Abstract

Cardiac arrest is a traumatic event, both for patients and their family members. Traditionally, healthcare professionals have often been reluctant to offer family members the opportunity to witness cardiopulmonary resuscitation (CPR) attempts. However, professional bodies globally have begun to recommend the use of family-witnessed resuscitation (FWR) during CPR, identifying a range of potential benefits including supporting the patient, increasing family members’ confidence in healthcare professionals and, in some cases, promoting acceptance of the patient’s death.

This article explores the benefits of, and barriers to, the implementation of FWR during CPR. Despite the perceived benefits of FWR identified by professional bodies, healthcare professionals, and patients and their families, the evidence indicates there is ongoing reluctance among some healthcare professionals to incorporate FWR in practice. Therefore, standardised global policies aimed at the multidisciplinary implementation of FWR are required. Additionally, multidisciplinary training and education in CPR should be readily available, particularly in areas where CPR is frequently used, such as emergency departments.

Why you should read this article:

- To understand the ongoing debate about incorporating family-witnessed resuscitation (FWR) in practice
- To recognise the benefits of, and barriers to, implementing FWR during cardiopulmonary resuscitation
- To understand how multidisciplinary collaboration at an educational level, both nationally and globally, could lead to standardisation in FWR policies and guidance, which in turn could enhance family and person-centred care

Exploring the implementation of family-witnessed resuscitation

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Citation


Peer review

This article has been subject to external double-blind peer review and checked for plagiarism using automated software

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Conflict of interest

None declared

Accepted

16 January 2018

Cardiac arrest is a challenging and potentially traumatic clinical situation for family members (‘family’ refers to anyone the patient considers significant, whether they are an actual family member or not) and healthcare professionals, and it is not uncommon for healthcare professionals to experience physiological and psychological stress following a cardiopulmonary resuscitation (CPR) attempt (Gamble 2001, Davies and Perkins 2013, American Association of Critical Care Nurses (AACCN) 2016). CPR can also result in significant physical trauma for the patient; for example, one in five resuscitation attempts result in sternal fractures (Kottachchi et al 2009), while lung contusions (bruising) and lacerations to the liver have also been known to occur (Kaldirim et al 2016).

The potentially traumatic nature of CPR has meant that, traditionally, healthcare professionals have been reluctant to offer family members the opportunity to witness the procedure, with concerns including the potential psychological trauma experienced by family members and the presence of family members distracting the clinical team (McClenathan et al 2002). However, in their seminal nine-year study of family members who expressed a desire to accompany their relatives during an episode of CPR, Hanson and Strawser (1992) found that families benefited from being present, for example by finding comfort in witnessing the treatment their relative received from healthcare professionals.

There is a consensus among professional organisations that family-witnessed resuscitation (FWR) is a positive intervention. The European Resuscitation Council guidelines (Bossaert et al 2015) recommend that family members should be offered the opportunity to be present during resuscitation attempts, while the Resuscitation Council (UK) (RCUK) (2016) guidelines
recommend that parents should be permitted to witness attempts to resuscitate their children.

Boehm (2008) described the healthcare professional’s presence during a person’s final moments as a privilege, which should be shared with family members rather than viewed as a complication in the healthcare environment. This article explores the available evidence on FWR and considers the benefits of, and barriers to, its implementation. It also considers the guidance available for healthcare professionals, including nurses, and examines future recommendations for practice.

**Existing policies and guidance**

Since Hanson and Strawser’s (1992) seminal nine-year study, family presence during resuscitation has been widely debated, with several policies and procedures being developed in an attempt to standardise practice in this area. The European Resuscitation Council guidelines (Bossaert et al 2015) recommend that relatives be provided with the opportunity to be present during CPR. Professional bodies in the UK, US and Australia also recommend that families and patients be provided with the option of FWR (Australian Resuscitation Council 2006, Emergency Nurses Association 2014, AACCN 2016, RCUK 2016). However, the level of influence these guidelines have in practice is unclear; similarly, it is not understood whether they are sufficient to ensure patients and their families are always presented with the option of FWR (Chapman et al 2014, Porter et al 2014, 2015).

The World Health Organization (WHO) (2003) investigated resuscitation in a surgical setting, focusing on family inclusion in obtaining consent for invasive procedures and the importance of considering cultural factors during communication. For example, when discussing challenging subjects, some cultures regard the use of eye contact as respectful, while in other cultures eye contact may be seen as aggressive (WHO 2003). The WHO (2012, 2016) subsequently developed additional policies on neonatal resuscitation; however, these did not specifically recommend FWR. In the absence of organisations globally providing specific FWR policies and guidelines, the standardisation of FWR in practice could prove challenging (Meyers et al 2000).

