CARDIFF AND VALE UNIVERSITY HEALTH BOARD
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Family Witnessed Resuscitation

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Contents

1 INTRODUCTION

Family Witnessed Resuscitation (FWR) is the practice of allowing relatives to remain present whilst their loved one is resuscitated. FWR is not a new concept however it remains to be a controversial subject this could be due to the divide amongst health care professionals on their views regarding FWR. It is important that health care professionals understand the rationale for FWR and be able to manage these situations sensitively and effectively.

2 PURPOSE OF PROCEDURE

This guidance had been produced to support Health Care Workers (HCW) with Family Witnessed Resuscitation in their practice. The general public are becoming increasingly aware and more knowledgeable about health care and the options that are available to them and in turn more relatives may ask to remain present during the resuscitation of a loved one. Input from media resources such as TV hospital dramas and factual television documentaries have exposed the general public to the process of resuscitation which may also have contributed to this expectation.

3 AIMS OF PROCEDURE

The aims are as follows

- To ensure that patients and relatives are treated with dignity and respect.
- To ensure their human rights are respected.
- To promote current practice based on, RCN, RCUK, ERC guidelines.
- To promote holistic care.
- To implement a consistent approach for relatives witnessing resuscitation.
- To provide guidance to all health care professionals at Cardiff and Vale UHB who may be involved in the resuscitation of patients with relatives requesting to remain present.

4 DEFINITIONS

4.1‘FWR’

Family Witnessed Resuscitation is the practice of allowing relatives to be present whilst there family member is being resuscitated (RCN 2002).

4.2‘Resuscitation’

Resuscitation is also used to cover a wide range of events in the acute area including fluid replacement, trauma, respiratory or cardiac problems (RCN 2002).

4.3'Family'

The term family applies to the patient's next of kin (partner or parent) or a member of the immediate family. The presence of children during the resuscitation is usually inappropriate. Except in exceptional circumstances the number of relatives should not exceed two.

4.4'CPR'

Cardiopulmonary resuscitation may include chest compressions, defibrillation, and artificial respiration in an attempt to restart the heart.

4.5 'DNACPR'

Do Not Attempt Cardiopulmonary Resuscitation orders apply only to cardiopulmonary resuscitation. It should be made clear to the patient, people close to the patient and to the health care team that it does not imply "non treatment" and that all other treatment and care appropriate for the patient will be considered and offered. The All Wales DNACPR policy (2015) should be adhered to. All DNACPR decisions should be documented on the All Wales DNACPR form and placed in the front of the patients notes.

4.6 'PRUDiC'

All Wales multi-agency **'Procedural Response to Unexpected Deaths in Childhood' (2010)** . The aim of PRUDiC is to ensure uniformity across wales in the multi-agency response to unexpected child deaths in Wales. The PRUDiC procedure introduced a framework for all unexpected deaths of children from birth to 18 years.

5 THE BACKGROUND TO FAMILIES WITNESSING RESUSCITATION

The concept of FWR was initially developed in 1982 in Foote Hospital in Jackson, Michigan, USA. Traditionally family members were excluded from being present during resuscitation, due to the belief that resuscitation was too traumatic for family members to witness and that it would affect staff performance. Two separate incidents occurred where relatives demanded to remain present during the resuscitation. Following this Foote Hospital examined their policy and conducted a nine year retrospective study where relatives were given the choice to remain present. The results highlighted FWR as a positive experience from the perspective of staff and relatives who were involved in the study this led to the development of a formal FWR policy. Following this initiative there has been further studies have analysed FWR and its effects on family, staff and the patient. All of the studies highlighted one of the benefits as preserving the wholeness, dignity and integrity of the family from birth to death.

In the United Kingdom the Emergency Nurse Association became the first professional body to support FWR by making an official statement recommending the development

of multidisciplinary guidelines for FWR. Many governing bodies responsible for providing resuscitation training and education support the importance of allowing relatives to witness with support resuscitation (RC UK1996, ALSG 2001).

6 RESPONSIBILITIES AND IMPLICATIONS ON CLINICAL PRACTICE

6.1 Rationale for allowing relatives to witness a resuscitation attempt

- Prior to attending the hospital it is quite common for relatives to be present when their loved one has become unwell and in some circumstances they may well have been the ones to initiate CPR. Therefore not allowing the relative to remain present once in the hospital environment can be deemed as an unsupportive action from a health care professional.

- Allowing family presence can bring reality to the situation which in turn can prevent a prolonged period of denial during the grieving process.

- Can aid the grieving process as they are able to say goodbye and hold their loved one whilst they are still warm.

- Can allow the relative to say anything they need to this can prevent the feeling of guilt during the grieving process.

- The relative can also see that everything possible has been done to save their loved one.

- Can allow relatives to see the reality of resuscitation which can be less horrifying than they may be imagining.

