

Witnessing resuscitation

Guidance for nursing staff

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Introduction

There are an estimated 25,000 to 30,000 resuscitation attempts in the UK every year¹. The specialist areas that are most likely to be involved are accident and emergency (A&E) departments and critical care. Dealing with the suddenly bereaved can be difficult for all nursing staff, regardless of their experience². This booklet provides a literature review on witnessing resuscitation and offers guidance to help nursing staff understand the issues and implications for nursing practice.

Background to RCN guidance

A resolution debated and carried at the RCN Congress 2000 called for Council to work with relevant organisations to develop guidelines on witnessing resuscitation, that is, the practice of enabling relatives to stay in the resuscitation room while their loved one is being resuscitated.

The resolution was carried overwhelmingly with the majority of speakers in favour of the concept of allowing relatives into the resuscitation room to witness resuscitation. A few delegates argued that the patient themselves might not like to have their relatives present and also raised the issue of confidentiality. A letter written to the Chair of RCN Council also emphasised that 'choice' was a key factor, and that resuscitation 'would promote trust and confidence of the relatives and public in the staff who care for patients.'

Context

Issues concerning transparency and openness are timely and well made in the current climate following the Bristol Inquiry³ and other inquiries. These reports have considered the retention of organs and tissues following post-mortem examination. The NHS Plan for England⁴ promotes the provision of greater patient choice and states 'patients are the most important people in the health service'. Section 7 highlights that there has been criticism that patients have not been properly involved in decisions about resuscitation. Subsequently, there has been a push to ensure that every hospital in the UK implements a local resuscitation policy based on guidelines published by the British

Medical Association, the Royal College of Nursing and the Resuscitation Council⁵. The changing culture of involving patients in the decision-making process of treatment opens up the possibility of discussing resuscitation and if close relatives should be present.

A letter from a critical care nurse to the Chair of RCN Council commented that "Resuscitation is not just an event that takes place in A&E departments, it takes place across a wide range of care environments and this must be taken into account. The charged environment of an accident and emergency resuscitation room is very different to the controlled environment of the intensive care area for example". Resuscitation is also a term used to depict a wide variety of events in the acute care setting, and could be fluid replacement, trauma, respiratory, or cardiac. For the purposes of this guidance the term resuscitation is used to refer to cardiopulmonary resuscitation which can be attempted when cardiac or respiratory functions cease.

The Resuscitation Council (UK) published a report in 1996⁶ which recommends that relatives should be allowed to witness resuscitation attempts and that they should be supported by appropriately trained health care professionals. The report states that in many cases relatives prefer to be present if given the choice, partly because they can see that everything possible is being done for the dying person and because they feel their presence might have some positive benefit on the outcome.

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Perceptions and effects of witnessing resuscitation – what the literature says

The subject of supporting witnessed resuscitation is not new, reports of policies to introduce such practice first appeared in the early 1980s. In 1995 the RCN and the British Association for Accident and Emergency Medicine (BAEM)⁷ recommended that ‘witnessed resuscitation should be considered and supported if at all possible’. More recent work appears to show both public support and a desire for inclusion in the resuscitation process.

Boyd⁸ in a review of the literature noted that the key areas covered were:

- ◆ the relative’s perception of witnessed resuscitation
- ◆ staff perceptions of witnessed resuscitation
- ◆ the effect of witnessed resuscitation on relatives
- ◆ the effect on staff of witnessed resuscitation.

Boyd suggests that there is a small amount of research that indicates both satisfaction and psychological benefit for those relatives witnessing resuscitation. However, there is only very limited literature on the effects on health care providers, but what there is appears to indicate that there are no negative effects. Support for witnessed resuscitation is not universal amongst health care professionals and concerns for the medico-legal implications have been voiced. The quality and credibility of the research has been criticised and would indicate the need for further work to validate the initial findings.

In 1992 a survey by the Foote Hospital in Michigan concluded that allowing family members to be present assisted the grieving process in most cases^{9,10}. Relatives were briefed by hospital staff and given the choice of

being present during the resuscitation. The manner and sensitivity in which the question was posed eliminated any guilt among those who declined to be present. Relatives were taken into the resuscitation room once the resuscitation team was ready, and supported throughout. However, if invasive interventions were performed relatives were removed from the room but allowed to return if they wished.

