

## CLINICAL QUESTION:

Does family presence have a positive or negative influence on the patient, family, and staff during invasive procedures and resuscitation?

## PROBLEM:

The practice of allowing family members to be present during the resuscitation of or invasive procedures on their relative is one that has been discussed over the past few decades. With the rise of family-centered care, family input into healthcare decisions has increased and strict visitation policies have relaxed, even including family at the bedside during invasive procedures and resuscitation. This concept was first presented in the early 1980s when Foote Hospital in Michigan began a program to facilitate the practice of family member presence during resuscitation as a response to demands by families (Doyle et al., 1987). Hanson and Strawser (1992) presented data from the program as the seminal research on this topic. Since then, research has centered on several different aspects of this issue. For both the initial CPG and this update, the literature indicates that healthcare workers and family members support family presence. New research has not yielded any findings that would change the practice recommendations for allowing family presence during resuscitation.

Description of Decision Options/Interventions and the Level of Recommendation	
Family member presence during invasive procedures or resuscitation should be offered as an option to family members and should be based on written institution policies (Basol et al., 2009; Ferrara et al. 2016; Goldberger et al. 2015; Howlett et al., 2010; Lederman et al. 2014; Madden & Condon, 2007; Pankop et al. 2013; Sak-Dankosky et al. 2014; Zavotsky et al. 2014).	A
Concerns that family presence is detrimental to the patient, the family, or the healthcare team are not supported by the evidence (Celik et al. 2013, Bjorshol et al., 2011; Fernandez et al., 2009; Fernandes et al., 2014; Hassankhani et al., 2017; Jabre et al., 2013; Jabre et al., 2014; McAlvin et al., 2014; Nigrovic et al., 2007; O'Connell et al., 2007; Porter et al., 2014; Sacchetti et al., 2005; Yavuz et al., 2014; Youngson et al., 2016).	B
Acceptance of family presence may have some cultural basis (Al-Mutair et al., 2012; Günes & Zaybak, 2009; Hassankhani et al., 2017; Koberich et al., 2010; Lai et al., 2017; Leung & Chow, 2012; Masa'Deh et al., 2013; Soleimanour et al., 2015; Young, 2014; Youngson, Currey & Considine, 2016).	B
Healthcare professionals support the presence of a designated healthcare professional assigned to family members present to provide explanation and comfort (Basol et al., 2009; Dingeman et al., 2007; Dwyer, 2015; Dwyer & Friel, 2016; Fallis et al., 2008; Kuzin et al., 2007; Madden & Condon, 2007; McClement et al., 2009; O'Connell et al., 2007; Stefano et al., 2016; Twibell et al., 2015)	B
Educating staff in the development, implementation, and evaluation of policy regarding family member presence provides structure and support to healthcare professionals involved in this practice (Basol et al., 2009; Butler et al., 2014, Carroll, et al., 2014, Chapman et al., 2011, Ferrara et al., 2016; Guzzetta, 2016, Howlett et al., 2010; Madden & Condon, 2007; Zavotsky et al., 2014).	B

A	Level A (High)	Based on consistent and good quality of evidence; has relevance and applicability to emergency nursing practice.
B	Level B (Moderate):	There are some minor inconsistencies in quality of evidence; has relevance and applicability to emergency nursing practice.
C	Level C (Weak)	There is limited or low quality patient-oriented evidence; has relevance and applicability to emergency nursing practice.
NR	Not Recommended	Not recommended based upon current evidence.
I/E	Insufficient Evidence	Insufficient evidence upon which to make a recommendation.
N/E	No Evidence	No evidence upon which to make a recommendation.

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