Family-centred care: review of opinions among staff

Kieran McLaughlin and colleagues present results from a literature review on the support given to families before, during and after attempts to resuscitate their loved ones.

Abstract

The sudden admission to an emergency department (ED) of a patient requiring resuscitation can be a traumatic experience for families, who often require a great deal of support from ED staff. The needs of such staff must be considered too if the care of patients and families during resuscitation attempts is to be improved. This article discusses the findings of a systematic review of the literature on family-centred care during and after resuscitation attempts, and reveals that, although families appear to favour witnessed resuscitation, the practice remains controversial among healthcare professionals. Chaotic workloads, time restraints, lack of education and poor coping abilities all appear to affect wider implementation of the practice in EDs.

Keywords

Family-centred care, holistic, resuscitation

BETWEEN 25,000 and 30,000 resuscitations are attempted in UK emergency departments (EDs) each year (Royal College of Nursing (RCN) 2002). In such cases, the families of those being resuscitated look to ED clinicians for support and guidance (Redley et al 2003). Emergency nurses (ENs) are required to deliver care that meets the needs of patients' families (Department of Health (DH) 2000, 2001, 2004), which can include allowing them to witness attempts to resuscitate their loved ones.

In children's nursing, the presence of families during resuscitation attempts, often referred to as 'witnessed resuscitation', has long been accepted. In adult settings, however, the practice is less common and continues to generate controversy, even though organisations such as the British Association for Accident and Emergency Medicine (1995), Resuscitation Council (1996), RCN (2002) and European Federation of Critical Care Nursing Association (Fulbrook et al 2007) have published guidance in support of it. Similarly, there has been a great deal of research into the needs of family members in critical care units and other acute hospital settings, but much less has been undertaken on their needs in EDs, particularly during and after resuscitation attempts.

To redress this situation, the author undertook a systematic review of the literature on family-centred care during resuscitation, focusing on:

- The views of patients who have been resuscitated.
- The needs of patients' families during and after resuscitation attempts, their views of family-witnessed resuscitation and aftercare, and the effects on them of witnessing the resuscitation of their loved ones.
- The roles and views of ENs, and the effects on them of the presence of families during resuscitation attempts.
- Obstacles to the provision of family-centred care, and the roles of training and hospital guidelines in overcoming them.

This article, whose search methods and results are summarised in Table 1, also outlines the limitations of other studies of family-witnessed resuscitation.

Patients

Views Research into patients’ views on family-witnessed resuscitation is limited. However, in a survey of 21 patients who had been resuscitated successfully and 40 other patients who had been admitted for emergency care, Albarran et al (2009) found that almost all members of the former group and slightly more than half of the latter group...
thought that families benefited from being present during resuscitation attempts. Most patients are unconcerned about issues of confidentiality but Albarran et al (2009) recommend that, when patients are admitted, staff seek their permission for family presence during resuscitation.

Families

Needs during resuscitation Sudden admission to EDs of patients who require resuscitation is often traumatic for their families, yet the needs of families have traditionally been overlooked by ED staff (Tye 1996, Socorro et al 2001, Redley et al 2003).

Socorro et al (2001) identify communication with nurses, meaningful information, proximity to loved ones, staff support and comfort as the most important features of care received by families attending EDs, while Redley et al (2003) found that family members prioritised meaningful information and proximity to their loved ones.

Needs after resuscitation Much of the literature on care after resuscitation attempts concerns the needs of families after the death of loved ones in EDs. Li et al (2002), for example, found that many bereaved families want to view their loved ones’ bodies as soon as possible and to touch them while they are still warm. Socorro et al (2001) noted that families want adequate time to spend with their deceased loved ones.

Many ENs acknowledge that families need follow-up care after the resuscitation or sudden death of loved ones (Flam 1999), even though this is not always offered (Hallgrimsdottir 2000). Bereavement programmes can also offer ENs a ‘satisfying and meaningful conclusion’ to their involvement in sudden death, and so improve their coping abilities (Saines 1997). Ping et al (2002) note that, although such bereavement services are readily available in Hong Kong, most of the families in their study were unaware of them.