6.2 Ground Rules for FWR

- Relatives must be asked if they want to remain present and their wishes must be respected. Clear documentation of verbal consent should be written in the medical notes.

- There must be an appropriate member of staff available to take responsibility care of the relatives. If there is no member of staff available then the relative should be not allowed to remain present. The family members must never be left alone during the resuscitation.

- If FWR is not offered it is essential that the reasons why are documented.

- If the relative is present during the resuscitation, this should also be clearly documented in the medical notes.

- If the relative does not speak English, an interpreter should be sought as soon as possible to help the health professional provide adequate support. However this may take some time but must not interfere with the patient's care or delay treatment or resuscitation.

- If CPR is successful and the patients survives. The patient must be informed that their relative was present during the resuscitation.

- There is no reason to believe that the patient has already refused permission for relatives to be present if they require CPR or that if competent, they would refuse.

- The resuscitation team leader has overall responsibility to determine the best time for the relatives to enter and that they may be asked to leave depending on the patient's condition and procedures being undertaken (see 11.3).

6.3 When relatives may be asked to leave or not enter the resuscitation room

- If family members are unable to remain calm and disrupt the team's efforts they may be asked to leave the resuscitation room. However different cultures may have different emotional responses, which need to be taken into consideration when assessing relative emotional responses.

- If relatives are extremely intoxicated and behaving inappropriately they can be asked to leave the resuscitation room. However if intoxicated relatives are behaving appropriately they should be allowed into the resuscitation room.

- If there is no available appropriate health care worker to support the relative during and after the resuscitation.

- If the patient has injuries that could be deemed as too traumatic for relatives to witness which could have a negative psychological impact on the relative.

- Family member tries to become physically involved in the resuscitation of their loved one.

6.4 Decision to stop resuscitation in the presence of relatives

- This decision should be made quietly in consultation with the rest of the resuscitation team and if possible the relatives should be informed of the decision.

- If the patient survives initial resuscitation but a subsequent DNACPR order is made, the relatives should be informed of this decision. Even though relative's views have no legal status in terms of actual decision making, health professionals should respect the relative's family life and the delivery of information is an important part of human rights considerations.

- Gradually staff should leave the area one by one, those who have no active involvement leaving first. The team leader and support nurse staying to support the relatives.

- Removal of equipment from the patient depends on local UHB policy and if the patient is a child the PRUDiC procedure needs to be followed.

- When relatives are ready the nurse should escort them out of the area and follow the UHB bereavement guidelines.

7 SUPPORTING THE RELATIVES

7.1 Preparation of the relatives before entering the resuscitation area

- Prior discussion with the allocated nurse regarding what they may see and hear must take place outside the resuscitation area.
- It is important that relatives are informed about the patient's appearance, smells they may be exposed to, treatments being performed, and equipment being used on their loved one.
- Relatives need to be informed when they are able to touch and hold their loved one.

7.2 Rules Relatives must be made aware of prior to entering the area

- At no time they will be left alone during or after the resuscitation
- At times they may be asked to leave the resuscitation room, depending on the activities that are being undertaken.
- Number of relatives allowed will depend on the space available in the resuscitation area.
- Relatives may leave the resuscitation area at any time.

7.3 Designated Family Support Person (FSP)

- Must remain in contact with the relatives and must not get involved with the treatment of the patient.
- The FSP must be able to talk to the relatives in a clear understanding manner, without the use of euphemisms.
- The FSP must have an understanding of the workings of the resuscitation so they can pre-empt the actions of the team to provide the relative with information.
- They should act on behalf of the family.
- The FSP should communicate with the team leader on the patient's prognosis.
- The FSP should remain with the family during and after the resuscitation.

8 Post Resuscitation care

- If the family were not present during the resuscitation, before entering the resuscitation they need to informed about how their relative will look and feel and if there is any remaining equipment in situ.

- Deaths relating to children, relatives need to be informed about the need for a multidisciplinary investigation (PRUDiC procedure).
- Professionals need to take into account any religious and cultural beliefs which may impact on post resuscitation care.
- Information leaflets on bereavement should be given and available for relatives.
- Information on the role of the coroner maybe required.
- Information will need to be provided about when and how they will be made aware of the post mortem results.
- Advice on how to go about making funeral arrangements may be required.
- Contact details and telephones numbers may be required by the relative to contact regarding any questions they may have.
- All professionals involved with post resuscitation care will need to be aware of the requirements of the law but being sensitive to the distress of the family.
- Health care workers need to be aware on occasions of suspicious circumstances that the relative, parent or carer may be arrested in order to secure and preserve evidence for an effective investigation to be conducted.

9 ROLES AND RESPONSIBILITIES

9.1 RC (UK), and RCN National Guidance

Cardiff and Vale NHS UHB aims to comply with this national guidance to healthcare professionals both through the development of this policy and the production of an information leaflet for patients and relatives.