In the UK, the Nursing and Midwifery Council (NMC) (2014, 2015) stated that nurses must be competent in providing holistic care, which respects individual choice and works in partnership with patients and their families; however, the actions taken in specific scenarios such as FWR are not clearly defined, which could lead to ambiguity in education and training. Alternatively, it could be suggested that specific scenarios such as FWR can only be guided at a local level and are dependent on setting; for example, FWR guidance in a hospital emergency department might vary from that provided in the community (Chapman et al 2014, Porter et al 2014, 2015).

**Benefits of implementing family-witnessed resuscitation**

**Managing trauma**

FWR can assist families with the grieving process, particularly with the acceptance of their relative’s death, while it can support them psychologically to manage such a potentially traumatic event (Meyers et al 1998, Jabre et al 2013). Evidence has identified that family members who were given the opportunity to be involved in witnessing CPR were less likely to experience symptoms of post-traumatic stress disorder than those not offered the opportunity to be present (Jabre et al 2013). To maximise any benefits of FWR, and to assist family members in managing a potentially traumatic experience, one healthcare professional should be designated to provide emotional support to the family during the event (Porter et al 2014, 2015, Dwyer and Friel 2016).

**Providing choice and person-centred care**

There are several reasons why family members may choose to be involved in FWR, including (De Stefano et al 2016):

- To be actively involved in the resuscitation process.
- To support the patient during CPR.
- To witness the efforts of the resuscitation team; for example, understanding the resuscitation process can assist some relatives to accept the death of a family member.

Patients who have survived a cardiac arrest have attested that FWR provided comfort and might have enabled their family members to experience a sense of closure, had the CPR attempt been unsuccessful (Duran et al 2007, Bashyreh and Saifan 2015, Dwyer 2015). Patients may also benefit when family members are offered the opportunity to perform an advocacy role during FWR, giving the patient a voice during what can be a traumatic experience that is dominated by healthcare professionals and clinical interventions.
Person-centred care can be promoted by identifying one healthcare professional in any clinical area who can support family members during CPR (Porter et al 2014).

Patients can experience an increased sense of companionship with their family during FWR (Mcmahon-Parkes et al 2009). From a cultural perspective, some Muslim family members prefer to take part in FWR so that they can witness their relative entering the ‘next life’ (Al-Mutair et al 2012). Importantly, FWR can also assist healthcare professionals to become ‘emotionally aware’ of the patient undergoing CPR, which means that the resuscitation attempt becomes focused on saving the life of an individual, rather than simply undertaking a clinical procedure (Meyers et al 2000, Eichhorn et al 2001).

Improved understanding of treatment
Being present during a CPR attempt can reduce family members’ anxieties about what is happening to their relative, as well as enabling them to communicate important clinical information about the patient’s condition (AACCN 2016). Chapman et al (2014) detailed the benefit of enabling family members to provide relevant information about the patient’s medical history during FWR, which could inform treatment decisions. Similarly, providing families with the opportunity to witness a resuscitation attempt can improve their understanding of the intervention (Madden and Condon 2007, Porter et al 2015, Dwyer and Friel 2016).

Involving patients and relatives in the planning and implementation of FWR also enables them to be immediately informed of any resuscitation attempt and have access to the required information (Meyers et al 2000, Eichhorn et al 2001, Mcmahon-Parkes et al 2009). In addition, healthcare professionals should recognise that any resuscitation attempt will have repercussions for all those involved with the patient, not merely the patient themselves (Wagner 2004, Barreto et al 2017).

Barriers to implementing family-witnessed resuscitation

Differing views between healthcare professionals
There are varying opinions across professional disciplines on the use of FWR and the need for shared decision-making between multidisciplinary teams during CPR attempts (Meyers et al 2000, Madden and Condon 2007, Mian et al 2007). For example, there are disparities between healthcare professionals’ views of FWR, with nurses appearing more supportive of the intervention than doctors (Duran et al 2007, Oman and Duran 2010, Dwyer and Friel 2016). Additionally, there are conflicting views within the medical profession about the appropriateness of FWR, with concerns regarding safety, the emotional effects on family members, and the potential for staff to be inhibited by being observed (Meyers et al 2000, Duran et al 2007).

Multidisciplinary collaboration is vital during CPR, and the response to any cardiac arrest should be coordinated by a designated team leader. Clear policies and guidance are required to reduce and ultimately eliminate potential conflicts within resuscitation teams and to promote safe practice. It is important that decision-making about FWR is shared between healthcare professionals of varying disciplines, as opposed to being led exclusively by the medical team (Madden and Condon 2007, Dwyer and Friel 2016).

