Role of the family support person during resuscitation


Summary
This article discusses family witnessed resuscitation and describes the need for a healthcare professional to be available to support the family before and during this experience. Careful explanation and emotional support are required during the event and if cardiopulmonary resuscitation is unsuccessful, further explanation and support will be required. A family support person is usually a nurse but could also be a hospital chaplain or social worker. The chaplain’s background and ability to interpret medical information, combined with the emotional and spiritual support he or she can offer, make the chaplain suitable for this role. However, for some patients and families a chaplain’s involvement might not be appropriate. The authors suggest that further research and evidence-based guidance should be developed to maximise the benefits of a family support person’s presence during witnessed resuscitation.

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Advantages and disadvantages

Advantages
There is a growing body of evidence that indicates the strengths of family witnessed resuscitation. Evidence suggests that, in cases where the resuscitation attempt was unsuccessful, most family members felt that witnessing this event was beneficial in coming to...
terms with their loss (Bassler 1999). Additional benefits for the family have been reported (Twibell et al 2008a), including the knowledge that all attempts to resuscitate had been carried out and that witnessing this helps family members receive prompt information.

The incidence of post-traumatic stress disorder in those witnessing resuscitation has been found to be lower than in those not attending (Robinson et al 1998). Finally, in the event of an unfavourable outcome, witnessing resuscitation can enable closure to begin by instigating the grieving process (MacLean et al 2003, Booth et al 2004, Baskett et al 2005).

Disadvantages Baskett et al (2005) highlighted the importance of ensuring family members are aware they have a choice about whether or not they wish to attend the resuscitation of their loved-one. Possible limitations of family presence during witnessed resuscitation continue to be raised. Those choosing to witness the procedure might find the experience upsetting and not what they had expected (Meyers et al 2004), therefore preparation is key to the supportive process.

Members of resuscitation teams have expressed concern that family members may interfere with the resuscitation process (Fullbrook et al 2005). While evidence suggests that this is unlikely, it is important to ensure that family members are assessed throughout to ensure prompt action is taken to safeguard patients should it be necessary (Farah et al 2007). Concerns have been raised that the presence of families can inhibit staff performance (McClenathan et al 2002), may cause increased anxiety in the resuscitation team and could possibly lead to litigation involving the healthcare professional (Boyd 2000, Hallgrimsdottri 2000, MacLean et al 2003, Blundell et al 2004, Fullbrook et al 2005).

Health and safety issues also require consideration. McClenathan et al (2002) reported rare instances in which family members fainted and had to be resuscitated themselves. Vigilance and support are needed to avoid this happening. Defibrillation and the use of sharp instruments during the resuscitation process can pose a danger to family members observing such events, so risk management and safety precautions must be taken.

Ensuring a good and safe experience

To support family members during resuscitation there is general agreement that an individual who is not part of the resuscitation team is present (Baskett et al 2005, Farah et al 2007). In this article the term family support person is used to describe this individual (Farah et al 2007), however other terms, such as family facilitator and chaperone, have also been used to describe the role (Cottle and James 2007, Twibell et al 2008b). To enable family members who do not speak English to understand fully family witnessed resuscitation, all possible steps should be taken to obtain the services of an interpreter, even though timely access might be difficult because of the urgent nature of the situation.

The role of the family support person is pivotal in providing optimal supportive care to people witnessing the resuscitation of a family member. Guidance on what this role may entail is emerging (Farah et al 2007). European Resuscitation Council guidelines highlighted the need for families’ presence to be managed in such a way that “…the experience of the relative is the best under the circumstances” (Baskett et al 2005). It is suggested that providing a family support person will ease the process.

Preparation of family members before entering the resuscitation room is vital (Farah et al 2007, RCUK 2007). It is imperative that clear ground rules are set to ensure that the presence of family members does not affect the resuscitation attempt (Farah et al 2007). Family members need to receive information on the events they are likely to witness, and an explanation about invasive interventions and the physical effects that these can have on their relative. It is also important to make it clear that the person being resuscitated may or may not be able to hear them and that he or she is likely to be unresponsive (Hanson and Strawser 1992).

Encouraging family members to touch and talk to the patient and being able to provide comfort are also important facets of this role (Hanson and Strawser 1992, Manias and Street 2000).

Guzzetta and Ratner (2006) advocate that the family support person should encourage family members to position themselves either at the top or bottom end of the bed to make physical contact easier. If the situation becomes overwhelming or those witnessing feel faint, then the family support person can assist in escorting family members from the room (Hanson and Strawser 1992). It is important that this allocated person remains with family members throughout the process (Twibell et al 2008b).

Decisions to end a resuscitation attempt will need to be dealt with in a sensitive manner, ideally involving family members and the resuscitation team (RCN 2002). Some family members might have difficulty coming to terms
with this decision and the family support person plays a particularly important role at this time.

A decision to abandon the resuscitation attempt should be fully explained in conjunction with guidance on what is likely to follow (Baskett et al 2005). As the family support person is likely to have been with the family member throughout the resuscitation attempt, he or she is ideally placed to be part of this process. The family support person might also contribute to the debriefing and support of the resuscitation team.

**The nurse as family support person**

Most of the literature recommends that a nurse undertakes the role of the family support person during family witnessed resuscitation and, in practice, nurses appear to be the healthcare professionals most likely to undertake this role (RCN 2002, Baskett et al 2005, Twibell et al 2008b). Knowledge of the procedures associated with resuscitation and availability to assist in this process suggest that nurses are an appropriate choice to provide information and support to family members during such events. Although this knowledge base has advantages, there can be difficulties in separating this role from the resuscitation attempt (Hallgrimsdottir 2000, Newton 2002).