Table 1 Summary of literature review method and results

<table>
<thead>
<tr>
<th>Method</th>
<th>Results</th>
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<tr>
<td>Electronic journal databases searched</td>
<td>British Nursing Index, CINAHL Plus with Full Text, EBSCO Psychology and Behaviour Sciences, Medline, Maternity and Infant Care, PubMed and the Cochrane Library.</td>
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<tr>
<td>Inclusion criteria</td>
<td>Articles published in English between 1995 and 2013 that investigate the experiences and opinions of patients and their families in emergency departments (EDs), and the provision of care during resuscitation and aftercare in EDs.</td>
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<td>Exclusion criteria</td>
<td>Studies undertaken outside EDs or published before 1995.</td>
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<tr>
<td>Subject of studies</td>
<td>Twenty six relevant articles were retrieved. Of these:</td>
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<td></td>
<td>■ Twelve concern family presence during resuscitation in EDs.</td>
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<td>■ One concerns family presence during resuscitation of a child.</td>
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<td></td>
<td>■ Four concern care of families in EDs.</td>
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<td>■ Nine concern aftercare, mainly bereavement care, in EDs.</td>
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<td>Type of studies</td>
<td>Twenty two articles involve quantitative research. Of these:</td>
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<td>■ Fifteen are based on written questionnaires.</td>
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<td>■ Four are based on telephone interviews.</td>
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<td>■ One is based on a face-to-face questionnaire.</td>
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<td>■ One is based on a face-to-face audit.</td>
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<td>■ One is based on a pre- and post-survey questionnaire on implementation of a family-presence programme.</td>
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<td></td>
<td>Four articles involve qualitative research. Of these:</td>
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<td>■ Three are based on semi-structured interviews.</td>
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<td>■ One is based on observations.</td>
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<td>Location of studies</td>
<td>Australia (n=3), Belgium (n=1), Hong Kong (n=2), Singapore (n=1), Spain (n=1), Turkey (n=1), UK (n=11) and United States (n=5). The remaining article compares practice in the UK and Iceland.</td>
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Various authors have found that family members who have witnessed resuscitation attempts experience psychological trauma (Redley and Hood 1996, Mitchell and Lynch 1997, Booth et al 2004, Ong et al 2004, Yanturali et al 2005, Mian et al 2007), although other authors reject this (Robinson et al 1998, Meyers et al 2000). Robinson et al (1998), for example, report no adverse psychological effects among such family members, although their study involved only eight relatives.

Ong et al (2004) found that families who have witnessed resuscitation attempts are more likely than others to appreciate that everything possible has been done for their loved ones, while Meyers et al (2000) suggest that such families can better understand their loved ones’ conditions and are better able to cope with the failure of resuscitation attempts.

**Views on family-witnessed resuscitation** According to Meyers et al (2000), most families agree with witnessed resuscitation and those who have experienced it would do so again. Of 135 family members who had lost loved ones, 108 (80 per cent) would have liked to have been present during resuscitation had the option been available, while 132 (98 per cent) think they have a right to be present on such occasions.

Earlier work by Meyers et al (1998), in which the opinions of 25 family members were recorded, produced similar results. Twenty four (96 per cent) families said they have a right to be present during attempts to resuscitate their loved ones, 20 (80 per cent) would have liked to have been present had the option been available, 17 (68 per cent) think their loved ones would have wanted them to have been present and 16 (64 per cent) think it would have helped their grieving process.

**Views on aftercare** In an audit involving 483 family members in the UK, Parris et al (2007) reported that 362 (75 per cent) want medical terms used on death certificates explained to them and 68 (14 per cent) want the circumstances of death explained. If possible, such information should be written because families are often too shocked to absorb verbal information after the sudden death of loved ones (Li et al 2002).

**Staff**

**Roles** In a survey of 54 ENs in three EDs in Glasgow, Hallgrimsdottir (2000) found that 52 (96 per cent) believe that caring for families is part of their role but only 19 (35 per cent) think their practice is evidence based. In a later study, which compares nursing in Iceland and the UK, Hallgrimsdottir (2004) found that nurses in Iceland spend more of their time caring for families than those in Scotland.

Emergency nurses in a UK-based study by Byrne and Heyman (1997) failed to identify ‘caring for families’ as part of their roles and said their priority is to deal with physical, rather than psychological, aspects of care. They attributed this preference to a lack of time, perpetual interruptions and a constant awareness of their need to undertake other tasks. They therefore regarded holistic care as impossible to achieve. Meanwhile, Wiman and Wikblad (2004) found that ENs engage in 61 ‘negative aspects’ of caring, including disinterest, insensitivity, coldness and inhumanity, but only 36 ‘positive aspects’, including openness, concern for patients, moral responsibility, dedication and courage.

Ekwall et al (2009) found that, of 128 family members who had accompanied patients to EDs, 86 (67 per cent) were satisfied with the service they witnessed or received. This report has limited validity, however, because it excludes the families of patients who arrived at EDs by ambulance.

**Views** Professional opinion on family presence during resuscitation attempts tends to differ, with nurses being more in favour of the practice than doctors (Mitchell and Lynch 1997, Helmer et al 2000, Meyers et al 2000, Yanturali et al 2005, Mian et al 2007). Mitchell and Lynch (1997) found that, of 81 nurses surveyed, 73 (90 per cent) are in favour of family presence. The researchers also found that the practice is more likely to be accepted by senior doctors than by junior staff.