Healthcare professionals have concerns about family members potentially interfering in the process of FWR and the disruption that could result (Mian et al 2007, Chapman et al 2014). Researchers have also outlined the necessity for family members to be assessed to determine their ability to manage emotions such as grief before being offered the opportunity to attend FWR, thus potentially eliminating any disruption to the process (Meyers et al 2000, Chapman et al 2014).

While research demonstrates that some patients recognise that the presence of family members during CPR may aid decision-making, others felt that conflicting opinions could arise, potentially causing a dilemma for healthcare professionals between family-centred care, which should consider the experience of the relatives of those undergoing CPR, and person-centred care (Smith and Taylor 2010, McCormack and McCance 2011).

Patient and family trauma
FWR has the potential to be traumatic and stressful, particularly for family members who witness the event, with research identifying a link between FWR and negative psychological outcomes, including anxiety, depression and post-traumatic stress disorder (Eichhorn et al 2001, Compton et al 2009, Jabre et al 2013).

Concerns raised by healthcare professionals about FWR included increased stress levels and psychological trauma for family members, as well as issues relating to dignity, personal privacy and the provision of adequately trained staff to assist relatives with the emotional trauma of witnessing CPR (Newton 2002, Chapman et al 2014). Furthermore, research has found that relatives believe FWR should only be offered to ‘emotionally stable’ family members (Meyers et al 2000, Bashayreh and Saifan 2015).

Bashayreh and Saifan (2015) found that relatives believed only immediate family should be offered the opportunity to witness CPR; however, attempting to identify immediate family could be challenging for healthcare professionals, with potential complications related to family disputes or blended families. It is also important for healthcare professionals to remember that while support is often available for healthcare professionals who may experience CPR frequently, family members who witness a single cardiac arrest can experience long-term traumatic memories of the event (Leadership Alliance for the Care of Dying People 2014).

Lack of education and training
Training is a vital component of FWR provision; however,
some healthcare professionals involved may not have received any formal FWR training, while others may be unfamiliar with FWR policies (Chapman et al 2014, Porter et al 2014, 2015). This is a common challenge in suboptimal organisational cultures, where inadequate training, and suboptimal staff recruitment and retention can affect the efficacy of FWR (Maddock 2002, Sun 2008, Manley et al 2011, McCance et al 2013).

After a CPR attempt, both with or without the presence of family members, clear guidance for healthcare professionals is essential. This enhances the confidence of healthcare professionals in situations such as FWR, where they may experience feelings of vulnerability with regards to their competence (Porter et al 2014, Bray et al 2016, Bull 2016). It is also important to consider healthcare professionals’ previous experience of FWR, because positive experiences can result in improved self-confidence (Meyers et al 2000, Chapman et al 2014).

Studies assessing relatives’ perspectives on FWR concluded that further training or guidelines are required to increase public awareness of FWR and enable family-centred care (Wagner 2004, Boehm 2008, Compton et al 2009). Similarly, health education is required to improve the public’s knowledge of CPR and invasive procedures, which would, in turn, inform family members and support timely decision-making during resuscitation attempts (Boyd 2000, Dwyer 2015). According to Bashayreh and Saifan (2015), family members can be uncertain about their rights and are often unsure whether to ask healthcare professionals if they can be present during CPR.

Cultural issues
Cultural differences can negatively affect the provision of FWR, with standardised FWR guidance required to improve the quality of FWR globally (Parial et al 2016). Al-Mutair et al (2012) demonstrated the importance of culturally sensitive guidelines by assessing FWR practice in Saudi Arabia, which outlined the range of potential views of FWR. For example, some Muslim families considered FWR to be ‘unhealthy’ (Al-Mutair et al 2012). Another study conducted in the Philippines detailed the lack of culturally sensitive policies and guidelines globally, resulting in families simply following the requests made by healthcare professionals to leave the bedside during a resuscitation attempt (Parial et al 2016). Therefore, it is important for healthcare professionals to consider patients’ and families’ cultural and religious beliefs when discussing the option of FWR, and this should be embedded in policies and guidelines as standard practice.

Considerations for future practice

Standardised guidance
Despite the perceived benefits of FWR outlined by professional bodies, healthcare professionals, and patients and their families, a reluctance to use FWR in practice remains (Madden and Condon 2007, Mian et al 2007, Chapman et al 2014). While FWR is recommended by professional bodies such as the Emergency Nurses Association (2014), AACN (2016) and RCUK (2016), standardised culturally sensitive global policies are required to guide healthcare professionals’ practice (Meyers et al 2000).