On a practical level, insufficient staff numbers can mean that it is unrealistic for a nurse to undertake the role of family support person (Albarran and Stafford 1999). This could be addressed by using an on-call service to provide support (Twibell et al 2008b).

The spiritual aspect of clinical nursing practice is not always developed owing to a lack of time (Aldridge 2006), and a similar problem can arise among nurses working in family support person roles. Furthermore, lack of confidence in dealing with spiritual care may hinder nurses in providing effective support during resuscitation (Sutton P, Chaplaincy and Patient Affairs Manager, Royal United Hospital, Bath, 2005, personal communication). The role of the family support person could be developed through greater emphasis on its potential in pre and post-registration nurse education.

The emotional impact of the role on nurses also requires consideration. Ellison (2003) found that 70% of nurses felt unable to deal with the needs of family members who witnessed resuscitation. This was because of the nurses’ own emotional needs and other clinical duties.

**The chaplain as family support person**

In the US, hospital chaplains have taken on the role of family support person (Hanson and Strawser 1992, Meyers et al 2000, Sanford 2002, Guzzetta and Ratner 2006, Twibell et al 2008b). In the UK there appears to be limited evidence of chaplains performing the role (Cottle and James 2007).

Providing support to patients, families and healthcare professionals during times of emotional trauma continues to be a fundamental element of a chaplain’s work (Coffey and Curd 2000). These experiences can equip chaplains to develop expertise in the specific clinical event of family witnessed resuscitation. Their experience in providing professional support during critical incidents has been reported as being valued (Grosvenor 2005, Aldridge 2006), and this experience and expertise means they are well placed to provide greater support to family and team members. However, it is important that the chaplain understands and has had experience of this process to contribute effectively.

The role of the chaplain as family support person might differ to that of the nurse. This is because the chaplain’s unique experiences and expertise can enable a more spiritual dimension, for example by enabling feelings and emotions to be shown in a therapeutic way (Coffey and Curd 2000). Aldridge (2006) discusses the ‘bilingual’ abilities of the chaplain in understanding professional language used by other healthcare professionals and translating it for families and patients. Therefore, ‘for families confused by hearing too many voices giving conflicting information’ (Aldridge 2006), such as during a cardiac arrest, a chaplain’s presence can be invaluable.

A further advantage of chaplains undertaking this role can be the support they can give the resuscitation team. Their experience of providing support during critical incidents further equips them to provide an attentive and reassuring debrief after the event (Sutton P, Chaplaincy and Patient Affairs Manager, Royal United Hospital, Bath, 2005, personal communication). In cases where there might be conflict between the team and family members they are well placed as ‘trained arbitrators’ to resolve such disputes (Coffey and Curd 2000).

Additional differences in the role of family support person can exist following an unsuccessful resuscitation attempt. The European Resuscitation Council (Baskett et al 2005) has indicated it is important that family members have the opportunity to review their experience of witnessing a resuscitation attempt and, if necessary, be given advice and guidance about registering the death of a loved one. Nurses have constraints on their time that prevent prolonged family support (Grosvenor 2005). In contrast, chaplains might feel able to stay with the family until they leave the hospital (Coffey and Curd 2000).
2000). Chaplains might also be able to provide subsequent pastoral care including assisting with funeral arrangements (Hanson and Strawser 1992).

While some chaplains might have medical knowledge, this is not always the case. If chaplains are to fulfil the role of family support person during family witnessed resuscitation some medical knowledge is essential (Hanson and Strawser 1992). The DH (2003) has advocated that opportunities for professional development and finances are made available to chaplains. Development should include specific training and support.

A further issue that needs to be considered is that chaplains are generally unavailable out of hours, except through an on-call service (Sutton 2003). Chaplains are to fulfil the role of family support unless working patterns change it is likely that the chaplain’s role will be limited to office hours.

The appropriateness of the presence of a religious figure such as the hospital chaplain — whose role is to serve people of all faiths and those of no faith — will need to be considered carefully for some families. The chaplain’s role is developing to meet the spiritual, but increasingly less religious, needs of patients and families (Wright 2001). Dykstra (1990) has indicated that a person’s ‘religious history’ might be unknown and as a result some family members may be reluctant to allow a chaplain to be present at this time. It is therefore imperative that the patient’s or the family’s choice is respected in this matter.

References


Further education and research

The family support person’s role during family witnessed resuscitation attempts appears to be valuable. However, few studies have been conducted into the role, and its potential needs to be investigated further (Halm 2005). Research that considers this specific role from the perspective of family members, the resuscitation team and those providing this role is needed. Comparisons of how the role is performed by differing professionals such as nurses and hospital chaplains are also required.

The European Resuscitation Council has highlighted the need for the family support worker to be trained for the role (Baskett et al 2005), therefore training programmes need to be developed and evaluated. Adopting a multidisciplinary approach to this enables experiences to be shared and helpful strategies to be developed. Hospital chaplains who undertake this role can provide valuable insights to nurses about how this role can be developed in the future.

Conclusion

The role of the family support person is important during the resuscitation process. This role can be undertaken by nurses or chaplains and there are advantages and disadvantages to both. Nurses’ clinical knowledge and experiences of resuscitation are valuable and they are available to offer support 24 hours a day, but their time is often limited. Chaplains are able to provide families with spiritual support and practical help, such as advice on funeral procedures, but might not be available out of hours and might not be appropriate for some families. More research should be undertaken and more guidance developed to maximise the benefits of the family support person’s presence during family witnessed resuscitation. 

References


