compared with other studies.

Other Findings. Further analyses were conducted to determine if there was a correlation between any of the variables of knowledge, perceptions, and advocacy of FPDR. There were correlations found between knowledge and perceptions of FPDR. Participants who had knowledge of the CPGs and facility policy on FPDR agreed that family should be present, family presence improves communication, family presence does not cause a disruption to the resuscitation process, and family presence does not increase the stress of healthcare providers involved. In other words, having knowledge of FPDR has a positive impact on perceptions of the practice.

There were also correlations found between knowledge and advocacy of FPDR. When participants knew about the CPGs and facility policy on resuscitation, they were more likely to have invited family to be present or would invite family to be present if given the chance.

Finally, there was a correlation found between experience with FPDR and perceptions of the practice. Participants who have been involved in the resuscitative effort of a patient with family presence report that they do not believe family presence will cause a disruption to the resuscitative process. They findings also show that nurses who have been involved in FPDR have had a positive experience with the practice.

Observations

Perhaps the most interesting finding after conducting this study was that nurses reported knowing about the CPGs related to FPDR but were not aware of their facility having a policy on FPDR. The correlations demonstrated that participants who knew about FPDR had more positive perceptions of the practice and were likely to advocate for

it. Based on these findings, educating the nurses within this ED about the facility policy on FPDR could have a positive impact on utilization rates of FPDR.

Evaluation of Theoretical Framework

The theoretical framework that was used to guide this research was Kolcaba's Theory of Comfort. This theory focuses on holistic nursing care and describes comfort as the desired outcome (Petiprin, 2016). The data from this study supports this theory. The study findings support the assumption in Kolcaba's theory that comfort is provided to patients through many contexts: psychospiritual, as nurses agree that FPDR can reduce feelings of uncertainty for the family; physical context, as nurses believe that family should be allowed to be present; and the environmental context, as nurses believe that having family present could enhance communication between the family and healthcare providers. The findings also suggest that nurses believe the statements in the theory that say comfort can be provided in the form of relief and transcendence. Nurses reported that they believe FPDR allows family members to know all is being done to resuscitate their family member, which could provide comfort through relief. Nurses also reported that they believe FPDR facilitates the grieving process, which could provide comfort through transcendence.

Evaluation of Logic Model

The results of this study support the proposed logic model in Chapter I. The inputs of time, staff, researcher, materials, research, education, and experience were put into this project. There were more materials and time put into the project that were not expected initially, because of the hard copies of the instrument that had to be printed and delivered in-person at the daily shift huddles. The activities were fulfilled as an

instrument was developed and did in fact measure knowledge, perceptions, and advocacy of FPDR. The outputs were partially fulfilled, as only some of the emergency department nurses completed the survey instruments. Finally, the outcomes were partially achieved. Understanding ED nurses' knowledge of FPDR was achieved in the short-term. The mid-term goal of increasing utilization of FPDR and long-term goal of enhancing patient- and family-centered care in the ED are goals that are not yet measured. It is the researchers hope that this project will inform the ED nurses about FPDR, therefore increasing utilization of the practice. Doing so would enhance patient- and family-centered care.

Limitations

One limitation in the study is the small sample size. The survey was sent to 108 registered nurses in the ED. Various methods were attempted to increase the number of participants including sending out reminder emails and presenting in-person to deliver hard copies of the survey. Despite these attempts, there were still only 60 participant responses to the survey. This low number of responses and small sample size could lead to a type II error. Another limitation is this project focused only on nurses in the ED. There are multiple disciplines involved in resuscitation, so including others such as respiratory therapy, physicians, chaplains, and nursing assistants could lead to a greater understanding of factors impacting FPDR. Within a healthcare facility, there are also many units that participate in resuscitation of a patient. It would be useful to know the knowledge, perceptions, and advocacy of FPDR by different units or specialties in order to adapt an institutional policy.

The instrument used was appropriate for the sample. Attempts were made to use an instrument that was already developed and validated, but permission was never

obtained to use the instrument. The instrument in this study was formulated based on the current literature and was evaluated by other ED staff nurses and this scholarly project committee. There did not appear to be any negative impacts on the project with the use of this instrument. However, it would have been more ideal to utilize an instrument that had already been evaluated for content and face validity.