Hallgrimsdottir (2004), who compares opinions on witnessed resuscitation held by 58 nurses in Iceland with those held by 56 nurses in Scotland, reveals that 23 (40 per cent) Icelandic nurses but only five (9 per cent) UK nurses agree with the practice. The figure for the UK is surprising given that, of 161 UK EDs surveyed, 127 (79 per cent) allow families to be present during resuscitation attempts (Booth et al 2004).

Similarly, Redley and Hood (1996) found that, of 132 ED staff in the UK, 90 (68 per cent) have experienced family presence during resuscitation, 19 (14 per cent) agree that families should be invited into resuscitation rooms, 82 (62 per cent) would agree to it but only at predetermined times and under controlled circumstances, and 15 (11 per cent) think families should never be invited into resuscitation rooms. Meanwhile, in a study of opinions among 53 doctors and 79 nurses in Singapore,
Ong et al (2004) found that 42 (80 per cent) doctors and 62 (78 per cent) nurses are opposed to family-witnessed resuscitation. Sacchetti et al (2000) and Yanturali et al (2005) suggest that ENs who have experience of families being present during paediatric resuscitation attempts are more likely to favour the practice. However, Hallgrimsdottir (2000) notes that, although 21 (39 per cent) of 54 ENs in Glasgow surveyed have experienced family presence during resuscitation, only seven (15 per cent) of them agree with the practice.

Mian et al (2007) undertook a study of the views of ED staff before and after implementation of a family presence programme. They found that, after the programme had been implemented, the number of staff who believe that families benefit from the programme had increased, but that the number who support the practice had decreased.

The main reason healthcare professionals oppose the presence of family-witnessed resuscitations is a fear that families would interrupt the procedure (Redley and Hood 1996, Mitchell and Lynch 1997, Ong et al 2004). Redley and Hood (1996), and Ong et al (2004), suggest that ED staff are worried that their behaviour during resuscitation attempts may be viewed by families as offensive. In addition, there are concerns among staff that some family members could become verbally or physically abusive during resuscitation attempts (Yanturali et al 2005) and that their presence during failed attempts increases the risk of legal repercussions (Helmer et al 2000, Ong et al 2004, Yanturali et al 2005).

**Effects of family presence** Many authors have found that family presence can increase staff stress levels, a potential reason for their opposition to the practice (Redley and Hood 1996, Mitchell and Lynch 1997, Helmer et al 2000, Ong et al 2004, Yanturali et al 2005). In this context, Mian et al (2007) found that psychological distress among physicians is greater than that among nurses during attempts to resuscitate patients.

Dealing with distressed family members in EDs can be traumatic for emergency staff. All participants in a study by Socorro et al (2001) reported that caring for bereaved families has a major emotional effect on them and, of 54 Icelandic ENs surveyed by Hallgrimsdottir (2000), 43 (80 per cent) said that caring for bereaved families is the most difficult aspect of their job, 39 (72 per cent) said that they find such care distressing and 26 (48 per cent) said they need emotional support after providing it.

Several studies report that the presence of families becomes particularly problematic when practitioners must decide when to stop their resuscitation attempts, with Yanturali et al (2005) identifying this as the third main reason for staff to oppose family presence. In a survey of opinion among 82 ED staff members, for example, 56 (68 per cent) said that the decision to cease resuscitation becomes more difficult to make when relatives are present (Mitchell and Lynch 1997).

The presence of families can result in more aggressive resuscitation efforts and thereby increase nurses' workload (Meyers et al 2000). However, such families are more likely to be reassured that everything possible has been done to resuscitate their loved ones and are therefore less likely to require explanations about the process (Flam 1999, Li et al 2002), which could reduce nurses' workload.

Most ENs acknowledge that they can struggle to cope with emotionally intense sudden-death situations (Saines 1997) yet, in Tye's (1996) study of 30 ENs, 17 (56 per cent) said they are unsupported at work after patients die suddenly. In such situations, some ENs rely on work colleagues or family members for support, but most prefer debriefing sessions with colleagues (Saines 1997, Flam 1999, Hallgrimsdottir 2000).

**Family-centred care**

**Obstacles to provision** Attempts to provide holistic, family-centred care can be hindered by a variety of obstacles (Flam 1999). According to Hallgrimsdottir (2000), most ENs in the UK say that staff shortages are the main obstacle to providing adequate care to families. Flam (1999) adds that ENs are precluded by their heavy workloads from accompanying doctors who break bad news to relatives after resuscitation attempts have failed.

Saines (1997), meanwhile, found that the suddenness of patient admission and resuscitation, combined with an inability to establish a prior rapport with families, left ENs no time to prepare for associated problems, which in turn hindered their ability to provide high quality care.

