CRITICAL CARE NURSES' PERCEPTIONS OF FAMILY WITNESSED RESUSCITATION IN THE KINGDOM OF SAUDI ARABIA

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ABSTRACT

Resuscitation can be visually disturbing and stressful, even to the most experienced of clinical staff. Allowing family members to remain with patients during resuscitation efforts has sparked controversy among medical and nursing staff members.

A quantitative descriptive study was conducted to describe the perceptions of critical care nurses of family witnessed resuscitation (FWR) and the factors contributing to these perceptions at one tertiary hospital in the Kingdom of Saudi Arabia (KSA). A non-probability convenience sample of 70 critical care nurses was used to collect data. The findings of the study revealed that the majority of critical care nurses were not in favour of FWR. These nurses believed that the process of witnessing a loved one being resuscitated would be traumatic for relatives, and increase possible litigation against medical and nursing personnel.

The study recommended that a clear policy about FWR should be in place. Critical care training should include the trends that will empower its nurses to address the gaps in their knowledge and to reflect on FWR.

KEYWORDS: critical care nursing, emergency care, emergency resuscitation, family witnessed resuscitation, intensive care units

INTRODUCTION AND BACKGROUND INFORMATION

Different views regarding the presence of family members during resuscitation are being debated. Reasons stated against the presence of family members during resuscitation include that the family would have traumatic memories of the event should the resuscitation be unsuccessful (Axelsson, Zettergren & Axelsson, 2005:164). Contrary to this view, evidence from studies conducted indicates that family members' presence

might help them to understand the severity of the patient's condition and appreciate their loved one's care (Quest, 2008:14). A study on families who lost loved ones during resuscitation attempts reported that 80% of the families would have wanted to be present if the option had been offered to them (Meyer et al., 2000:32).

Some research (Tsai, 2002:119) supports family witnessed resuscitation (FWR). However, opponents of this practice fear that it could increase litigation against the medical staff and family members could cause interference during resuscitation procedures (Yanturali et al., 2005:6). Thus, FWR might be discouraged based upon attitudes and conjectures, as opposed to empirical evidence (Boyd & White, 2000:171). Denying family members the experience might be perceived as a way through which health workers continue to perpetuate their own myths of control (Marrone & Fogg, 2003:32). Some of the reasons stated in favour of FWR are that: fear and anxiety might be reduced; the family might feel supportive and helpful to health team members; and the family might have closure because they know that everything possible has been done for their relative (MacLean et al., 2003:208). However, family members might not be allowed to be present during resuscitation and critical care professionals might still be divided on whether families should be present or not. It is from these ongoing debates that this study explored and described the perceptions of critical care nurses towards FWR.

THE RESEARCH PROBLEM

The Emergency Nurses Association (ENA) of the United States (US) has responded to the growing demands for FWR over the past decade (Cole, 2002:4). Qualitative researchers have explored the lived experiences of family members' presence during resuscitation. The studies done on nurses' views were mainly from the Western countries and focused on the perspectives of patients and health providers (Halm 2005:496). No study could be found that had been done in the United Arab Emirates (UAE) given the fact that the majority of the nurses working in the UAE are expatriates. Most of these nurses are not Muslims and in the UAE the Muslim religion, or Islam, provides the framework that directs every aspect of human behaviour. In the Kingdom of Saudi Arabia (KSA), the family is the patient's primary support system. The family members stay at the patient's bedside most of the time, but should resuscitation be necessary, the family members are excluded from the patient's room during the procedure. This indicates that FWR is not allowed in hospitals in the KSA, neither are there scientific research results to support this idea.

RESEARCH QUESTIONS

The study intended to answer the following questions: 'What are the critical care nurses perceptions towards family witnessed resuscitation?' and 'What are the factors contributing towards these perceptions?'

OBJECTIVES OF THE STUDY

The objectives of the study were to explore the perceptions of critical care nurses towards FWR; to describe the factors contributing to these perceptions; and to make recommendations which will influence the policy on FWR at one hospital in the KSA.