Standardised FWR policies would enable national bodies in individual countries to formulate supplementary guidance, which could incorporate the cultural needs of local populations (Al-Mutair et al 2012, Bashayreh and Saifan 2015, Parial et al 2016). Policy standardisation could also provide clarity and confidence for healthcare professionals during cardiac arrest (Oman and Duran 2010, Doolin et al 2011, Dwyer and Friel 2016). However, providing standardised culturally sensitive policies globally could prove challenging because of cultural diversity. Alternatively, exemplary leadership through innovation and education could be used to model a shared vision of FWR (Kouzes and Posner 2012).

While there is widespread support for FWR globally (Australian Resuscitation Council 2006, Bossaert et al 2015, RCUK 2016), it is important to develop standardised culturally sensitive global guidelines to further guide healthcare professionals in the provision of FWR (Al-Mutair et al 2012, Bashayreh and Saifan 2015, Parial et al 2016).

Assessment
Research indicates that offers to witness CPR should be extended to family members following comprehensive assessment, including relatives’ emotional stability (Meyers et al 2000, Chapman et al 2014, Bashayreh and Saifan 2015). However, healthcare professionals could be placed in a challenging position when having to quickly assess relatives’ emotional stability in such a pressurised situation as cardiac arrest (Macy et al 2006, Madden and Condon 2007, Chapman et al 2014). Intuitive expertise is essential when such complex decision-making is required, and intuition allied to clinical knowledge could enable healthcare professionals to develop the confidence to make efficient and appropriate clinical judgements about FWR. This illustrates the need for ‘reason’, which comes from knowledge of FWR policies and guidance, and ‘intuition’, which stems from experience and an extensive understanding of FWR (Benner et al 2009, Bray et al 2016).

Advance care planning
Developing confidence among healthcare professionals is vital to ensure caring conversations with patients can be conducted at the appropriate time, for example by using appropriate communication skills to ascertain patients’ wishes without causing unnecessary distress (Fredriksson and Eriksson 2003, Bray et al 2016). Advance care planning can promote autonomy, although this type of conversation may be challenging to conduct in the event of a sudden cardiac arrest (Smith and Taylor 2010, McCance et al 2011, McCormack and McCance 2011). Advance care planning should be incorporated

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into the admission process, which would enable patients and their families to be educated on the options in relation to FWR (Thomas 2011).

Education and training

Confidence-building and education about FWR, incorporating theoretical learning alongside clinical placements, could become part of undergraduate education programmes for healthcare professionals, enabling students to become confident in facilitating FWR (Meyers et al 2000, Chapman et al 2014, Bray et al 2016). Furthermore, education in FWR could be extended into public health, enabling the general public to become informed of the choices involved (Madden and Condon 2007).

The importance of education, such as clinical supervision following a FWR attempt, in increasing healthcare professional’s confidence has been outlined in the literature, as has the connection between healthcare professionals’ increased self-confidence and training using FWR simulation (Mian et al 2007, Chapman et al 2014, Porter et al 2014, 2015, Bray et al 2016). Multidisciplinary training in FWR should be readily available, especially in areas such as emergency departments, where cardiac arrest and CPR occur frequently (Chapman et al 2014, Bray et al 2016, Dwyer and Friel 2016).

**Recommendations for practice**

The author recommends that the following areas are addressed to enable the practice of FWR to become standardised:

- Any future research should be conducted nationally, to assess standardisation in the implementation of FWR.
- Healthcare professionals’ leadership and confidence in implementing FWR should be improved through the provision of accessible FWR policies and guidelines.
- The use of FWR policies and guidelines should become standard practice in all acute settings to provide a multidisciplinary response to resuscitation events.
- Community care services should incorporate advance care planning, which would provide acute healthcare professionals with immediate access to vital patient information on admission and enable quick and accurate decisions to be made about FWR.
- Further research is required in the medical profession to address significant disparities in doctors’ knowledge of FWR.

**Conclusion**

While there is evidence that family members can benefit from FWR, debate continues about whether they should be routinely permitted to witness CPR. FWR is a multifaceted subject, which requires careful consideration and the evidence demonstrates that many healthcare professionals have been reluctant to implement FWR in practice. However, this article has described the benefits FWR can have for patients and their families, as well as healthcare professionals involved in CPR.

Standardised culturally sensitive policies can provide guidance on the implementation of FWR, and multidisciplinary training in FWR should be readily available in areas such as emergency departments, where cardiac arrest and CPR occur frequently. Multidisciplinary collaboration at an educational level, both nationally and globally, could lead to standardisation in FWR policies and guidance, which in turn would provide increased family and person-centred care.

**References**


