12-1-2005

Nurses' Perception of Family Presence During Resuscitation

Josephine Njoku
San Jose State University

SAN JOSE STATE UNIVERSITY
SCHOOL OF NURSING

MASTER'S PROGRAM PROJECT OPTION (PLAN B)
PROJECT SIGNATURE FORM

STUDENT NAME Josephine Njoku

SEMESTER ENROLLED fall 2005

TITLE OF PROJECT Nurses' perception of family presence during resuscitation.

NAME OF JOURNAL American Journal of Critical Care.

The project and the manuscript have been successfully completed and meet the standards of the School of Nursing University. The project demonstrates the application of professional knowledge, clinical expertise, and scholarly thinking. An abstract of the project and two copies of the manuscript are attached.

[signature] FNP 05/20/09

ADVISOR'S SIGNAURE **DATE**

[signature] 5/20/09

ADVISOR'S SIGNAURE **DATE**

Please submit the form to the Graduate Coordinator. Attach abstract, two copies of the manuscript, and the documentation of submission to the journal (i.e., postal receipt or email).

Submission Confirmation for Nurses' perception of family p resuscitation

From: [redacted] on behalf of **AJCC**
[redacted])
Sent: Tue 5/19/09 1:51 PM
To: [redacted]

AJCC American Journal of Critical Care

Dear Mrs Njoku:

Your submission "Nurses' perception of family presence during resuscitation" has bee *American Journal of Critical Care*.

You will be able to check on the progress of your paper by logging on to Editorial Ma The URL is [redacted]

We will send you another correspondence once the editors have examined the manu suitability. A reference number will be assigned to your manuscript once the editors a the peer review process.

Thank you for submitting your work to the *American Journal of Critical Care*.

Sincerely,

Mike Gaetani
Editorial Office Manager/Peer Review Coordinator
American Journal of Critical Care
[redacted]

NURSES' PERCEPTION OF FAMILY PRESENCE DURING RESUSCITATION

FAMILY PRESENCE DURING RESUSCITATION

Josephine Njoku, RN, BS, MS Candidate 09

San José State University, School of Nursing

[redacted]

Irene Daniels Lewis, RN, DNSc, FAAN

Professor/Chair Community Mental Health

San José State University, School of Nursing

One Washington Square, San Jose, CA 95192-0057

Virgil Parsons, RN, DNSc

Professor

San José State University, School of Nursing

One Washington Square, San Jose, CA 95192-0057

Send Correspondence to: Josephine Njoku

Email:

[redacted]

The Institutional Review Board at San José State University approved the study.

Keywords: Family witnessed resuscitation; teleological model;

Abstract

Background Family witnessed resuscitation (FWR) is the concept of allowing family members at bedside during cardiopulmonary resuscitation. Studies have shown that the lack of standard policies by hospitals regarding FWR forces nurses to make different decisions regarding family presence at bedside during resuscitation. The framework for this study is Sandman's teleological model.

Objectives To examine nurses' perceptions of having family members present during adult cardiac resuscitation.

Methods A descriptive study of 57 registered nurses (n = 57) from northern California was conducted. Participants completed a mailed survey consisting of a 22-item Likert scale questionnaire titled "Family Presence Risk-Benefit Scale."

Results Analysis from the questionnaire showed that the majority of participants were between the ages of 40-63 and had more than 20 years of working experience. About 51.9% worked in units with no formal policy on FWR and 71.7% had participated in a cardiac resuscitation. Study results show that nurses had varied opinions, but there were no statistically significant results to indicate that the majority of nurses favor FWR.

Conclusions The study found there was no statistically significant data to conclude there was any consensus among nurses about the risks or benefits of families at bedside. This study concludes that nurses want to be present in the room if their loved ones were being resuscitated. To help nurses with decision-making guidelines during resuscitation, it is recommended that health-care institutions establish standard policies regarding FWR. Further studies need to be conducted to investigate nurses' perceptions regarding FWR.

NURSES' PERCEPTION OF FAMILY PRESENCE DURING RESUSCITATION

FAMILY PRESENCE DURING RESUSCITATION

Josephine Njoku, RN, BS, MS Candidate 05/09

San José State University, School of Nursing

[redacted]

Irene Daniels Lewis, RN, DNSc, FAAN

Professor/Chair Community Mental Health

San José State University, School of Nursing

One Washington Square, San Jose, CA 95192-0057

Virgil Parsons, RN, DNSc

Professor

San José State University, School of Nursing

One Washington Square, San Jose, CA 95192-0057

Send Correspondence to: Josephine Njoku

[redacted]

The Institutional Review Board at San José State University approved the study.