**Role of education** Healthcare professionals' education and experience appears to determine their competence in meeting families' needs, and several authors report that ENs feel inadequately educated in this area (Tye 1996, Flam 1999, Hallgrimsdottir 2000, 2004, Socorro et al 2001).

Flam (1999), for example, discovered that neither nurses nor physicians had been taught during their basic training how to notify people of bad news. Meanwhile, Hallgrimsdottir (2004) found that only
eight (14 per cent) of 58 nurses in Iceland and 32 (57 per cent) of 56 nurses in Scotland had been offered bereavement training in their workplaces.

However, in a study of the value of a short training programme in bereavement care to 30 UK-based ENs, Tye (1996) found that 18 (60 per cent) had previously received some education on the subject during their pre-registration courses. Twenty seven (90 per cent) of the ENs said that their anxiety about death and dying was less after they had completed the programme and 14 (47 per cent) found the programme helpful.

According to Saines (1997), meanwhile, ENs in sudden-death situations, tend to attribute increases in their knowledge and skills to improvements in their professional practice.

Role of hospital guidelines Of the 54 ENs in Hallgrimsdottir’s (2000) study, 38 (71 per cent) think that hospitals require clear policies on family-witnessed resuscitation and that staff should always be prepared to support families.

In a later study of 58 ENs in Iceland and 56 ENs in the UK, the same author found that 83 (73 per cent) nurses from both groups think that hospitals should develop such policies, but that only nine (16 per cent) of the Iceland-based ENs and 24 (43 per cent) Scotland-based ENs rely on guidelines on caring for families in EDs (Hallgrimsdottir 2004).

Limitations There are a number of limitations to the studies discussed in this article. Although more than half of them achieved Bowling’s (2002) recommended response rate of 75 per cent, those by Meyers et al. (1998), Flam (1999), Hallgrimsdottir (2000, 2004), Helmer et al. (2000) and Parris et al. (2007) did not. Byrne and Heyman (1997), Saines (1997), Robinson et al. (1998), Meyers et al. (2000), Booth et al. (2004) and Albarran et al. (2009) failed to report the response rate to their studies.

Another limitation is the poor sampling methods adopted by some authors. Studies by Tye (1996), Byrne and Heyman (1997), Saines (1997), Robinson et al. (1998), Meyers et al. (1998), Socorro et al. (2001) and Wiman and Wikblad (2004), for example, are based on fewer than 30 participants, which means their findings cannot be easily generalised. Other studies, such as those by Redley and Hood (1996), Mitchell and Lynch (1997), Sacchetti et al. (2000), Booth et al. (2004) and Albarran et al. (2009), do not describe their sample populations accurately and so the exact numbers of populations in various sub-groups are difficult to ascertain.


References


can result in significant bias and errors if the samples are unrepresentative of target populations (Gerrish and Lacey 2010, Byrne and Heyman 1997, and Ekwall et al 2009), provide no accurate descriptions of the sampling methods used, which raises questions about the rigor, reliability and validity of their studies.

Meanwhile, studies by Mitchell and Lynch (1997), and Wiman and Wikblad (2004), lack anonymity and so could produce biased results. The risk of bias in Mitchell and Lynch’s (1997) study of opinions among doctors and nurses is increased, moreover, because the authors sampled 71 doctors but only ten nurses.


Finally, several studies were limited by data analysis. Redley and Hood (1996) provide no breakdown of responses among nurses and doctors, for example, and do not distinguish between the six hospitals they surveyed. Similarly, Sacchetti et al (2000) combined staff into a single group to provide results statistics and they offer no details about their test statistics.

These points raise questions about the quality and robustness of the studies’ results, and indicate that their results cannot be easily generalised.

Conclusion

Although the concept of family-centred care is emphasised in the literature on children’s nursing, the authors’ review suggests that it is rarely discussed in the literature on EDs.

Although there is a great deal of evidence on families’ needs and preferences during resuscitation, there is a conflict of opinion and disparity of views about the practice among healthcare professionals. Although fear is a major contributing factor to staff opposition to family-witnessed resuscitation, chaotic workloads, time restraints, education and coping abilities also affect its delivery in EDs.

Pressures on EDs are likely to escalate and staff may have to change their practice to overcome the obstacles to care outlined in this article. Meanwhile, hospital managers must equip staff with the skills and knowledge they need to deliver this aspect of practice, and must attempt to create an organisational culture in which holistic family-centred care is valued. Although several studies make similar recommendations, they appear to have gone unheeded in EDs. Appropriate guidance through hospital policies, educational programmes, follow-up programmes for families and improved support mechanisms for emergency care staff may help transform this area of practice.


