Family Presence During Resuscitation

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Mixed Methods Design

- Sequential exploratory design in two phases
Mixed Methods

- Phase one
  - Victorian wide survey of Emergency personnel
  - State wide survey of ED staff
    - 27 ED – 18 participated
    - 347 surveys
Survey Findings

- 65 Doctors and 282 Nurses completed the survey

- More comfortable for family to be present during paediatric rather than adult resuscitations.

- 93% of emergency staff have received NO formal FPDR training

- Don’t know what to say

Family have the right to be present
Helps with the grieving process
BLS & ALS training

- 49-87% have completed BLS & ALS in Adult & Paediatric resuscitation.
- Doctors
  - Adult ALS  65% (n=42)
  - Paed ALS  49% (n=32)
- Nurses
  - Adult ALS  87% (n=244)
  - Pead ALS  72% (n=204)
FPDR policy

• Doctors
  Yes – 4.6% (n=3) – only 1 doctor has read the policy
  No – 40% (n=26)
  Unsure 55.4% (n=36)

• Nurses
  Yes – 5% (n=14) – only 6 nurses have read the policy
  No – 36.2% (n=102)
  Unsure – 57.8% (n=103)

• 7 Emergency personnel out of 375 surveyed have read FPDR policy
Who is in the team

• Team Leader, Airway Nurse, Airway Doctor, Procedure Nurse, Procedure Doctor, Scribe.
What to say

• N - How to communicate with family. What to explain and how much detail to give. What support services to offer. When to bring them into resuscitation

• D - How best to explain stuff like procedures. What is occurring, how much to disclose as the resuscitation gets worse.
ER - DRIP

- E – Emergency personnel (describe the members of the team)
- R – Reassurance (everything possible is being done)
- D – Diagnosis (what’s wrong with the patient / cause of arrest if know)
- R – Regular updates (outline the frequency of visits to give information)
- I – Interventions (describe the procedures being done to the patient)
- P – Prognosis (potential outcomes / need to transport patient / Severity of condition)

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Phase Two

• Observations (2 weeks at each venue)
  • 1 Rural department
  • 1 Metropolitan department.

• Data collection
  • Field notes
  • 26 Resuscitations
  • 29 interviews
6 Main Themes Emerged

- Importance of the Care Coordinator
- Balance of Power
- Delivering bad news
- Life experience generates confidence
- Allocating roles
- Family centred care in action

- Future issue – use of recording devices during resuscitations
Rural Resuscitation – Case study

• 65 year old male patient brought in via Ambulance
• Past history of a CVA 6mths ago
• Was attending his brothers funeral
• Collapsed at home before funeral
• Family contacted during funeral
Family

• Were taken to the relatives room
• Escorted in only after the patient was stabilised
• Patient was air lifted to Melbourne
• Chance to say goodbye
Given to relatives
Comments

• “FPDR is very personal, no one really knows what they would do until put in that position. I believe family should be given the option. some may change their minds”.

• “As healthcare providers we need to care for our patients holistically and that includes family”.
Thank you for listening - Questions

Mixed Methods: Ideal for research in the emergency department

Additional publications