Keywords: Family witnessed resuscitation; teleological model;

Abstract

Background Family witnessed resuscitation (FWR) is the concept of allowing family members at bedside during cardiopulmonary resuscitation. Studies have shown that the lack of standard policies by hospitals regarding FWR forces nurses to make different decisions regarding family presence at bedside during resuscitation. The framework for this study is Sandman's teleological model.

Objectives To examine nurses' perceptions of having family members present during adult cardiac resuscitation.

Methods A descriptive study of 57 registered nurses (n = 57) from northern California was conducted. Participants completed a mailed survey consisting of a 22-item Likert scale questionnaire titled "Family Presence Risk-Benefit Scale."

Results Analysis from the questionnaire showed that the majority of participants were between the ages of 40-63 and had more than 20 years of working experience. About 51.9% worked in units with no formal policy on FWR and 71.7% had participated in a cardiac resuscitation. Study results show that nurses had varied opinions, but there were no statistically significant results to indicate that the majority of nurses favor FWR.

Conclusions The study found there was no statistically significant data to conclude there was any consensus among nurses about the risks or benefits of families at bedside during resuscitation. This study concludes that nurses want to be present in the room if their loved ones were being resuscitated. To help nurses with decision-making guidelines during resuscitation, it is recommended that health-care institutions establish standard policies regarding FWR. Further studies need to be conducted to investigate nurses' perceptions regarding FWR.

Background

Family witnessed resuscitation (FWR) is the act of allowing family members at the bedside during a cardiopulmonary resuscitation episode. FWR is an ongoing issue that nurses and families face in the health-care setting.[1, 2, 3] There is mixed support for this issue.[2, 4, 5, 6] It is apparent that FWR offers both advantages and disadvantages to all involved, but to help nurses make better decisions about FWR a set of guidelines would be beneficial.[6] Other studies suggest the need for nurses to be trained about the value of FWR.[7,8]

Varied reasons have been suggested as to why some nurses have negative attitudes towards FWR. Some suggested reasons are: family members may become disruptive or confrontational;[4,5,6] families may have reservations or be confused about resuscitation procedures;[6] family members may develop an unfavorable psychological view of resuscitation;[2,5,9] and FWR may lead to lawsuits against health-care workers.[8,10]

There are also studies that suggest FWR may lead to a positive outcome. Some positive reasons are: it is easier for families to accept an unfortunate ending of a resuscitation effort;[11,12] and it gives families the opportunity to witness that the health-care staff did whatever they could and should have done in a resuscitation episode.[8] Some family members also believe they have a right to be present during cardiopulmonary resuscitation.[13]

Although the Emergency Nurses Association (ENA)[14] and the American Heart Association (AHA) guidelines for cardiopulmonary resuscitation recommend FWR,[15] many hospitals are deficient in standard policies.[1,2,7] Lack of hospital written policies on FWR creates a dilemma for nurses about what to do with family members during

resuscitation.[7,14] Some studies recommend that health-care facilities develop standard protocols for nurses to rely on during cardiopulmonary resuscitation.[2,3,7,8,14]

Theoretical Framework

This study is based on the theory of teleological (utilitarian) ethics, a theory that uses morality to evaluate the consequence of any action. If that action is satisfactory to all parties involved, then one would have made a good moral choice.[16] It is a model that can be used in examining the difficult choices nurses are forced to make in their daily work, and is used in this study to examine the risks and benefits of having family members at the bedside during cardiopulmonary resuscitation.[17]

By using such a framework to analyze how nurses should handle critical decision-making during resuscitations, nurses are able to consider the benefits and risks associated with all available choices before making a decision regarding FWR.[18] In the midst of an adult resuscitation episode in a setting that has provided the health-care staff with a protocol and guidelines on FWR, nurses are able to follow the recommended policies. But in the absence of a protocol, nurses have to evaluate the situation and make critical decisions about the positive and negative risks before allowing the families at bedside.[16]