The survey results revealed that 76% of the relatives participating believed that adjustment to the death of the relative, as well as their grieving process, had been made easier, with 94% indicating they would participate again. A number of the respondents (64%) felt their presence was beneficial to the dying family member, believing that they might be able to hear them and have the comfort of feeling that their last ‘goodbye’ and ‘I love you’ was heard. This theory is also supported in other literature^{11,12}. Health care providers were more in favour of having parents present during paediatric resuscitation than of relatives present during an adult resuscitation. This reflects the growing trend of increased parental participation in the care of children and the general acceptance of the presence of parents during paediatric resuscitation, which many staff regard as a ‘right’ for parents¹³.

Hampe found that the least supportive measure was to remove the family members as they expressed three main needs: to be with the dying person; to be kept informed; and to know that the dying family member was not in pain¹⁴.

A UK study in 1997¹⁵ found that there were no adverse psychological effects amongst relatives who witnessed resuscitation, all of whom were satisfied with the decision to remain with the patient. The trial was discontinued when the clinical team involved became convinced of the benefits to relatives of allowing them to witness resuscitation if they wished. Psychological follow-up of relatives at three and six months found fewer symptoms of grief and distress in the group who had witnessed resuscitation than in the control group. Of the patients who survived none believed that their confidentiality had been compromised.

Recently, published articles have concentrated on evidence that considers the effects on family members and staff groups during the resuscitation process^{16,17}. Bloomfield¹⁸ urges caution. At a time when health care practitioners are becoming increasingly aware of the ethical dimensions of their work it is important when considering evidence-based practice to be aware of the

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Preparation for witnessing resuscitation

wider context. He argues that 'conclusions drawn from data must be scrutinised from a broad perspective in order to ensure that proposals drawn from them fit soundly with our moral reasoning.' Bloomfield is not convinced that research which concentrates on the psychological effects on relatives is sufficient when the question of patient consent (which risks treating the patient as a means to an end) is ignored in the wider debate. Walker believes that recognition of a relative's right to witness resuscitation is dependent upon health care professionals' willingness to promote the principle of respect for autonomy¹⁹.

The time during resuscitation may be the last opportunity for family members to see and touch their relative while they are still alive. Although health care providers aim to support family members there is evidence to show that the perspectives and needs of the family can be misjudged by the health care provider. According to one assessment, nurses working in intensive care units perceived family members' needs accurately only 50% of the time²⁰.

The Emergency Nurses Association (ENA) was one of the first organisations to issue a formal position statement that supports family presence during resuscitation and invasive procedures²¹.

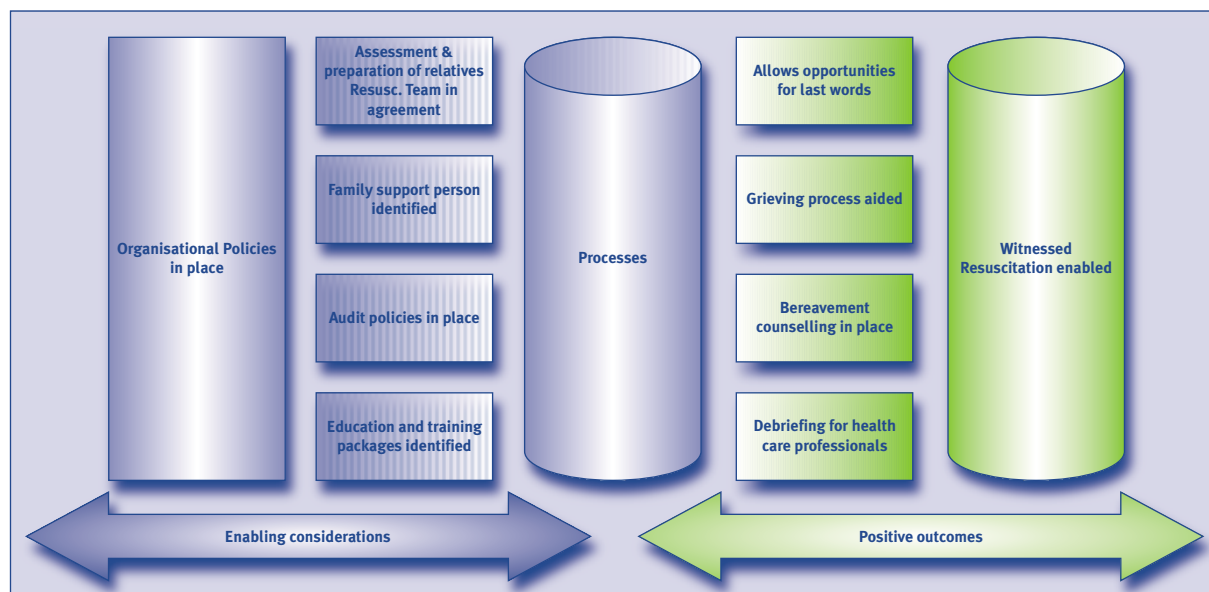
As witnessing resuscitation is becoming more common, it is quite likely in future that relatives may insist on being present. Morgan²² suggests that the changing needs of the community should be anticipated and careful planning is required to accommodate this change. Nursing staff should acknowledge the importance of the feelings of the family, but do not allow this to take priority over the resuscitation attempt. It is suggested that a co-ordinated approach can result in positive outcomes (see Figure 1).