Implications for Future Projects and Research

This project focused specifically on registered nurses in the emergency department. Future research on the topic of FPDR should include other units or specialties along with other disciplines besides nursing. Expanding a project on this topic could lead to a greater understanding of the various factors that impact the utilization of FPDR. There could certainly be a difference in factors between the emergency department to the intensive care unit to the medical-surgical unit. Further projects could also focus on FPDR in pediatric or neonatal units. These units may have significantly different factors at play in a resuscitation situation.

Future projects should also examine the differences in perceptions between healthcare providers in rural versus urban areas. In rural areas, healthcare providers often know their patients. This may present more of a challenge to the implementation of FPDR. Rural areas may also have different factors which impact their perceptions of the practice such as less staff and resources to facilitate the practice. Greater understanding of the phenomenon and why there is inconsistent implementation could lead to the development of focused education for all disciplines involved in resuscitations. Further research could then be carried out that determine if education makes a difference in the

utilization of the practice. Doing so, could potentially promote improved patient- and family-centered care.

Implications for Practice and Education

There are implications for practice and education based on the findings of this study. The outcomes of this project revealed fears including FPDR being too traumatic for the family. Current literature has demonstrated that this is not true and being present can actually reduce PTSD-related symptoms (De Stefano et al., 2016; Jabre et al., 2014). Another finding with future implications is that the majority of the nurses were not aware of the policy on FPDR in their facility and nurses who were aware of this policy were more likely to advocate for FPDR. Providing education to nurses on FPDR, specifically the facility's policy, could increase the utilization of the practice. By doing this, patient- and family-center care could be improved.

Conclusion

The purpose of this project was to address the problem of inconsistent implementation of FPDR in the ED. In order to change practice, it must be understood why someone may or may not utilize a specific practice. This project aimed to understand the current level of knowledge of FPDR, the perceptions surrounding FPDR, and the rates of advocacy of FPDR by nurses in the ED. This project led to a greater understanding of what ED nurses know at this specific facility about FPDR, their perceptions of the practice, and their implementation rates of FPDR.

The findings suggest that most nurses know about FPDR, but there are fears related to the practice. Further, the study found that nurses who either had knowledge about FPDR or nurses with experience with FPDR had positive perceptions of FPDR and

were more likely to advocate for the practice in their clinical setting. These results demonstrate the importance of informing nurses within a facility about FPDR and the FPDR statement in the code blue policy. By enhancing awareness and education, the perceived barriers to implementation can be overcome and the multiple benefits for the family and healthcare workers can be reaped. The utilization of FPDR can help ensure that the highest level of holistic nursing care is provided to patients and families during this critical time.

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APPENDIX

Appendix A

Demographic Questionnaire

1. What is your age?

   _____

2. Which gender do you identify as?

   _____

3. How many years of experience as a registered nurse do you have?

   _____

4. What is the highest degree in nursing that you have completed?

   _____

5. What is your ethnicity?

   _____

Appendix B

Survey on the Perceptions, Knowledge, and Advocacy of Family Presence During Resuscitation

Purpose: The purpose of this survey is to assess the perceptions, knowledge, and advocacy of family presence during resuscitation by nurses in the emergency department.

Please choose the extent to which you agree or disagree with the statements based on the following scale:

1-Strongly Disagree, 2-Disagree, 3-Agree, 4-Strongly agree

1. There are evidence-based clinical practice guidelines published for family presence during resuscitation

   1 2 3 4

2. The facility that I work in has a policy on family presence during resuscitation

   1 2 3 4

3. There should be a family support person when family is present during resuscitation

   1 2 3 4

4. Family should be invited to be present during resuscitation of their loved ones

   1 2 3 4

5. I would want to be present if my family member was being resuscitated

   1 2 3 4

6. Being present during resuscitation of their loved one is a traumatic experience for the family

1 2 3 4

7. Family presence will cause a disruption to the resuscitation process

1 2 3 4

8. Family presence will increase the stress of the healthcare providers performing the resuscitation

1 2 3 4

9. Family presence during resuscitation will increase the number of lawsuits against healthcare providers

1 2 3 4

10. Family presence during resuscitation facilitates the grieving process for the family

1 2 3 4

11. Family presence during resuscitation helps the family see that everything was done for their loved one

1 2 3 4

12. Family presence during resuscitation reduces feelings of uncertainty for the family

1 2 3 4

13. Family presence during resuscitation is beneficial for the healthcare providers involved

1 2 3 4

14. Family presence during resuscitation facilitates a connection between the healthcare providers and the family members

1 2 3 4

15. Family presence improves communication between the healthcare providers and family members

1 2 3 4

16. I have been involved in the resuscitative effort of a patient

1 2 3 4

17. I have been involved in the resuscitative effort of a patient while family was present

1 2 3 4

18. I have had a positive experience with family presence during resuscitation

1 2 3 4

19. I have offered family to be present during resuscitation of their loved one

1 2 3 4

20. If given the chance, I would offer family to be present during resuscitation of their loved one

1 2 3 4

Appendix C

Pittsburg State University Application for Approval of Investigations Involving the Use of Human Subjects

Pittsburg State University
Application for Approval of Investigations
Involving the Use of Human Subjects

This application must be completed by the Investigator and sent to the Office of Graduate and Continuing Studies by the first Tuesday of the month during the fall and spring academic semesters to be considered for full review on the second Tuesday of the month.

Expedited and exempt reviews can be turned in any time. For questions about the review process contact Brian Peery in Russ Hall, #112, Ext. 4175.

1. Investigator(s) Name(s): Myranda Prather

2. Department: School of Nursing

3. Local Address: 615 E Cheyenne St Gardner, KS 66030

4. Phone: (620)330-3304

5. E-mail Address: myrandaprather@gus.pittstate.edu

6. Project Title: Understanding the Knowledge, Perceptions, and Advocacy of Family Presence During Resuscitation by Emergency Department Nurses

7. Expected Completion Date: May 2020

8. Expected Starting Date: August 2019

9. Is this project (check all that apply): Use review criteria in Form CR-1 to determine which category of review applies.

☐ Application for Full Review ☐ Protocol Change ☐ Thesis/Special Investigation

☐ Being submitted for external support ☐ Continued Review ☐ Application for Expedited Review

☐ Being conducted in a foreign country ☐ Faculty Research ☑ Application for Exempt Review

☐ Publishable research ☐ A Class Project

10. If notification of human subject approval is required give date required: November 2019

Name of agency: PSU Irene Ransom Bradley School of Nursing

11. If you are a student, complete the following:

Faculty Sponsor: Jennifer Harris

Department: School of Nursing

Phone: (620) 235-4447

**** If submitted externally, a complete copy of the proposal must be submitted to the IRB.****

CERTIFICATION AND APPROVAL

Certification by Investigator: I certify that (a) the information presented in this application is accurate, (b)only the procedures approved by the IRB will be used in this project, (c)modifications to this project will be submitted for approval prior to use, and that all guidelines outlined in the PSU Policy and Assurance Handbook for the Protection of Human Research Subjects will be followed as well as all applicable federal, state and local laws regarding the protection of human subjects in research as outlined in Form VA-1.

Signature of Investigator — Date: 09-30-19

Faculty Sponsor: If the Investigator is a student, his/her Faculty Sponsor must approve this application. I certify that this project is under my direct supervision and that I accept the responsibility for ensuring that all provisions of approval are met by the investigator.

Signature of Faculty Sponsor — Date: 9-30-19

Department Review Committee Chair: I acknowledge that this research is in keeping with the standards set by our department, university, state and federal agencies and I assure that the student principal investigator has met all departmental requirements for review and approval of this research.

Signature of Department Review committee Chairperson — Date: 10-4-19

CPHRS Chairperson — Date: 10/3/19

I. Description of the Subjects (If advertising for subjects, include a copy of the proposed advertisement.)

A. How many subjects will be involved? Approximately 130