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Society of
Critical Care Medicine
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Family Presence Protocols: A Nurse's Perspective

Mark D. Weber, RN, PCCNP

Family presence during invasive procedures and resuscitations has been occurring since the mid-1980s.¹ Following its beginnings in the emergency department, family presence (FP) has become increasingly prevalent in the healthcare setting, spreading to critical care units. Many nurses and healthcare practitioners familiar with FP argue its

benefit to the family and healthcare team. The reasons for skepticism and the perceived benefits are outlined here, as more hospital teams weigh the pros and cons of this practice.

Family presence has become a heavily debated topic in the last decade. Part of the driving force in this debate has been the inception of family-centered care, defined as "an innovative approach to the planning, delivery and evaluation of healthcare that is grounded in mutually beneficial partnerships among healthcare patients, families and providers."² As families have become more involved in their children's care, the progression to FP for resuscitations and procedures has been intuitive for many units. Families have appreciated and embraced the opportunity to have increased involvement, even during times of extreme crisis. But as the practice of FP takes hold, some nurses feel uncomfortable with this change. Many fear that the family will disrupt, contaminate and hinder invasive procedures. In addition, some healthcare workers believe that allowing the family to be present at the bedside during a resuscitation may lead to an emotional breakdown that will hinder resuscitative efforts. These feelings of skepticism lead to a strong resistance to the initiation of FP policies. A survey of 984 acute and critical care nurses by MacLean et al revealed that only 36% of those surveyed brought families back for cardiopulmonary resuscitation and 44% had brought them back for invasive procedures.³

The Data

Several factors have been associated with the attitudes of nurses in relation to their support of FP. A nurse's level of self-confidence in relation to FP has a strong bearing on the support of its future practice. In a survey of 85 emergency department personnel, Sanchetti et al showed that past experience with FP supports the continued practice.⁴ The relationship of personal experience with FP and the staff member's positive perception of the practice was strong ($P < 0.03$). Once a

(see *Family Presence Protocols: A Nurse's Perspective*, page 7)

I AM SCCM WINNER

One Venezuelan Physician Exemplifies the Strength of Perseverance and Dedication

In 2006, Pablo Perez-D'Empaire, MD, decided to attend his first Critical Care Congress. He traveled from his hospital in Caracas, Venezuela, to the 36th Critical Care Congress in Orlando, Florida, prompted by his mentors in Latin America who often stressed the extensive networking and learning opportunities of the meeting. The event – his first international conference – exceeded his expectations. Beyond the educational sessions and hands-on workshops, Congress opened personal and professional doors that enabled him to become a leader and champion in his country. His efforts serve as an inspiration and an example, prompting the Society of Critical Care Medicine (SCCM) to choose Perez-D'Empaire as the winner of the I AM SCCM campaign.

Throughout 2008, the Society has been recognizing its members and their dedication to improving patient-centered care through the I AM SCCM campaign. Perez-D'Empaire is one of many whose achievements and experiences will be highlighted during the 38th Critical Care Congress in the hopes that their dedication may inspire others.

Perez-D'Empaire's I AM SCCM story began when he met R. Phillip Dellinger, MD, FCCM, during a pre-Congress educational session in Orlando. Dellinger told him about the Surviving Sepsis Campaign (SSC) and its mission to improve the management, diagnosis and treatment of sepsis. "I was really interested in bringing the Campaign back to Venezuela because there were no similar efforts to improve sepsis care in my country," Perez-D'Empaire remembered. "The Campaign seemed like a good opportunity to bring attention to quality improvement in the Venezuelan critical care community. Because of our limitations as a developing country, we sometimes forget that new alternatives are available to provide the right care to our patients."

(see *I AM SCCM Winner*, page 7)



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Family Presence Protocols: A Nurse's Perspective

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staff nurse has been involved with a successful FP interaction, the fear of the unknown is frequently resolved and self-confidence is attained. In a study of 375 nurses, Twibell et al measured the perception of self-confidence and its relation to the perceived risks and benefits of FP.⁵ The nurses' correlation to the risks and benefits of FP are significantly related to their measured level of self-confidence ($r = 0.56$, $P < 0.001$).

A second factor that has been associated with nursing attitudes toward FP is holding membership in a professional organization. It has been shown that nurses who hold advanced certification and membership in professional organizations more strongly support FP.⁶ In the same study by Twibell et al, nurses who belonged to a professional organization perceived significantly higher benefits and lower risks to FP ($= 5.3$, $P < 0.001$) than nurses who were not associated with a professional organization.⁵

Several professional organizations have published position statements supporting FP. The American Academy of Pediatrics (AAP), American College of Emergency Physicians (ACEP), American Association of Critical-Care Nurses (AACN), Emergency Nurses Association (ENA), and the Society of Critical Care Medicine (SCCM) all sup-

port FP. Nurses who surround themselves with leaders in the field are more aware of the perceived benefits of FP and will be more apt to support its practice.

Protocol Implementation

Should a critical care unit decide to implement FP practices, the nursing leadership has a large role in incorporating a program and ensuring proper buy-in. To increase the success of FP, it is imperative that the nursing leadership establish clear protocols before initiating such a substantial change in practice.

The survey by MacLean et al showed that in 2003, only 5% of units had active FP policies in place.³ Of the nurses surveyed, 75% said they would prefer to have a policy in place. An effective policy gives clear guidelines to everyone involved in the event. The AACN issued a practice alert in 2004 summarizing the key features that should be included in the creation of an FP policy and outlining benefits to the family, the role of the family facilitator and contraindications to FP. In addition, the ENA has published a toolkit to assist in the implementation of an FP program.