Support for relatives

When supporting families a systematic approach is called for and the following should be considered²³:

- ◆ personal feelings about death and loss, as they may give insight into how others feel
- ◆ the resuscitation team members' thoughts about having families present. A written survey may elicit frank responses
- ◆ education programmes on crisis intervention, grief and the grieving process. Informed staff members may be more willing to support the process.

Figure 1: The enabling considerations and positive outcomes of witnessed resuscitation



The importance of a senior member of staff briefing the relatives prior to taking them to the resuscitation area is an essential good practice point²⁴. The preparation should include:

- ◆ informing them about the patient's condition
- ◆ discussing what they will see, hear, touch and smell in the area
- ◆ a description of the patient's appearance, equipment being used, and the procedures being undertaken
- ◆ answering any questions or concerns that may be raised.

Establishing ground rules

Family members also need to understand and agree to some basic ground rules so that resuscitation can be maintained. Ground rules may include:

- ◆ that the resuscitation team will determine the best time for the relatives to enter the area and that they may be asked to leave depending on the patient's condition and the interventions being used
- ◆ that family members will be escorted from the area if they become overwhelmed, or disturb the resuscitation efforts of the team (a security officer could be informed or available for assistance)
- ◆ that a family member will never be left alone during resuscitation or a procedure.

Many protocols also state that the agreement of the resuscitation team is sought prior to bringing relatives into the resuscitation area.

When relatives should not be allowed into the resuscitation room

Whilst this publication provides guidance to help support witnessed resuscitation, there is literature available which does identify reasons to discourage health care professionals from supporting witnessed resuscitation^{25,26} and the following should be given consideration when assessing any situation:

- ◆ family members' uncontrolled grief could disrupt the smooth functioning of the resuscitation team
- ◆ family members could become physically involved in the resuscitation attempt

- ◆ the team's emotions could be affected adversely by the presence of the family
- ◆ observation of resuscitation activities and proceedings could increase legal risks
- ◆ observed actions or remarks by medical or nursing staff may offend grieving family members²⁷
- ◆ witnessing resuscitation is an experience that is non-therapeutic and traumatic, and could haunt the surviving family members²⁸
- ◆ there may not be enough adequately trained staff to implement a supportive role to the family²⁹.

When relatives should be allowed into the resuscitation room

Reasons why relatives should be supported to witness a resuscitation:

- ◆ the relative is able to see rather than being told that everything possible is being done. This comes from the belief that the reality of the resuscitation room is far less horrifying than the fantasy
- ◆ the relative is able to touch the patient while he or she is still warm – warm often means alive to the general public
- ◆ the relative can say whatever he or she needs to say while there is still a chance that the dying person can hear
- ◆ the grieving process is traumatic enough without removing any processes that may help adjustment³⁰.

Guidance for preparation of relatives witnessing resuscitation

Organisational policies need to be in place giving details of:

- ◆ how relatives will be assessed and prepared
- ◆ identify who will support individuals
- ◆ protocols for ensuring that the resuscitation team is in agreement for witnessed resuscitation to take place.