Using Sandman's teleological model to explain nurses' perceptions regarding FWR, an analysis is made of all the steps involved in the process of a nurse making decisions about FWR. This requires "identifying and describing the normative situation; identifying and describing the different possible alternatives; assessing and evaluating the different alternatives; and deciding on, implementing and evaluating the chosen alternative."[17]

Consequently, when nurses are faced with the dilemma of whether or not to allow families at bedside during cardiopulmonary resuscitation, identifying the normative

situation means examining what the current rule or policy is at their place of work regarding FWR. The second step, describing possible alternatives, means that nurses can evaluate the benefits of allowing the family at bedside. If a decision is made not to accommodate the family due to space or other reasons, then frequent updates about the resuscitation will need to be given. The third step requires nurses to evaluate the choices and their implications for family members, as well as medical staff. The final step involves implementing whatever course of action the nurses decide.

Since several studies indicate that many health-care facilities lack policies and protocols on adult FWR,[2,7] nurses are left to examine on a case-by-case basis what choices they have, evaluate these choices, and make a decision that benefits the patient, families, and nursing staff. Using the theoretical framework of Sandman's teleological model, this study examines whether the decision should benefit all the parties involved.

Purpose

The purpose of this study was to survey the perceptions of nurses by answering these questions:

- What are the perceptions of nurses about FWR?
- Is there a relationship between years of experience and having a favorable/unfavorable perception of FWR?
- Does the lack of standard policies by hospitals regarding FWR force nurses to make varied decisions?[8]
- How can we help guide best practice?

Methods

Design:

This descriptive study used a survey, which consisted of a 22-item Likert scale questionnaire that was mailed to 300 Registered Nurses within northern California. The number of respondents was 57 (n=57). The survey was used to collect variable demographic data about the subjects. Such variables included age, years of experience, work settings, highest nursing degree, position as a nurse, and clinical area of practice or unit. Respondents were also asked to state "yes or no" as to whether or not respondents had participated in a cardiac resuscitation episode.

Respondents were asked to state "yes, no, or I don't know" to a question asking if their units had a policy on FWR. The survey tool examined nurses' perceptions about FWR by asking the respondents to rate their responses to questions on a 1 to 5 point scale of agreement (1=least agree; 5= strongly agree). The study was approved by the Institutional Review Board (IRB) at San José State University.

Sample and setting:

Permission was granted to recruit study participants from a mailing list obtained through the Californian Board of Registered Nursing (BRN). The inclusion criteria were that participants be registered nurses licensed through the BRN and have a mailing address within northern California.

Instrument:

The questionnaire used in this study titled "Family Presence Risk-Benefit Scale" was developed by Twibell et al.[1] Permission to use this instrument was granted by the *American Journal of Critical Care* (AJCC). The original questionnaire consisted of 22

questions, but this researcher added a section to collect demographic data from the subjects.

Reliability and validity of instrument:

The instrument used for this research has documented content validity which is stated in the original published work of Twibell et al. The authors stated that "clinical experts in family presence, academicians, and statistical experts in design and testing provided content review of the items."[1]

Procedures:

Data collection was from May to June 2008. After obtaining approval from the IRB of San José State University, a cover letter and survey questionnaire were mailed to 300 registered nurses with mailing addresses within northern California. Participants were randomly chosen from a mailing list obtained from the BRN. From more than 2000 names on the BRN mailing list of RNs in northern California zip codes, 300 RNs were randomly selected. A total of 57 nurses responded to the survey.

Participants were given an instructional sheet on how to fill out the survey. They were instructed to enclose their completed survey in the stamped return envelope provided, and mail it back within 2 weeks of their receiving the surveys. A postcard was mailed to participants 1 week after the survey was sent out. This served as a reminder to complete and mail back the survey. The returned questionnaires were maintained with confidentiality and the survey was anonymous.

Data analysis:

Data were analyzed by using the Statistical Package for the Social Sciences (SPSS). Analysis of descriptive data included frequencies and percents. The same type of

descriptive statistical analysis was conducted on each survey item to determine nurses' favorable or unfavorable perception of FWR. *S*pearman correlations were computed to determine whether a relationship existed between years of experience and perception of FWR.

Independent sample *t*-tests were conducted to determine nurses' perception of FWR in relation to policy and years of experience. One set looked at perception by policy and compared nurses who worked on units with established policy on FWR with those who worked on units without a written policy. A second set looked at perception by years of experience and compared nurses with less than or equal to 20-years' experience to nurses with more than 20-years' experience.