Significance of the study

In line with the holistic model of care adopted by hospitals, nurses should be able to reflect on what happens in their units. The respondents should seek to understand the implications of FWR for both the patients and their families. In addition they should be able to address their perceptions on FWR to render quality patient care.

DEFINITIONS OF KEY CONCEPTS

Critical care nursing is a nursing specialty that is involved with caring for critically ill patients with life threatening conditions and their families (Urden, Stacy & Lough, 2002:167).

Emergency resuscitation refers to the restoration of vital signs by mechanical, physiological and pharmacological means in the event of cardiac arrest or abrupt cessation of cardiac functions (Madden 2006:218).

Intensive care refers to the specialised care of patients whose conditions are life threatening and require constant monitoring (Woodrow, 2006:4).

A family refers to a group of people who live together whether being a nuclear family (parents and their children) or extended family (Taylor, Lilies & Mone, 2005:56). In the current study, a family refers to a group of people related by blood.

Family witnessed resuscitation (FWR) is the process of active resuscitation in the presence of family members (Boyd & White, 2000).

RESEARCH DESIGN AND METHODOLOGY

In the current study, a non-experimental quantitative and descriptive design was used to elicit information from the critical care nurses at one tertiary hospital in the KSA. A quantitative design was based on the premise that individuals' attitudes and perceptions could be quantified by assigning a number to the perceived qualities of things (Babbie & Mouton 2002:48). The study utilised a survey method to describe the area of concern. Burns and Grove (2005:233) and Polit and Beck (2004:56) have stated that surveys are excellent tools for measuring attitudes and perceptions in a large population.

Setting

The study was conducted at one tertiary hospital in the KSA. At the time of the study, the total population of the country was 5.1 million comprising of 66% Saudis and 34% foreigners. The hospital where the study was conducted is a 660 bed tertiary referral centre, serving the KSA and surrounding countries. All medical and surgical specialties are catered for in the critical care units. The critical care departments include one neonatal intensive care unit (NICU), one coronary care paediatric ICU, one cardiothoracic ICU, two medical-surgical ICUs, one cardiovascular telemetry unit and one surgical recovery unit. The critical care department also manages an onsite hyperbaric oxygen therapy unit. Nurses come from over 40 countries and nationalities creating one of the most diverse workforces in the Middle East. As many as 97.0% of the nurses were expatriates from Africa, Australia, Europe and America whilst 3.0% came from the UAE (UAE Annual Report, 2002:45).

One of the conditions of employment for nurses working in an ICU in this hospital is that they must pass the competency test in cardio-pulmonary resuscitation (CPR). The family is often not included in the resuscitation procedure. Should the resuscitative efforts fail and the patient die, the doctor (together with the patient's primary nurse and the social worker, if available), will inform the family about the death of their relative. In most cases the announcement is made via an interpreter as most patients are Arabic speaking compared to most healthcare workers who are English speaking.

Population and sample

The population comprised nurses working in the critical care areas in the participating hospital. Some of the respondents were intensive care trained and others were intensive care experienced. A non-probability convenient sample of 100 critical care nurses from five critical care units was obtained. This sample was chosen because it was convenient and economical in the sense that the researcher was employed at this hospital and all respondents were ICU nurses exposed to frequent resuscitation procedures. Only those who were willing to participate were included in the study.

Criteria for inclusion

The respondents had to be critical care qualified or experienced nurses, working in ICUs, and who had passed the competency test in CPR.

Data collection

Data were collected during May 2007. A questionnaire with open-ended and closed-ended questions was used to collect data. Literature was used as the basis for compiling the questionnaire with the help of the statistician. The questionnaire was used because it was cost effective, required less time to administer and offered complete anonymity. It also facilitated the absence of interviewer bias. Many people could thus be reached within a short space of time as the researcher was working in this hospital. A disadvantage of this method is a low response rate if questionnaires are posted (Burns & Grove 2005:265). To prevent this problem, each questionnaire was hand delivered and collected by the researcher. Open-ended questions required the respondents to provide their own words while closed-ended questions required the respondents to select answers from a provided list of possible answers.