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Supporting relatives in the resuscitation area

Before entering the resuscitation area the family should have decided who will go first, especially if only one or two relatives are allowed in at any one time. Once in the resuscitation room the relative should be shown where to stand, this should be close to the patient if possible, so that they are able to touch or hold a hand. The support person will remain near to the family members and provide information and explanations regarding the interventions and activities taking place. Relatives will be informed about the likelihood of the patient being able to hear should they wish to communicate by voice and touch. Depending on the family needs, explanations may occur at the bedside or in a relatives' room where additional questions can be raised. In addition to the support person, a chaplain may be able to offer spiritual support and comfort.

the relatives. When most staff have left, the staff member carrying out cardiac massage should stop and leave quietly. The anaesthetist should then turn off the ventilator and, when possible, remove the endotracheal tube, stop all intravenous infusions, and then leave the area

- ◆ when ready, the nurse should then escort the relatives out of the area and follow the bereavement guidelines as determined by local policy
- ◆ the team leader will talk to the relatives in the relatives' room answering any questions that may arise
- ◆ all support staff are to be involved in the de-briefing.

Guidance on supporting relatives in the resuscitation area

Organisational policies need to identify:

- ◆ where relatives may stand, and how many relatives can be accommodated in the area etc
- ◆ how decisions to discontinue resuscitation can be managed.

Stopping resuscitation

The decision to stop resuscitation should be approached carefully. Key issues and steps identified by Morgan³¹ include:

- ◆ relatives must be supported by an experienced trained nurse, assigned to them solely for this purpose
- ◆ if the prognosis is very poor and the chances of successful resuscitation are slim the relatives should be informed before entering the room
- ◆ the decision to stop resuscitation should be made quietly. All staff involved should be consulted and, if feasible, the relatives should also be included in the discussions
- ◆ the team leader, with the help of the support nurse, should inform relatives that the resuscitation attempt has failed and that it is about to stop
- ◆ gradually, one by one, staff should leave the area; those with no active involvement leaving first, the team leader and support nurse staying to support

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Following resuscitation

If death occurs, the relatives need to be told what they will see and hear when they are escorted back into the resuscitation area to view the body. They should be given as much time as they need or is possible with the deceased family member. A bereavement policy should be in place, which should be followed if resuscitation has been unsuccessful.

Specific areas of concern include:

- ◆ support for the bereaved relatives
- ◆ ensuring that any other patients in the area are not distressed or affected by events
- ◆ critical incident stress de-briefing for staff members involved.

Health care professionals' responses to the interventions may need to be assessed as any resuscitation can be potentially psychologically stressful. The Emergency Nurses Association (ENA)³² suggests that a critical incident stress management programme can be an add-on to a family presence programme, and assist staff with reducing the negative effects of a critical incident.

Guidance on supporting relatives following resuscitation

Policies need to be in place detailing how debriefing will be managed.

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Medico-legal issues

Witnessed resuscitation involves both patients and relatives and raises legal and ethical issues. Generally, supporting witnessed resuscitation is less likely to bring complaints or lawsuits as a result of the bond formed between staff and families. The relatives will have seen that all that could be done for the patient was done.

Confidentiality

A patient's permission is required before medical information may be disclosed to a third party. This assurance of confidentiality creates a bond of trust that encourages patients to disclose personal information to health care professionals.

Allowing relatives into the resuscitation room can be seen as ignoring the patient's right to confidentiality, and those who breach this confidentiality could find themselves the subject of disciplinary action or possible litigation³³. Bowker and Stewart claim that 'between a quarter and a third of patients do not seem to want their relatives involved in decisions about whether resuscitation should be attempted', and believe that it is unlikely that these patients would want their relatives to witness the actual procedure³⁴. In response, the Chairman of the Resuscitation Council Project Team³⁵ argues that the risks, although correct, are outweighed by the potential benefit to the relative or close friend. Currently, this remains a theoretical discussion as no complaint has yet been brought before any of the statutory bodies such as the Nursing and Midwifery Council (NMC)[†] or the General Medical Council (GMC).

It has been argued that confidentiality is breached when relatives are informed that a family member has been admitted to hospital and is gravely ill. However, when a patient is unable to communicate relatives may be invaluable in providing additional medical information.

From a legal viewpoint, relatives in the UK have no legal rights in the care of adult patients. However, a recent

[†] Previously called the United Kingdom Central Council for Nursing Midwifery and Health Visiting (UKCC) but transformed in April 2002 into a new regulatory body called the Nursing and Midwifery Council (NMC).

trend towards increased patient autonomy has altered the views of patients and relatives towards acute care provision. Many relatives will have been present at pre-hospital resuscitation attempts and witnessed resuscitation in many circumstances.