A designated family facilitator should be a part of all FP protocols. The family facilitator is a team member who stands with the family, attending to their needs and describing, in appropriate terms, what is happening. Many times this role is given to the staff nurse, who also has to be involved in the resuscitation. It is important that the family facilitator be someone not actively involved in the resuscitation process,

such as a social worker or clergy member.

Education is also crucial in the success of an FP policy. Bassler et al showed that after educating 46 nurses on the benefits of FP, the percentage of nurses who would offer it increased from 11% to 79%.⁷ Important aspects of education include demystifying the fallacies surrounding FP and increasing the level of confidence with the practice.

Nursing support for FP has been increasing in the past decade. Nurses whose institutions have FP policies report that their involvement in the practice has led to increased care for the patient, increased professional behavior, assistance in the bereavement process, and an opportunity for increased patient and family education.³ Knott et al also found that the families reported positive closure with the death experience, had a better sense for the scope of care, and were able to see that all was done for their family member during the resuscitation event.⁸

In conclusion, nurses' attitudes toward FP are strongly related to their past experiences and predetermined ideas. To ensure implementation of FP is positive and beneficial, unit-specific guidelines and staff education must be performed before initiation of an FP program. Once these measures are in place, the nursing staff can approach FP opportunities with confidence. This confidence will carry the practice of FP through to success. ▲

References and disclosures are available at www.sccm.org/criticalconnections.



I AM SCCM WINNER

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Though Perez-D'Empaire's institution, Hospital de Clinicas Caracas, had been informally following the SSC guidelines, staff had not been measuring their results. They had no way to know if they were making progress and Perez-D'Empaire was aware of miscommunication problems between the intensive care unit (ICU) and the emergency room.

Empowered by new professional contacts, a refreshed commitment and the latest knowledge, Perez-D'Empaire returned to his critical care unit at Hospital de Clinicas Caracas with new ideas and tools to improve early identification and treatment of sepsis. He accessed materials via the SSC Web site and translated the information from English to Spanish, including the guidelines-related pocket guides, posters and slides. He then scheduled sepsis educational programs for multiprofessional teams from the ICU, emergency department and other hospital wards.

Soon, the SSC bundles began to be accepted as evidenced-based practice throughout the hospital, and performance was documented through use of the free SSC database. These efforts alone marked an important improvement in patient care. Once staff could see their progress and problem areas through documented results, they were more likely to embrace the protocols and work to identify and solve issues.

However, Perez-D'Empaire wanted to go further. While resuscitation and management bundle compliance results were improving, long-lasting, cultural change was needed. Teamwork and improved communication were key to ensuring sustainable results. He wanted to extend his effort and sought more resources from the Society.

Seeing Perez-D'Empaire's commitment to the Campaign, Dellinger invited him to participate in the SSC North American Summits. Hospital de Clinicas Caracas was the only institution represented in the Summit from outside the United States. The summits were organized as a series of workshops and networking opportunities among hospitals that had implemented the Campaign's software-based performance improvement program and had begun collecting data.

The lessons learned at the SSC North American Summit paid off, and Perez-D'Empaire again returned to the hospital with fresh ideas. This time he taught the staff concepts related to the Institute of Healthcare Improvement's Plan-Do-Study-Act cycle and implemented various communication strategies. "Teamwork is definitely a key to implementing a quality improvement program. Without attention to teamwork, none of this would have been possible," Perez-D'Empaire said.

When it came time to share data with other North American SSC Summit par-

ticipants, Hospital de Clinicas Caracas ranked among the top SSC performers in bundle compliance. The group has entered 102 charts into the database. Performance to date has indicated a resuscitation bundle compliance of 40.54% and a management bundle compliance of 67.56%. This stellar performance is a testimony to the entire team's attention to evidence-based medicine.

"We were very proud of these results," Perez-D'Empaire said. "I am very impressed with what Pablo was able to accomplish," Dellinger said. "He took initiative after achieving success and engaged the Venezuelan Critical Care Society, which recognized his potential to lead Surviving Sepsis Campaign efforts within the country. His accomplishments are indeed impressive."

Hospital de Clinicas Caracas was the first hospital in Venezuela to implement the SSC, but Perez-D'Empaire is determined to spread his knowledge throughout the region. He has worked with four hospitals within Caracas and with six hospitals from other Venezuelan cities to hold educational sessions, showcasing his hospital's own successes and helping others achieve similar results. He communicates regularly with his Latin American colleagues in Brazil, Mexico, Chile and Argentina, who also are implementing the Campaign. This is the kind of knowledge-sharing that has made the SSC so successful; everyone can be a leader simply by sharing information and introducing the bundles to their colleagues at other hospitals, regardless of the size or location of the facility. "Showing our results to other hospitals has made others more enthusiastic about SSC implementation," Perez-D'Empaire said. "Clinicians realize that with effective teamwork, it is possible to achieve better results despite the challenges in our healthcare system."

"You will have a lot of obstacles, but if you really believe in the programs, you should try," he said. "In Latin American, these types of programs are really needed because we have limited resources as developing countries. Programs like the Surviving Sepsis Campaign and organizations like the SCCM provide very important opportunities for doing new things."

Perez-D'Empaire truly illustrates the spirit of I AM SCCM. Using the resources provided by SCCM and fueled by his drive to improve patient care, Perez-D'Empaire has made a difference that will reach far beyond his own practice. His efforts to implement the SSC will have lasting effects on patient care in Latin America. It is hoped that his story will inspire this year's Congress attendees to return to their ICUs to generate their own stories of inspiration. "There is still a lot of work ahead and many goals to achieve, but becoming an SCCM member was definitely an important step on my professional development," Perez-D'Empaire said. "That is why I am very proud to say that I am SCCM." ▲