Appointments were made with the respective head nurse of each unit. He or she was given 20 questionnaires to hand out to respondents. One hundred questionnaires were distributed. A letter was attached to each questionnaire explaining the purpose of the study, also stating that permission had been granted from the management of the participating institution, and with the researchers' contact details.

Reliability and validity

The researchers ensured validity of the data in that the same measuring instruments were given to all the respondents. The questionnaire was also pre-tested on four nurses who were not part of the final study and corrections were implemented as suggested before the final tool was administered. The reliability of the instrument was checked through the use of Cronbach's alpha reliability test. The initial alpha coefficient was 0.720, but after deleting four statements, the alpha coefficient increased to 0.824.

Data analysis

A total of 70 questionnaires was received from the critical care nurses who responded. Data were captured on an excel spread sheet, cleaned and exported to the EPI INFO programme and then presented in frequency tables.

ETHICAL CONSIDERATIONS

Permission for the study was obtained from the Research and Ethics Council of the hospital. Ethical clearance to conduct the study was obtained from the Research and Ethics Committee of the Department of Health Studies of the University of South Africa. Informed consent was obtained from each respondent. Confidentiality was assured by making the research information available to the researchers only. Respondents were informed that there was no sponsorship, and the decision to undertake the research was the choice of the researcher. No names were written on the questionnaires. Respondents were assured that participation was voluntary and they were free to withdraw from the study at any time with no untoward consequences.

RESEARCH RESULTS

Biographical data

The biographical data revealed that 27.1% (n = 19) of the total of 70 critical care nurses were males and 72.9% (n = 51) were females, a normal gender pattern in critical care units. Of the respondents, 34.3% (n = 24) were 30–39 years old with only 7.2% (n = 5) in the oldest age group of 50–59 years. The highest educational qualification was a master's degree in nursing achieved by only one (1.4%) respondent. Of the respondents 60% (n = 42) had bachelor's degrees in nursing and 38.6% (n = 27) had diplomas in nursing. Respondents came from 12 different countries as indicated in table 1.

Table 1: Countries where respondents trained

Country	n	%
Philippines	12	17
India	10	14
Canada	9	13
South Africa	7	10
Jordan	6	9
United States of America	6	9
Malaysia	5	7
England	4	6
Lebanon	3	4
Australia	3	4
Czech Republic	2	3
Kingdom of Saudi Arabia	2	3
New Zealand	1	1
Total	70	100

Of the respondents, 51.4% (n = 36) cared for adult patients and 18.6% (n = 13) for children, while 30.0% (n = 21) cared for both adults and children.

Respondents' previous experiences with FWR

Only 15.7% (n = 11) of the respondents had been involved with FWR. Those respondents with previous experience believed it had more positive than negative effects for the families concerned.

Preference for FWR

Of those who had not been involved in FWR, 90% (n = 63) would not allow the presence of family members during resuscitation. They feared that the presence of the family members could interfere with the resuscitative efforts. These findings are similar to those by Moreland (2004:62), who documented that nurses feared that FWR might increase stress levels, be disruptive and increase litigation possibilities. The 10% (n = 7) of respondents who preferred the presence of FWR, believed that it would facilitate the grieving process and enhance closure and healing. These results were similar to those of MacLean et al. (2003:206).

Emotional stress for medical and nursing staff members

Most of the respondents (84.2%; n = 59) indicated that FWR would increase the stress levels of both medical and nursing staff members. This view is supported by Goodenough (2001:53), who stated that FWR was a threat to nurses and harmful to implement. Meyers et al (2000:36), as well as Boyd and White (2000:174), reported opposing findings.

Relative's perceptions of the presence of family members' interference with resuscitation efforts

Almost all respondents (90%; n = 63) felt that the presence of relatives during resuscitation would interfere with the resuscitation efforts. Similar findings were documented by Cole (2000:2) who reported that nurses feared relatives would panic, become uncontrollable and disrupt the resuscitative efforts. Only seven (10.0%) respondents agreed that the presence of relatives would not pose any threat to the resuscitative efforts.