Consent

Obtaining a patient's consent to allow relatives into the resuscitation room will often be impossible, although any known pre-existing wishes of the patient must be respected. It is a general and ethical principle that valid consent must be obtained on every occasion when a health care professional wishes to initiate treatment or any other intervention, except in emergencies or where the law states otherwise. This principle reflects the rights of patients to determine what happens to their own bodies and is a fundamental part of good practice³⁶. Increasingly the courts are recognising the power of advanced directives or 'living wills'. These are documents made in advance of a particular condition or situation that may arise, and indicate the individual's wishes or the choices that they are likely to make if that situation should occur.

Capacity and incapacity

Health care practitioners should assume that every adult has the capacity to decide whether to consent to, or refuse proposed treatments or interventions. If a patient's choice appears irrational, that is not evidence that they lack capacity or competence. If an adult lacks capacity and has not given any indication of their wishes, decisions will need to be made based on the 'best interests' of that patient.

Best interests and who decides

The GMC³⁷ offers advice on the options that need to be considered when looking at the best interests of a patient who lacks capacity. This includes:

- ◆ the options for treatment or interventions which are clinically indicated
- ◆ any evidence of the patient's previously expressed wishes
- ◆ any knowledge of the patient's religious or cultural beliefs

- ◆ views about the patient's preferences given by a third party, for example, a close family member
- ◆ considering which option least restricts the patient's future choices, where more than one option seems reasonable.

The Resuscitation Council suggests that patients who have had a cardiac arrest and are undergoing resuscitation may be more aware than previously thought. Sometimes patients are conscious for a few fleeting moments and may benefit from the chance to express a 'final' message. There is also anecdotal evidence that the presence of a loved one may be beneficial to the patient.

Avoiding harm to those who witness resuscitation (nervous shock)

There are potential disadvantages of relatives being present, for instance, the reality of resuscitation may prove distressing, particularly if the relatives are uninformed³⁸. Relatives should be offered support. It is quite possible that the family member may have been present during the initial resuscitation and, in some cases, the first to start the process of CPR. Under these circumstances the resuscitation room may be less shocking than previously expected. Current evidence suggests that it is more distressing for relatives to be separated from their family member during these critical moments than to witness attempts at resuscitation^{39,40}. In response to the question: 'do the legal risks increase if a family member sees an error or misinterprets what she sees' Goldsworth suggests that:

'... someone who feels angry or uninvolved is most likely to sue for malpractice, real or imagined. By staying with a family member, supporting her, and explaining what she sees, may actually help decrease the legal risks'⁴¹.

The Resuscitation Council (UK) recommends that relatives if possible should be offered the opportunity to witness resuscitation and this reflects the findings on relatives' attitudes.

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Avoiding harm to nursing staff involved with the family

Adequate training and bereavement counselling should be in place for all staff members. It is also important to have a support network for critical incident analysis or informal debriefings. Mitchell⁴² believes the value of critical incident stress debriefing should not be underestimated as it prolongs the careers of personnel. It is crucial that further opportunities for discussion are explored to help identify the short and long-term effects of witnessed resuscitation. Although there is limited research revealing the effects on health care providers, there are no known deleterious effects to date.

Implications for nursing practice

In order for the practice of witnessed resuscitation to be supported and developed the implications for nursing practice need to be considered. These include:

- ◆ education provision to help equip nurses so that they are able to provide relevant information on procedures and patient response, and so that they can provide constant support to relatives
- ◆ a need for definitive research that considers the efficacy and practicality of witnessed resuscitation
- ◆ the development of policies and guidance to facilitate witnessed resuscitation
- ◆ the development of nursing roles which concentrate on family support before, during and after resuscitation, including bereavement care.

Guidance on nurse practice

Education and training provision should be made available.

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Comments from RCN members

The debate on witnessing resuscitation has produced many comments from members and we are grateful to all those who have contacted us. The following comments are from two members (who wish to remain anonymous), and illustrate the strength of feeling on this sensitive issue. The feedback of those who were supportive outnumbered the comments from those who did not support witnessed resuscitation.

