**CHILDREN'S HOSPITAL**
**Columbus, OH**

EMERGENCY SERVICES
POLICY MANUAL

ORIGINATED: 11/94
REVISED: 5/95, 5/98
REVIEWED: 5/01

**SUBJECT:** **FAMILY SUPPORT AND FAMILY PRESENCE DURING INVASIVE PROCEDURES AND RESUSCITATION SITUATIONS**

**Purpose:** To ensure patients and families are provided care consistent with the philosophy of family-centered care and established emergency care standards.

**Philosophy:** The family is a constant in the patient's life. Family participation and involvement in patient's health care promotes collaborative relationships among the health care professional, the patient, and the family. The strengths and coping strategies of the family should be recognized and incorporated into the care of the patient.

**Policy:** Family members will be permitted in the treatment room during invasive procedures and/or resuscitation situations in accordance with the provisions/instructions stated below.

**Related Nursing Standards:** Patient Care Standards: Structure Standard I, II; Process Standards I-V, and Outcome Standards II and III.

**Definitions:**

1. **Invasive Procedure:** Any intervention that involves manipulation of the body and/or penetration of the body's natural barriers to the external environment.

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

3. **Family:** A relative of the patient or any person (significant other) with whom the patient shares an established relationship.

4. **Family Support Person:** A staff member, who has no direct-care responsibility, assigned especially to initiate interventions to assist the family and provide emotional and psychosocial support.

5. **Direct-Care Provider:** Health care providers involved in the direct care of the patient, including the principal RN/care manager, attending physician, assisting nursing staff, resident physician, consultant physicians, surgical trauma team leader, and suture/ortho technicians.

**Procedure:**

**1. Patient and Family Assessment**

Assessment of the patient's and the family's desires and needs will be initiated as soon as practical. Assessment of the patient and family includes questions focused to elicit information about the patient's and/or family's perceptions, desire/willingness and comfort with being present, previous experiences, customary coping strategies, and established support systems.

Being present during invasive procedures or resuscitation is not something that all families want. Family members who choose not to be present during such events must be supported in their decision without judgement.

**2. Direct-Care Provider Decision**

a. The direct-care providers will be informed of the family's arrival and request to be present in the treatment or resuscitation area.
b. Direct-care providers are encouraged to have the family present in the treatment or resuscitation area when the family desires to be present.
c. Direct-care providers must be in agreement with the family support person to have the family present during invasive procedures.
d. The direct care providers will retain the option to request that the family be escorted away from the bedside and/or out of the room if deemed necessary.
e. Accommodations to bring the family to the bedside will 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 the patient may exhibit, the patient's role during the procedure, and the family members' roles in providing comfort and reassurance.

During resuscitation situations, the family must be clearly informed of the status of their loved one and prepared for the interventions that are in progress and the sights and sounds that will be encountered prior to entering the trauma room. The family will be informed: 1) how many family members may enter the room at one time; 2) where they will stand initially; 3) when they will be able to move the bedside; 4) why they may be asked to step out of the room; 5) when they can leave the room; and 6) any other pertinent factors to the situations.

**4. Departmental and Situational Constraints**

a. A family support person must remain with the family in the treatment area during resuscitations.
b. Family members who exhibit evidence of violent behavior, loss of self-control, etc. will be restricted from the treatment room during that time.
c. The number of family members at the bedside at a given time will generally be limited to two unless special circumstances/needs are identified (i.e., cultural issues).
d. Each treatment situation will be assessed individually for constraints and/or special circumstances.

**5. Family Support Resources**

Monday through Friday*
24 hours/day ED Social Worker (SW on-call 5 a.m.-8 a.m.)
3 p.m.-8 a.m.: Nursing Supervisor
24 hours/day: In-house Chaplain or Chaplain on-call
Saturday, Sunday and Holidays:
24 hours/day ED Social Worker
24 hours/day Nursing Supervisor
24 hours/day: In-house Chaplain or Chaplain on-call

*Additional Family Support resource personnel include: Emergency Department Clinical Nurse Specialist, Trauma Program Nurse clinician or Trauma Program Coordinator, Clinical Leaders, and the ED Charge Nurse (24 hours/day).

Support staff will be notified via the trauma pager system (Trauma Alerts) or paged by the Unit Assistant or ECC Specialist upon direction from the nursing or medical staff. The charge nurse (or designee) will function in the family support person role until the assigned staff arrive in the ED. When the designated support personnel arrive in the ED, the family support person role will transition to that staff member.

**6. Staff Role Responsibilities** (See Attachments A and B for Support Interventions)

**ED Charge Nurse:** Ensures family support person contacted for resuscitation situations. Acts in family support person role or designates another staff member until support staff arrive in ED. Assists direct care providers in facilitating family presence as needed. Participates in staff defusing, identifies need for formal critical incident stress debriefing and initiates appropriate action.

**Primary Nurse:** Provides direct patient care. Works with patients and families to identify support needs and assists them in meeting those needs without compromise to patient care. During resuscitation situations, facilitates family presence in conjunction with the family support person and other care providers.

Post-resuscitation (when patient dies in the ED): See Attachments A and B. Provides family opportunity to participate in initial aspects of post-mortem care if they so desire. In conjunction with family support person, complies and provides bereavement packet for family. Ensures Pastoral Care Notification of Death form is completed and forwarded.