Effect of FWR on the decision to stop resuscitation efforts

Of the respondents, 78.3% (n = 55) felt that FWR made the decision to stop resuscitation more difficult; 63.8% (n = 45) would prefer not to be present during the resuscitation

of their own loved ones; while 36.2% (n = 25) would prefer to be present during such efforts. Those respondents who did not support FWR were the same respondents who did not want to be present during the resuscitation of a loved one, and those who wanted to be present supported FWR.

Policy preferences

There were different views on policy preferences with regard to FWR. Of the ICU nurses, 40% (n = 28) preferred a written policy prohibiting the option of FWR; 25.7% (n = 18) were in favour of the policy; and 34.3% (n = 24) preferred a written policy on condition that the unit would allow the option of FWR as indicated in table 2.

Table 2: Respondents' preferred FWR policy option

Preferred FWR policy option	**n**	**% %**
Preferred a written policy allowing the option of family presence to CPR	18	25,7
Preferred a written policy prohibiting the option of family presence to CPR	28	40,0
Preferred no written policy but want the unit to allow the option of family presence to CPR	24	34,3
Total	70	100

When asked about the benefits of FWR for the relatives, the most common benefits identified were that relatives would be satisfied that everything had been done and the grieving process had been facilitated. Most respondents (83.8%; n = 59) believed that relatives should be supported by staff members during FWR. MacLean et al. (2003:42) stated that preparing, educating and updating family members for what they might experience is significant. In relation to staff performances, 50% (n = 35) of the respondents felt that FWR could inhibit the nurses' performance, whilst the rest of respondents felt otherwise.

DISCUSSION OF THE FINDINGS

Respondents who were in favour of FWR felt that the primary benefit for family members was that it facilitated the grieving process if resuscitation failed and the patient died. One respondent stated that 'it is comforting for the family to know that everything was done for the relative'. Another respondent stated that FWR facilitates closure. Similarly, Moreland (2004:59) documented that relatives believed that FWR helped their grieving process. MacLean et al (2003:47) reported that FWR provides an understanding for families to know that everything possible had been done for their loved ones.

The respondents' overriding memory of FWR in the study was one of dislike. This is in contrast to the study done by Grice, Picton and Deakin (2003:15), who reported that in the United Kingdom (UK), the attitudes of staff to FWR were positive. Respondents felt that allowing FWR might be too stressful for both relatives and staff involved. The concern that family members would be traumatised by observing such a procedure and such consequences might not benefit the relatives. Some believed that family members would be too distraught to understand what was happening and would be dissatisfied with the resuscitative efforts. Respondents also expressed that FWR could lead to chaos and confusion as the work space is sometimes limited. Of the respondents, 90% (n = 63) disagreed with FWR. They were of the opinion that it might increase litigation. Respondents also felt that the presence of relatives would prolong the resuscitation process although one respondent stated that 'it depends on the doctor present to terminate the resuscitative efforts when necessary'. The findings of this study are similar to the study by Yanturali et al. (2005:5) who feared FWR would lead to family interference and litigation. Goodenough (2001:54) found that staff disliked the presence of family during resuscitation as it was regarded as being a potentially harmful experience. Similarly, Moreland (2004:59) expressed concerns that family members would increase the stress levels of medical staff and disrupt the procedure. However, the study conducted by Boyd and White (2000:52), found no significant changes regarding the stress levels of healthcare workers.

CONCLUSIONS

The overriding perception of ICU nurses towards FWR was one of disapproval. Nurses reported that allowing the presence of family members during resuscitation might be stressful for both relatives and staff members involved. Those nurses who would prefer to be present during the resuscitation of their own loved ones, were also in favour of FWR.

RECOMMENDATIONS

Nurses should be encouraged to reflect on their FWR perceptions. Relatives should not be regarded as an added complication, but rather as an extension of the critically ill patient. There is a need for research with regard to family support during resuscitation efforts. A hospital policy and guidelines should be developed for critical care nurses to ensure effective management of family members during FWR or on hearing that their relative is dying or has died.

LIMITATIONS OF THE STUDY

Although the study's sample comprised 70 respondents who completed questionnaires, only 3.0% (n = 2) were from the KSA. Consequently, the results of the study cannot be generalised to the critical care nurses of the KSA.

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