Comments against witnessed resuscitation

“I am absolutely horrified at the suggestion of allowing relatives in when resuscitation is in progress. I work in a busy A&E dept and we pride ourselves that we run an efficient ‘resus’ room. However, to allow the resuscitation to become a side-show for spectators is unthinkable! Have we gone absolutely mad in today’s nursing? I’m all for a bit of relative participation in the patients care but allowing them to be present for ‘resus’ is nothing short of barbaric... What about the decision to stop, it is based on clinical assessment of the patient’s condition, much of which the shocked relative will not understand. There will need to be an extra member of staff to look after the relative, not least to make sure they don’t get in the way of proceedings. Where will that extra staff member come from?”

Support for witnessed resuscitation

“I am very interested in witnessing resuscitation as I fairly recently witnessed the resuscitation of my father within the coronary care setting. At the time I was working as a staff nurse in intensive care and was very much involved in ‘resus’. I am so glad that I was able to stay with my father during what turned out to be the last moments of his life. Initially when he arrested I was ushered out of the cubicle but after a moment or so I was desperate to be with him and more or less demanded to be allowed in the room. I had been with him from the start of his chest pain, through the

admission to the A&E and to the Coronary Care unit. It was awful to suddenly have to leave him. It was fortunate that the Clinical Nursing Manager was a friend of mine and was on duty that particular day, she enabled me to be present throughout the resuscitation. I think perhaps they would have needed security to prevent me!

I am so glad that I was able to be present and it has helped enormously with the grieving process. I can obtain some comfort knowing that I was with him during his last few moments of life and he was not just surrounded by strangers who did not know him as the kind gentle father he was. I had no interest and indeed took no notice of the actual ‘resus’ even though I have been professionally involved in many resuscitation attempts...”

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Conclusion

It is the view of the Royal College of Nursing that, where ever possible, witnessed resuscitation should be supported if that is the wish of the relatives and family members. However, the emphasis must lie with acknowledging the feelings of individuals, both relatives and staff.

Oliver⁴³ suggests that hospitals of the future will need to be creative in their offerings to families and loved ones who wish to be involved in patient care. It is crucial that family members are not pressurised into witnessing resuscitation but that they are aware it may help the grieving process. "It may seem barbaric to our great-grand children in the next century ... nurses now have the opportunity to lead the way in preserving the integrity of the family unit at the end of life. The advantages of allowing family members to be present seem to outweigh the disadvantages. If this practice is to be encouraged, we as health care professionals need to be able to articulate clearly to relatives what the hospital policy is and how they can play a useful and positive role."⁴⁴

Appendix 1:

Witnessing resuscitation: a check list for practice

This checklist is designed for staff working in accident and emergency departments or other areas where witnessed resuscitation may take place. A simple YES or NO can answer most questions. Where the answer is no, it may be advisable to review practice. The right hand column is for comments and suggestions for further action.

	Yes	No	Comments
1. Organisational policies identified and in place			
2. Does guidance exist to cope with stopping resuscitation?			
3. Do bereavement guidelines exist?			
4. Are there accessible educational policies for all team members which cover:			
◆ dealing with grieving relatives?			
◆ dealing with witnessed resuscitation?			
◆ dealing with bereaved relatives and follow-up services?			
◆ communication skills?			
5. Is there a system in place that allows access to experienced staff who can support relatives when required?			
6. Is there guidance in place for accessing security staff if required?			
7. Are there mechanisms in place for critical incident debriefing?			
8. Is there any access to stress debriefing in place?			

Appendix 2:

The Resuscitation Council (UK) Guidelines on the Principles Enabling Witnessed Resuscitation

Reprinted with permission from the Resuscitation Council (UK)⁴⁵

These guidelines are generalised but can be adapted to most circumstances, it is important to remember that every situation is unique and every person different.

The carer must be able to:

- ◆ acknowledge the difficulty of the situation. Ensure that the relative understands that they have a choice of whether or not to be present during resuscitation. Avoid provoking feelings of guilt whatever their decision
- ◆ explain that someone specifically to care for them will accompany them, whether or not they enter the resuscitation room. Make sure introductions are made and names are known
- ◆ give a clear and honest explanation of what has

Appendix 3:

happened in terms of the illness or injury and warn them of what they can expect to see when they enter the room, particularly the procedures they may witness

- ◆ ensure that they understand that they will be able to leave and return at any time and will always be accompanied
- ◆ ask the relative not to interfere for the good of the patient and their own safety. They will be allowed the opportunity to touch the patient when it is safe to do so
- ◆ explain the procedures as they occur in terms that the relative can understand. Ultimately this will mean being able to explain that the patient has failed to respond and has died and that resuscitation is to be abandoned
- ◆ advise that once the relative has died there may be a brief interval while equipment is removed after which they can return to be with the deceased in private. Under some circumstances the coroner may require certain tubes to be left in place
- ◆ offer the relatives time to think about what has happened and give them the opportunity for further questions.