**ED Physician:** Provides direct patient care. Facilitates family presence during invasive procedures and resuscitation situations in conjunction with other care providers. Coordinates family presence with other physicians involved (i.e., surgery, neurosurgery, etc.). Interacts with family as soon as practical. Completes "Patient Expiration Packet" and required notification when the patient dies in the ED.

**Social Worker, Chaplain, and/or Nursing Supervisor:** Acts in family support person roles. Provides support interventions in coordination with the direct care providers and identified medical or nursing liaison. Facilitates or assists with staff defusing, collaborates with charge nurse concerning need for critical incident stress debriefing.
Post-resuscitation (when patient dies in the ED): See Attachment B. In conjunction with primary nurse, compiles and provides bereavement packet for family.

**Bereavement Coordinators:** Coordinate family bereavement follow-up.

## Select References


• Institute for Family-Centered Care. Core principles of family-centered health care. *Adv Family-Centered Care* 1998; 4:2-4.
• Johnson BH, Thomas J, Williams K. *Working with Families to Enhance Emergency Medical Services for Children.* Washington, DC: Emergency Medical Services for Children National Resource Center; 2001.
• Institute for Family-Centered Care. Family-centered care: Questions and answers. *Adv Family-Centered Care* 1999; 5:5.
• Johnson B. Changing roles of parents in health care. *Children's Health Care* 2000; 19:234-241.

## ATTACHMENT A

## SUPPORT INTERVENTIONS: DIRECT-CARE PROVIDERS*

| RESPONSIBLE STAFF ROLE | SUPPORT INTERVENTIONS |
|---|---|
| All Care Providers | Introduce yourself, and other members of the care team as needed, to the patient and family. |
| Primary Nurse | Assess the patient's/family's emotional and psychosocial support needs. |
| Coordinated Primary Nurse | Facilitate family involvement and presence in accordance with patient and family's desires. |
| All Care Providers | Prepare patient and family for procedures, explain expected and/or desired outcomes. |
| All Care Providers | Address the patient by name, use the patient's name when talking with the family. |
| All Care Providers | Offer and provide comfort measures. Role model supportive comfort behaviors. |

| RESPONSIBLE STAFF ROLE | SUPPORT INTERVENTIONS |
|---|---|
| Primary Nurse and/or Physician | Communicate plan of care and known information. |
| Charge Nurse, Primary Nurse, or Physician | Initiate involvement of family support person as soon as the need is identified. |
| Charge Nurse | In resuscitation situations, ensure support personnel are notified immediately before the patient's arrival, if possible. |
| Primary Nurse, Charge Nurse, or Physician | Communicate with the support personnel: identified patient and family needs, patient status, response to interventions, etc. |
| All Care Providers | Prepare for patient and family privacy. |
| Coordinated Primary Nurse | When family is at the bedside or when providing clinical information to the family:<br>• Provide explanation of the interventions initiated and the patient's response.<br>• Use terminology appropriate to the person's level of understanding and avoid jargon.<br>• Provide opportunities for questions.<br>• Provide opportunities for the family to see and speak to the patient prior to inter- or intrahospital transfer. |
| Physician and Primary Nurse or Charge Nurse | If death has occurred:<br>• Inform the family of death in clear language.<br>• Explain the care provided.<br>• Let family know what to expect, what they will see, hear, smell.<br>• Work with the family support person to facilitate the family's viewing of the body.<br>• Include family support person when requests for tissue/organ donation and autopsy are made. |

*All direct-care providers (nurses, physicians, respiratory therapist, etc.) interacting with the patient and/or family are responsible for the intervention identified unless otherwise specified.

## ATTACHMENT B

## FAMILY SUPPORT PERSON: SUPPORT INTERVENTIONS*

**SUPPORT INTERVENTIONS**

Introduce yourself to the staff treating the patient and family.

Obtain information concerning the patient's status, response to treatment, identified needs.

Introduce yourself and other members of the support team to the family and patient.

Communicate known information concerning the patient's status.

Use the patient's name when speaking to the family.

Assess the patient's and family's emotional and psychosocial support needs and initiate measures to meet those needs.

Facilitate family involvement and presence in accordance with the patient and/or family's desires.

Prepare the family for the sights and sounds of resuscitation.

Assist the patient or family members in making phone calls.

Offer and provide comfort measures.

Accompany the family to the treatment or resuscitation area.

When providing support for the family at the patient's bedside, provide or ensure the following are done:
- Explanation of the interventions.
- Interpretation of medical/nursing jargon.
- Information concerning the patient's response to treatment/expected outcomes.
- Opportunity to ask questions.
- Opportunity to see and speak to the patient prior to intra- or interhospital transfer.

NEVER leave a family member unattended at the bedside during resuscitation or the performance of a procedure.

If death has occurred:
- Ensure the family has been informed about what to expect, what they will see and hear.
- Facilitate the family's viewing of the body.
- Provide as much time as the family needs.
- Offer the family time alone with their loved ones.
- Provide support during viewing, requests for tissue/organ donation, and requests for autopsy.
- Let the family know when it's OK to leave.
- Provide family with information concerning the disposition of the body, contact person, and phone number if they have questions later.

Participate in evaluation of staff's and own emotional needs. Assist in identifying need for critical incident stress debriefing, individual defusing of events, etc.

Participate, initiate, coordinate family bereavement follow-up at established intervals.

*The charge nurse or primary nurse will assist the family support person in identifying a medical or nursing liaison to assist with clinical information, answering questions, and bringing the family into the treatment area.

*Source:* Children's Hospital, Columbus, OH.