Results:

Frequencies and percents were determined for data collected on demographic variables that included: age, years working as a nurse, highest RN degree, position, work place, unit, written policy regarding family presence during resuscitation, and "I have participated in an adult resuscitation effort on my unit."

Data showed that the majority (60.7%) of participants were between the ages of 43-63, and a large percentage (77.8%) of the nurses indicated the number of years working as a nurse was more than 20. Just under half the respondents (48.2%) indicated that their highest degree was the Bachelor of Science in Nursing (BSN). Slightly more than half of the participants (50.9%) were staff nurses. The hospital was the most frequent workplace (56.1%) of all locations. All these results are summarized in Table 1.

To find out the types of units where the nurses were employed, the questionnaire offered choices that included "ER/Trauma, ICU/CCU/Step-down, OR/PACU, and

Other." The most frequent response (66%) by nurses indicated "Other" meaning they worked on units such as medical-surgical, oncology, short stay, and various types of units that currently exist in any health-care work place (see Table 1).

To ascertain if respondents worked on units with a written policy on FWR, participants were asked to answer with a "yes, no, or I don't know." A significant number (51.9%) responded as no, indicating that most of the respondents worked on units without any written policy on FWR. On the question asking if respondents had participated in an adult cardiac resuscitation, the majority (71.7%) responded as yes. The results are summarized in Table 1.

A descriptive statistical analysis was conducted on the responses from nurses to determine the relationship between their responses to specific questions and their favorable or unfavorable perception of FWR. The results are presented in Table 2. The minimum rating for the items was 1, suggesting the least possible agreement; rating number 5 suggested the strongest agreement. The survey item (question # 5) about "if my loved one were being resuscitated, I would want to be present in the room," had the highest mean ($M = 3.37$, $SD = 1.55$), suggesting that participants felt most strongly about being present in the room of a loved one's resuscitation. The survey item (question # 15) on "family presence during resuscitation is beneficial to physicians" had the lowest mean ($M = 2.21$, $SD = 1.25$), suggesting that participants were least in agreement with this area.

Spearman correlations were conducted on the 22 survey questions to examine if there was any relationship between years of experience as a nurse and having a favorable or unfavorable perception of FWR. The results indicated there was no statistically

significant relationship between years of nursing experience and having a favorable or unfavorable perception of FWR. The results are summarized in Table 3.

Independent sample *t*-tests were conducted on the 22 items to examine if there were any mean differences that existed with having a favorable or unfavorable perception of FWR and working on a unit with or without a policy on FWR (yes or no). The results of the *t*-tests were not significant, suggesting that there were no statistical differences with having a favorable or unfavorable perception of FWR, and working on a unit with or without any written policy on FWR. The results are displayed in Table 4.

Other sets of independent sample *t*-tests were also conducted on the 22 survey items to examine if there were any mean differences that existed with having a favorable or unfavorable perception of FWR, and the nurse's years of experience (20 years or less vs. more than 20 years). The results of the *t*-tests revealed there were no statistically significant differences. Most of the sample consisted of nurses with more than 20 years experience and this has an impact on these results. Results are displayed in Table 5.

Discussions:

Study data revealed that the majority of nurses who responded to the survey (60.7%) fall into the age bracket of 43–63 years old. Because the survey was sent to a random group, there is no way this researcher could have known the ages of participants because the mailing list from the BRN did not contain the nurse's date of birth. Analysis of the demographic data also revealed that most of the nurses (77.8%) who responded to the survey were nurses with more than 20 years' experience. Years of experience as a nurse do not seem to determine a nurse's favorable or unfavorable perception of FWR.

A major issue that may affect nurses' decision-making regarding FWR is the lack of standard policy and protocol in the nurses' work place. This study data show most of the nurses (51.9%) indicated they had no policy on FWR on their units. The major implication is that nurses have little guidance in how to handle families during this type of critical decision-making moment. Thus there is a need to focus on how health-care institutions could provide guidelines to help nurses make satisfactory decisions when faced with the choice of letting families stay at the bedside during adult resuscitation episodes. Results also indicated that the majority of nurses (66%) worked on units that are considered as non-critical care units in the health-care setting, and this might be a reason for the mixed responses about having a favorable or unfavorable perception on FWR

The study results show that nurses' perceptions vary and there seems to be no consensus about the risks and benefits of FWR. The implications of this study highlight that the concept of FWR needs to be promoted so that practicing nurses are more aware of its importance.