Model witnessed resuscitation policy – courtesy of Oxford Radcliffe Hospitals

Purpose

To ensure that patients and families are given care that is consistent with the philosophy of family centred and holistic patient care.

Philosophy

The family is the constant in a patient's life. Family participation and involvement in a patient's health care promotes collaborative relationships among members of the health care team, the patient, and the family. The strengths and coping strategies of the family should be recognised and incorporated into patient care.

Policy

Family members will be allowed into the treatment room during invasive procedures and all resuscitation situations, in accordance with the provisions and instructions stated below.

Definitions

Invasive procedure: Any intervention that involves penetration of the body's natural barriers to the external environment.

Resuscitation situations: The sequence of events including invasive procedures, which are initiated to sustain life and / or prevent further deterioration of the patient's condition.

Family: A relative of the patient or any person (significant other) with whom the patient shares a valued relationship.

Family support person: A staff member who has no direct care responsibility; allocated specifically to initiate interventions that assist the family and provide emotional and psychosocial support.

Special instructions

1 Patient and family assessment

Assessment of the patient and the family's desires and needs will be initiated as soon as practical. Assessment of the patient and family includes questions focused on information about the patients and /or families perceptions; desire, willingness or comfort with being present; previous experiences;

usual coping strategies; and established support system.

Staff must remember that being present during invasive procedures or resuscitation is optional for families. Family members who choose not to be present during such events must be supported in their decision without judgement.

2 Direct care providers decision

The direct care providers will be informed of the family's arrival and request to be present in the treatment or resuscitation area.

Direct care providers must agree with the Family Support Person about having the family present.

The staff providing direct care retains the option to request that the family be escorted away from the bedside and / or out of the room if deemed necessary. Space to bring the family to the bedside should be made as soon as possible, even if only briefly.

3 Preparation of the patient and family

Provide the family with timely information concerning procedures and other interventions. Preparation of patients and families should include information concerning the performance of the procedure, potential responses of the patients, the patient's role during the procedure and the families' role in providing comfort and reassurance. Before a family enters the resuscitation area they must be clearly informed of the condition of their loved one. A description of the procedures being performed and the sights, smells and sounds they will encounter should also be included. Inform the family of the following:

- ◆ how many family members may enter the room at one time
- ◆ where to stand initially
- ◆ appropriate time to approach the bed or trolley side
- ◆ situations when they may be asked to leave the room
- ◆ when they can leave the room
- ◆ any other factors pertinent to the situation.

4 Departmental and situational constraints

- ◆ A family support person must remain with the family in the resuscitation room during resuscitation.

- ◆ Family members who show evidence of violent behaviour, loss of self-control, or other aggressive behaviour should be excluded from the treatment area during that time.
- ◆ The number of family members allowed at the bedside will be limited to two unless special circumstances or needs are identified.
- ◆ Circumstances of resuscitation that generally preclude family presence during the intervention include emergency thoracotomy and escharotomy or burr holes, or lack of appropriate family support persons.

5 Family support resources

- ◆ A/E nursing or medical staff.
- ◆ Chaplain.
- ◆ Duty senior nurse.

6 Staff role responsibilities

- ◆ A/E sister: ensure family support is considered during resuscitation situations. Acts in family support person role or designates another staff member. Assists direct care providers in facilitating family presence as needed. Participates in staff diffusing, identifies need for formal critical incident stress debriefing, and initiates appropriate action.
- ◆ Airway nurse: provides direct patient care. Works with patients and families to identify support needs and a system in meeting those needs without compromising patient care. During resuscitation situations facilitates family presence in conjunction with the family support person and other care providers.
- ◆ Medical team leader provides direct patient care. Facilitates family presence during invasive procedures and resuscitation situations in conjunction with other health care providers. Interacts with families as soon as practical.
- ◆ Staff from outside A/E e.g. chaplain or senior nurse: acts in family support role. Provides support interventions and co-ordination with direct care providers and identified medical and nursing liaison. Facilitates or assists with staff diffusing and collaborates with sister concerning need for critical incident stress debriefing.

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