9.0 University Health Board

The UHB carries overall responsibility for the UHB. It has delegated powers from the National Assembly for Wales in respect of the ownership and management of hospitals and other health facilities; it is responsible for the performance of the UHB. The Chief Executive must ensure the UHB has an agreed Family Witnessed Resuscitation Guideline that respects patients' rights and that any decisions made by staff are informed via the Family Witnessed Resuscitation Guideline and relevant patient information.

9.3 Resuscitation Committee

The UHB Resuscitation Committee, led by its chairperson, meets on a regular basis. Its role is to ensure that UK Resuscitation Council guidelines for the resuscitation of victims of cardiopulmonary arrest are implemented effectively. Committee members should be conversant with contemporary issues related to new developmental knowledge.

9.4 Resuscitation Service

The Resuscitation Service is answerable to the Resuscitation Committee in terms of its clinical lead. It is responsible for implementing decisions made by the Resuscitation Committee and promoting good practice primarily through training and audit. The Resuscitation Service is responsible for assessing those it teaches and ensuring that they meet standards that reflect UK Resuscitation Council guidelines. The Resuscitation Service develops policies using guidance to ensure full multidisciplinary representation. It monitors cardiac arrest outcome and team response as well as adherence to resuscitation policies and procedures (including FWR guideline). The Senior Nurse for the Resuscitation Service will maintain, manage and develop the service, within available resources, to meet the needs of the UHB.

9.5 Directorate and Line Managers

While the UHB has the responsibility to ensure that resuscitation policies and relevant patient information are developed through the UHB Resuscitation service, those who manage staff, particularly clinical staff, have a responsibility to ensure that staff and, where relevant, patients and their relatives have access to and understand resuscitation policies, including this FWR guidance.

9.6 Individual Staff Members

While the UHB have a responsibility to provide a Resuscitation Service and its managers are responsible for ensuring staff have access to and understand resuscitation policies, procedures and guidelines, each individual is responsible for their own actions and professional practice. Individual staff members should familiarise themselves with UHB resuscitation policies and procedures. Health Care Workers have a responsibility to respect patient rights and confidentiality whilst ensuring that decisions relating to FWR are communicated to appropriate colleagues.

10 IMPLEMENTATION

Existing staff will be made aware of the policy through training and dissemination of this information to all appropriate directorates and managers in accordance with the management of policies and procedures for Cardiff and Vale UHB.

11 RESOURCES AND FUNDING

There is limited cost for the implementation of this guideline as it will be distributed electronically. UHB staff will be made aware of this guidance will be on advanced and basic life support courses.

12 AUDIT

The compliance of this guideline will involve undertaking audit. However it is acknowledged that audit will be difficult to achieve as cardiac arrests are unexpected. The cardiac arrest team and resuscitation practitioners would be utilised to assist with obtaining data for this audit.

13 EQUALITY

An Equality Impact Assessment has been undertaken to assess the relevance of this guideline to equality and the potential impact on different groups, specifically in relation to the General Duty of the Race Relations (Amendment) Act 2000 and the Disability Discrimination Act 2005 and including other equality legislation. The assessment identified that the guideline presented a low risk to the UHB.

The guideline is reflective of the national guidance produced by the RCN/ Resuscitation Council UK and European Resuscitation Council.

14 REFERENCES/FURTHER READING

This guidance is abstracted from or makes reference to the following publications.

A European survey of critical care nurse's attitudes and experiences of having family members present during cardiopulmonary resuscitation	Fulbrook P, Albarran J, Latour W International Journal of Nursing Studies 42 557-568	2005
All Wales Do Not Attempt Resuscitation DNACPR policy	NHS Wales	2015
Family presence at the bedside during invasive procedures and resuscitation	Emergency Nurses Association http:/www.ena.org/about/position/familypresence.asp	2001
Family presence during paediatric resuscitation: a focus on staff	McGahey P Critical Care Nurse 22(6)29-34	2002
Family presence in emergency department resuscitation: A proposed guideline for an Australian Hospital	Maurice H Australian Emergency Nursing Journal 5(3) 21-27	2001
Procedural Response to Unexpected Deaths in Childhood	Public Heath Wales	2010
Relatives in the resuscitation room: a review of benefits and risks (clinical)	Clift L Paediatric Nursing 18 (5) 14-18	2006
The New NHS: Modern, Dependable	Department of Health	1997
Witnessing Resuscitation: Guidance for Nursing Staff	Royal College of Nursing (RCN)	2002

It should be read in conjunction with the following UHB policies:

- ✓ Do not Attempt Cardiopulmonary Resuscitation (DNACPR)
- ✓ Resuscitation Procedure
- ✓ Policy for Breaking Bad News to Patients, Their Relatives and/or Carers

15 CONTRIBUTORS

Members of the Resuscitation Committee