Some issues that can be seen as limitations for this study include the small sample size (n=57) of nurses, the small number of respondents below the age of 43 years, and the small percentage of respondents with less than 20 years of nursing experience.

Conclusions and Recommendations:

This study provided the opportunity to examine nurses' perceptions about FWR. The results show that nurses are still divided as to whether families should be allowed to witness adult resuscitation. This study data showed that most nurses worked on units without a policy on FWR. Although the majority have participated in a cardiac

resuscitation, the results suggest that nurses have little guidance in how to handle families during this type of critical decision-making moment, and these can lead to varied decisions about whether to allow families at the bedside or not.

This study also concludes that nurses want to be present in the room if their loved ones were being resuscitated. They also perceived that physicians will not benefit by having the patients' family members at the bedside. Nurses perceptions of FWR and their years of experience as a nurse was not statistically significant. Also there was no statistical significance relating to whether a unit had a written policy on FWR and nurses favorable or unfavorable perceptions.

It is not uncommon for nurses to make instinctive decisions during moments of crisis, and such decisions may be unpredictable.[17] It is therefore important for nurses to have a policy about FWR to provide some guidance. But based on the principles of Sandman's teleological model that guided this study, nurses should assess and evaluate each situation carefully, taking into account the safety of the parties involved and available resources, before deciding on a course of action. To ensure best practice, and to determine whether a written policy is beneficial for nurses, there is a need for further research. Future studies could examine additional correlations, for example, whether working in critical-care units influence nurses' perceptions on FWR. Finally, nurse researchers may have to find ways of encouraging younger nurses and those new to the profession to become more involved as participants in the research process.

Table 1: *Demographic data*

Characteristic	Frequency	Percent
Age		
18-42	5	8.9
43-63	34	60.7
>63	17	30.4
Years Working as a Nurse		
10 years or less	8	14.8
11-20 years	4	7.4
More than 20 years	42	77.8
Highest Degree		
BSN	27	48.2
ADN	7	12.5
MSN	5	8.9
Other	17	30.4
Position		
Staff Nurse	27	50.9
Charge Nurse/Manager	6	11.3
NP/CNS/Nurse Educator	6	11.3
Other	14	26.4
Work Place		
Hospital	32	56.1
Surgical Center/Private Clinic	6	10.5
Community/Public Health Center	3	5.3
Other	16	28.1
Unit		
ER/Trauma	1	1.9
ICU/CCU/Step-down	13	24.5
OR/PACU	4	7.5
Other	35	66
Written Policy Regarding FWR		
Yes	5	9.6
No	27	51.9
Don't know	20	38.5
Participated in adult resuscitation		
Yes	38	71.7
No	15	28.3

Table 2: *Means, standard deviations, minimums and maximums for nurses that have a favorable and unfavorable perception of FWR.*

#	Descriptive Statistics	N	Min	Max	M	SD
1	Family members should be given the option to be present when a loved one is being resuscitated.	57	1	5	3.19	1.54
2	Family members will panic if they witness a resuscitation effort.	57	1	5	3.25	1.09
3	Family members will have difficulty adjusting to the long term emotional impact of watching a resuscitation effort.	57	1	5	3.07	1.26
4	The resuscitation team may develop a close relationship with family members who witness the efforts, as compared to family members who do not witness the efforts.	57	1	5	2.70	1.21
5	If my loved one were being resuscitated, I would want to be present in the room.	57	1	5	3.37	1.55
6	Patients do not want family members present during a resuscitation attempt.	56	1	5	2.89	0.90
7	Family members who witness unsuccessful resuscitation efforts will have a better grieving process.	56	1	5	3.04	1.28
8	Family members will become disruptive if they witness resuscitation efforts.	57	1	5	3.07	1.10
9	Family members who witness a resuscitation are more likely to sue.	57	1	5	2.60	1.13
10	The resuscitation team will not function as well if family members are present in the room.	56	1	5	2.80	1.34
11	Family members on the unit where I work prefer to be present in the room during resuscitation efforts.	45	1	5	2.78	1.16
12	The presence of family members during resuscitation efforts is beneficial to patients.	57	1	5	2.56	1.26
13	Family presence during resuscitation is beneficial to families.	57	1	5	2.98	1.28
14	Family presence during resuscitation is beneficial to nurses.	57	1	5	2.25	1.22
15	Family presence during resuscitation is beneficial to physicians.	57	1	5	2.21	1.25
16	Family presence during resuscitation should be a component of family-centered care.	56	1	5	3.05	1.29

