

FAST FACTS AND CONCEPTS #233
IMPLEMENTATION OF A FAMILY PRESENCE DURING RESUSCITATION PROTOCOL

Ciarán Bradley MD, MA, Melech Lensky BCC, JD, and Karen Brasel MD, MPH

Background *Fast Fact #232* discusses the history, benefits, and potential risks of allowing family presence during cardiopulmonary resuscitation (FPDR). Successful implementation of FPDR in an institution is dependent on using a structured protocol to maximize family support and patient safety. This *Fast Fact* discusses the key components of a successful FPDR policy.

Key Policy Components (adapted in part from Meyers, et al, 2000):

- **Facilitator:** Identify and train a core group of FPDR facilitators to respond to calls for FPDR. Facilitators should be trained to assess families, understand the functioning of the medical team, understand the facilitator's role in bringing the family to the medical theater, and provide post-resuscitation support. Potential facilitators can include social workers, chaplains, child life specialists, nurses and allied health professionals. The facilitator's specialty is less important than ensuring adequate training. Chaplains and social workers can be ideal for this task, however, as they may have more flexibility to respond, and are unlikely to step away from the family and become involved in the resuscitation. Ideally, facilitators would respond to all resuscitation events in an institution to assess the appropriateness and need for family presence.
- **Assessment:** Assess whether FPDR is appropriate in a given situation. First, the medical team must agree to FPDR. Second, the patient, if able, must provide his or her consent. Third, the FPDR facilitator should assess whether the family members are suitable candidates for FPDR. He or she should not offer it to individuals who are histrionic, combative, or overly disruptive. If the facilitator believes that the family members are suitable candidates for FPDR, then he or she should offer the opportunity to be present in the resuscitation area. Finally, staff should support family members in a decision not to witness resuscitation, and ensure that their emotional and informational needs are being met even if they are not at the bedside.
- **Number of Visitors:** Limit the number of family members brought to the medical theater to one or two. Greater numbers of visitors will be difficult to accommodate, given the constraints of the care area, and will stretch the facilitator's ability to maintain control of the visitors, offer emotional support, and answer questions. If a legal decision-maker for the patient has been identified, it can be beneficial to preferentially offer FPDR to that person, since he or she may be called upon to participate in real-time decisions during or immediately following the resuscitation.
- **Preparing the Family:** The facilitator should prepare the family members by providing 'ground rules' for their presence such as where they will stand, how long to remain, how to ask questions, and cautions about disrupting medical personnel providing patient care. Family members should be oriented to what to expect such as the patient's appearance, invasive procedures and the presence of blood, and presence of multiple, active health care professionals.
- **Facilitator's Role in the Care Area:** The FPDR facilitator must remain by the side of the family members. He or she should offer comfort and support, explain interventions and terminology when appropriate, and assist with grieving, while always being prepared to usher the family out of the care area should they become emotionally overwhelmed or distracting to the medical team. Facilitators with medical backgrounds should resist any temptation to participate in the procedures, assist caregivers, or critique what is occurring. Given the physical constraints of the resuscitation area and provided that the medical team is not disrupted, family members may be allowed to approach the bedside and offer physical comfort to their loved one.
- **Surrogate Decision-Making:** Family members present during an unsuccessful resuscitation might be asked to make decisions about continuing resuscitative efforts, or initiate such a request themselves. If the legal decision-maker is present (e.g., the patient's health care power of attorney or other designee as recognized by state law or institutional policy) it is appropriate for the medical team to follow an informed decision by the surrogate. If no legal decision-maker is available or clearly identifiable, the physician directing the resuscitation should make her or his own decision about the appropriateness of continuing resuscitation efforts based on an assessment of the likelihood of

success, and any available guidance provided by loved ones present. Some institutions have specific policies guiding these decisions.

- **Post-Event Family Support:** Families may need continued support and the opportunity to debrief afterwards. If the patient dies, families should be allowed as liberal access as possible to their loved one's body, and staff should refer families to a hospital or outside bereavement program.
- **Post-Event Staff Support:** Medical team members may need to debrief after a particularly troubling or emotional FPDR event. The institution's FPDR policy should identify the parties responsible for arranging a debriefing. Individuals at teaching institutions should be aware of the unique challenges FPDR can put on housestaff in their dual role as providers and learners.

References

1. Meyers TA, Eichhorn DJ, Guzzetta CE, et al. Family presence during invasive procedures and resuscitation: the experiences of family members, nurses, and physicians. *Am J Nurs.* 2000; 100:32-42.
2. Fernandez R, Compton S, Jones KA, et al. The presence of a family witness impacts physician performance during simulated medical codes. *Crit Care Med.* 2009; 37:1956-1960.

Author Affiliations: Medical College of Wisconsin, Milwaukee, WI (CB, KB); Froedtert Hospital, Milwaukee, WI (ML).

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