17 Family presence during resuscitation will have a positive effect on patient ratings of satisfaction with hospital care.	56	1	5	2.93	1.07
18 Family presence during resuscitation will have a positive effect on family ratings of satisfaction with hospital care.	56	1	5	3.00	1.12
19 Family presence during resuscitation will have a positive effect on nurse ratings of satisfaction in providing optimal patient and family care.	57	1	5	2.81	1.17
20 Family presence during resuscitation will have a positive effect on physician ratings of satisfaction in providing optimal patient and family care.	56	1	5	2.68	1.17
21 Family presence during resuscitation is a right all patients should have.	57	1	5	3.26	1.42
22 Family presence during resuscitation is a right that all family members should have.	57	1	5	3.16	1.49

Table 3: *Spearman Correlation on Years of Experience as a Nurse and a Favorable/Unfavorable Perception of FWR (r, p-value, N)*

	Years working as a nurse
Family members should be given the option to be present when a loved one is being resuscitated.	-.047 .736 54
Family members will panic if they witness a resuscitation effort.	.019 .892 54
Family members will have difficulty adjusting to the long term emotional impact of watching a resuscitation effort.	.034 .809 54
The resuscitation team may develop a close relationship with family members who witness the efforts, as compared to family members who do not witness the efforts.	.241 .080 54
If my loved one were being resuscitated, I would want to be present in the room.	-.071 .608 54
Patients do not want family members present during a resuscitation attempt.	-.044 .756 53
Family members who witness unsuccessful resuscitation efforts will have a better grieving process.	-.031 .823 53
Family members will become disruptive if they witness resuscitation efforts.	-.031 .824 54
Family members who witness a resuscitation are more likely to sue.	.053 .703 54
The resuscitation team will not function as well if family members are present in the room.	.048 .735

	53
Family members on the unit where I work prefer to be present in the room during resuscitation efforts.	-.156 .318
	43
The presence of family members during resuscitation efforts is beneficial to patients.	.054 .698
	54
Family presence during resuscitation is beneficial to families.	-.086 .537
	54
Family presence during resuscitation is beneficial to nurses.	-.044 .750
	54
Family presence during resuscitation is beneficial to physicians.	-.159 .250
	54
Family presence during resuscitation should be a component of family-centered care.	-.120 .393
	53
Family presence during resuscitation will have a positive effect on patient ratings of satisfaction with hospital care.	-.163 .245
	53
Family presence during resuscitation will have a positive effect on family ratings of satisfaction with hospital care	-.120 .394
	53
Family presence during resuscitation will have a positive effect on nurse ratings of satisfaction in providing optimal patient and family care.	-.101 .466
	54
Family presence during resuscitation will have a positive effect on physician ratings of satisfaction in providing optimal patient and family care.	-.113 .419
	53
Family presence during resuscitation is a right all patients should have.	-.052 .710
	54

Family presence during resuscitation is a right that all family members should have.	.025 .860 54	

Table 4: *T-tests on Questions by Policy*

Question	t	df	Sig	Yes M	Yes SD	No M	No SD
Family members should be given the option to be present when a loved one is being resuscitated.	.642	30	.526	3.80	1.64	3.33	1.47
Family members will panic if they witness a resuscitation effort.	.445	30	.660	3.40	1.52	3.15	1.10
Family members will have difficulty adjusting to the long term emotional impact of watching a resuscitation effort.	.172	30	.864	3.00	2.00	2.89	1.19
The resuscitation team may develop a close relationship with family members who witness the efforts, as compared to family members who do not witness the efforts.	.351	30	.728	3.00	1.58	2.78	1.25
If my loved one were being resuscitated, I would want to be present in the room.	.691	30	.495	4.20	1.30	3.74	1.38
Patients do not want family members present during a resuscitation attempt.	-.114	30	.910	2.80	1.48	2.85	.82
Family members who witness unsuccessful resuscitation efforts will have a better grieving process.	-1.612	29	.118	2.40	1.52	3.38	1.20
Family members will become disruptive if they witness resuscitation efforts.	.394	30	.696	3.20	1.48	2.96	1.19
Family members who witness a resuscitation are more likely to sue.	-.517	30	.609	2.20	1.10	2.48	1.12
The resuscitation team will not function as well if family members are present in the room.	-1.646	30	.110	1.60	.89	2.63	1.33
Family members on the unit where I work prefer to be present in the room during resuscitation efforts.	.135	26	.893	3.00	1.83	2.92	1.02
The presence of family members during r resuscitation efforts is beneficial to patients.	.898	30	.377	3.20	1.48	2.63	1.28
Family presence during resuscitation is beneficial to families.	.614	30	.544	3.60	1.52	3.22	1.22
Family presence during resuscitation is beneficial to nurses.	1.570	30	.127	3.20	1.48	2.19	1.30

Family presence during resuscitation is beneficial to physicians.	1.081	30	.288	3.00	1.41	2.30	1.32
Family presence during resuscitation should be a component of family-centered care.	.962	30	.344	3.80	1.10	3.26	1.16
Family presence during resuscitation will have a positive effect on patient ratings of satisfaction with hospital care.	.947	29	.352	3.60	1.14	3.12	1.03
Family presence during resuscitation will have a positive effect on family ratings of satisfaction with hospital care	.757	29	.455	3.60	1.14	3.19	1.10
Family presence during resuscitation will have a positive effect on nurse ratings of satisfaction in providing optimal patient and family care.	1.208	30	.237	3.60	1.14	2.89	1.22
Family presence during resuscitation will have a positive effect on physician ratings of satisfaction in providing optimal patient and family care.	1.076	29	.291	3.40	1.34	2.77	1.18
Family presence during resuscitation is a right all patients should have.	.819	30	.419	4.00	1.00	3.48	1.34
Family presence during resuscitation is a right that all family members should have.	.829	30	.414	3.80	1.10	3.22	1.48

Table 5: *T-tests on Questions by Age*

Question	t	df	Sig	20 or less M	20 or less SD	More than 20 M	More than 20 SD
Family members should be given the option to be present when a loved one is being resuscitated.	.441	52	.661	3.42	1.44	3.19	1.60
Family members will panic if they witness a resuscitation effort.	-.404	52	.688	3.17	1.34	3.31	1.00
Family members will have difficulty adjusting to the long term emotional impact of watching a resuscitation effort.	-.167	52	.868	3.00	1.48	3.07	1.26
The resuscitation team may develop a close relationship with family members who witness the efforts, as compared to family members who do not witness the efforts.	-1.899	52	.063	2.17	1.64	2.90	1.03
If my loved one were being resuscitated, I would want to be present in the room.	.521	52	.604	3.58	1.73	3.31	1.57
Patients do not want family members present during a resuscitation attempt.	.321	51	.749	3.00	1.13	2.90	0.86
Family members who witness unsuccessful resuscitation efforts will have a better grieving process.	.044	51	.965	3.09	1.38	3.07	1.28
Family members will become disruptive if they witness resuscitation efforts.	.096	52	.924	3.08	1.31	3.05	1.08
Family members who witness a resuscitation are more likely to sue.	-.530	52	.599	2.42	1.16	2.62	1.17
The resuscitation team will not function as well if family members are present in the room.	-.556	51	.581	2.58	1.38	2.83	1.34
Family members on the unit where I work prefer to be present in the room during resuscitation efforts.	1.322	41	.194	3.20	1.23	2.64	1.17

The presence of family members during r resuscitation efforts is beneficial to patients.	.028	52	.978	2.58	1.56	2.57	1.21
Family presence during resuscitation is beneficial to families.	.698	52	.488	3.25	1.66	2.95	1.19
Family presence during resuscitation is beneficial to nurses.	.755	52	.453	2.50	1.57	2.19	1.15
Family presence during resuscitation is beneficial to physicians.	1.614	52	.113	2.75	1.60	2.10	1.12
Family presence during resuscitation should be a component of family-centered care.	1.035	51	.305	3.42	1.51	2.98	1.23
Family presence during resuscitation will have a positive effect on patient ratings of satisfaction with hospital care.	1.410	51	.164	3.33	1.23	2.83	1.05
Family presence during resuscitation will have a positive effect on family ratings of satisfaction with hospital care	1.077	51	.287	3.33	1.23	2.93	1.13
Family presence during resuscitation will have a positive effect on nurse ratings of satisfaction in providing optimal patient and family care.	1.157	52	.253	3.17	1.53	2.71	1.09
Family presence during resuscitation will have a positive effect on physician ratings of satisfaction in providing optimal patient and family care.	1.226	51	.226	3.08	1.44	2.61	1.09
Family presence during resuscitation is a right all patients should have.	.559	52	.579	3.50	1.38	3.24	1.45
Family presence during resuscitation is a right that all family members should have.	-.048	52	.962	3.17	1.64	3.19	1.49

References

1. Twibell RS, Siela D, Riwitis C, et al. Nurses' perception of their self-confidence and the benefits and risks of family presence during resuscitation. *Am J Crit Care.* 2008;17:101-111. http://ajcc.aacnjournals.org/cgi/content/full/17/2/101 Accessed March 14, 2008.
2. Badir A, Sepit D. Family presence during CPR: A study of the experiences and opinions of Turkish critical care nurses. *Int J Nurs Stud.* 2007;44(1): 83-92.
3. Fulbrook P, Albarran JW, Latour JM. A European survey of critical care nurses' attitudes and experiences of having family members present during cardiopulmonary resuscitation. *Int J Nurs Stud.* 2005;42(5): 557-568.
4. Compton S, Madgy A, Goldstein M, Sandhu J, Dunne R, Swor R. Emergency medical service providers experience with family presence during cardiopulmonary resuscitation. *Resuscitation.* 2006;70(2): 223-228.
5. Ong ME, Chan YH, Srither DE, Lim YH. Asian medical staff attitudes towards witnessed resuscitation. *Resuscitation.* 2004;60(1): 45-50.
6. Duran CR, Oman KS, Abel JJ, Koziel VM, Szymanski D. Attitudes toward and beliefs about family presence: A survey of healthcare providers, patients' families, and patients. *Am J Crit Care.* 2007;16:270-279.
7. Madden E, Condon C. Emergency nurses' current practices and understanding of family presence during CPR. *J Emerg Nurs.* 2007;33(5): 433-440.
8. Fallis W, McClement S, Pereira A, Winnipeg MB. Family presence during resuscitation: A survey of Canadian critical care nurses' practices and perceptions.

Dynamics. 2008;19(3):22-28. http://www.lib.bioinfo.pl/pmid:18773712 Accessed December 26, 2008.

9. Wagner J. Lived experience of critically ill patients' family members during cardiopulmonary resuscitation. *Am J Crit Care*. 2004;13:416-420.
10. Macy C, Lampe E, O'Neil B, Swor R, Zalenski R, Compton S. The relationship between the hospital setting and perceptions of family-witnessed resuscitation in the emergency department. *Resuscitation*. 2006;70(1):74-79.
11. Booth M, Woolrich L, Kinsella J. Family witnessed resuscitation in UK emergency departments: A survey of practice. *Eur J Anaesth*. 2004;21:725-728.
12. Mangurten JA, Scott SH, Guzzetta CE, et al. Family presence: Making room. *Am J Nurs*. 2005;105:40-48.
13. Meyers TA, Eichhorn DJ, Guzzetta CE, et al. Family presence during invasive procedures and resuscitation: The experience of family members, nurses, and physicians. *J Adv Emerg Nurs*. 2004;26(1):61-73. http://pt.wkhealth.com/pt/re/tme/abstract.00007815-200401000-00011.htm Accessed December 26, 2008.
14. Emergency Nurses Association. Position statement: Family presence at bedside during invasive procedures and cardiopulmonary resuscitation. 2005. http://www.ena.org/about/position/PDFs/family Accessed December 26, 2008.
15. Mazer MA, Cox LA, Capon JA. The public's attitude and perception concerning witnessed cardiopulmonary resuscitation: Clinical investigations. *Crit Care Med*. 2006;34(12):2925-2928. http://www.ccmjournal.com/pt/re/ccm/abstract.00003246-200612000-00008.htm

Accessed December 26, 2008.

16. Day L. Family involvement in critical care: Shortcomings of a utilitarian justification. *Am J Crit Care*. 2006;5(2):223-225.

17. Bolmosjo IA, Edberg AK, Sandman L. Everyday ethical problems in dementia care: A teleological model. *Nurs Ethics*. 2006;13(4):340-359.

18. Halm, MA. Family presence during resuscitation: A critical review of the literature. *Am J Crit Care*. 2005;14(6):494-511.