



## CLINICIAN'S CORNER

# Meeting family care needs during resuscitative procedures and cardiac arrest in the emergency department

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## Background

Emergency nurses in Canada provide care to many thousands of critically ill and injured patients, and their families, each year (Rowe et al., 2020). Unfortunately, some Emergency Department (ED) patients and families report a lack of psychosocial and emotional caring (Gordon et al., 2010). Many resuscitative processes and procedures have been described as dehumanizing and traumatic for families (De Stefano et al., 2016; Jang & Choe, 2019). Significant negative emotional and physiological impacts may remain after hospitalization for the patient and their loved ones, whether receiving care for medical, (Davidson & Harvey, 2016) trauma, (McGahey-Oakland et al., 2007) or cardiac arrest presentations (Leske et al., 2013). Families of patients who survive (and those who do not survive) have reported persistent negative psychological effects weeks and months after receiving care in the ED (Jang & Choe, 2019; Keyes et al., 2014; Sawyer et al., 2020).

A systematic review on the topic of patient and family-centred emergency care suggests there are ways to combat negative care experiences and that nurses can greatly influence patient and family satisfaction and outcomes (Redley et al., 2003). A more recent review focused specifically on cardiac arrest care has identified five domains of family care needs: i) focusing on the patient survival, ii) collaboration of the resuscitation team and family, iii) consideration of the family's context, iv) family post-resuscitation needs, and v) dedicated policies and procedures (Douma et al., 2021). The purpose of this article is to provide an

evidence-based summary of approaches EDs and ED nurses can adopt to help meet family care needs during resuscitative procedures, including cardiac arrest care.

## Eight strategies for providing family-centred care during resuscitative procedures and cardiac arrest

### 1. Focus first on taking care of the ill or injured patient

Families want their loved ones to receive the best care possible. In situations where personnel are limited, families do not want to distract or impede care provision. For resuscitation, this means providing up-to-date evidence-based care, available guidelines and tools (Wyckoff et al., 2022). Only when their loved one's care needs can be met, do their needs also become a priority (Loch et al., 2023).

In large urban EDs, where there are numerous staff members to support resuscitation, spiritual care staff, social workers, and nurses can be assigned to liaise with and support families. In resource-limited settings, this will usually fall to the primary nurse.

### 2. Offer and support family presence or absence

Family presence during emergency department resuscitation has been researched since the 1980s (Doyle et al., 1987), and numerous professional organizations support this practice (Oczkowski, Mazzetti, Cupido, & Fox-Robichaud, 2015; Oczkowski, Mazzetti, Cupido, Fox-Robichaud, et al., 2015; Vanhoy et al., 2017). Research has repeatedly demonstrated that family presence

improves family-oriented outcomes, does not worsen patient outcomes, and is an ethically justifiable practice (Clark et al., 2013; Jabre et al., 2013; Oczkowski, Mazzetti, Cupido, & Fox-Robichaud, 2015; Toronto & LaRocco, 2019). Family-centred cardiac arrest care project collaborators (<https://osf.io/fox5g/>) advise that family members in the ED should be given the option of being present during cardiac arrest care. If they choose not to be present, they should be supported by a family liaison or support person outside the room in the hallway, a waiting area, or a purpose-built family room. (Douma et al., 2021).

The importance of a family liaison or support person to respond to questions and attend to family care needs has been identified across multiple studies (Larsson et al., 2013; Perman et al., 2018; Stewart, 2019; Tíscar-González et al., 2019) including during the COVID-19 pandemic (Gabbie et al., 2021) and aeromedical transport (Kirby et al., 2022). Noteworthy support needs of family members include being prepared for what they will see, receiving frequent updates (regarding what has happened, what is happening now and what happens next), providing somewhere to charge mobile devices, calling support persons, and receiving a cup of tea or a blanket (Carlsson et al., 2022; Steffen et al., 2020). The assignment of a family liaison or support person should be done assertively, and not left as an afterthought. Too frequently there is a diffusion of responsibility, where one or multiple staff may share some responsibility, yet the family's care needs are unmet.

### 3. Allow for closeness between family and patient

More than presence, such as watching from metres away in the resuscitation bay, some families will seek closeness with their ill or injured family member. The degree of physical proximity they seek will be based on their individual preferences (Stewart, 2019). Some families will want to actively care for their loved one by talking to them, touching them, praying and having religious ceremonies (Carlsson et al., 2022; Othman et al., 2020; Twibell et al., 2015). Emergency department staff should support such family requests, especially when they do not disrupt care processes. The experience of being supported by nursing staff to be close to their family member was described by family members as compassionate, (Jang & Choe, 2019) respectful, (Weslien et al., 2005) supportive, (Maxton, 2008) and empathetic (Carlsson et al., 2022).

### 4. Share information, communicate, and share decision making

As part of routine practice, emergency department staff should be prepared to frequently share information with family members. When multiple family members are present, it can be helpful to assign a single-family contact person to update and avoid duplication of effort. Numerous studies have identified information as the primary need of patients and families when receiving care (Holm et al., 2012; Hung & Pang, 2011; Illum, 2012; King et al., 2019):

- What is known? for example:
  - Working diagnosis, including what diagnoses are likely versus unlikely
  - Diagnostic imaging and laboratory results
- What remains unknown? For example:
  - Definitive diagnosis
  - Prognosis

- Who is providing care? for example:
  - Names and roles of members of the care team
- What are the care priorities right now? For example:
  - Symptom management
  - Resuscitative procedures
  - Transport to definitive care
  - Identification of reversible causes of cardiac arrest
- What happens next? For example:
  - Admission to an intensive care unit
  - Transfer to the cardiac catheterization suite or operating theatre
  - Post-mortem care
- What happened? Why did this happen?
  - 911 was called for...
  - An artery in the brain broke open and blood accumulated between the brain and the skull causing pressure...
  - Right now, we don't know why this happened, but that will be a priority of the team in intensive care...

Some families will want to have a role in their loved one's care. These families will want to communicate with emergency department staff, (Carlsson et al., 2022) be listened to (Edwardsen et al., 2002), and share information relevant to the patient's care (McGahey-Oakland et al., 2007). Participating in decision-making with physicians and nurses about the patient's care, including treatment decisions and termination of resuscitation efforts, has been identified as a shared decision-making priority of some families. (Carlsson et al., 2022; Cole et al., 2021; Jang & Choe, 2019; Stewart, 2019)

### 5. Consider the family context

It is important to consider the patient and family's context and culture, which may influence their care preferences. Authors from Saudi Arabia wrote a brief directive detailing an Islamic cultural perspective of family presence during resuscitation, describing strong extended family engagement and passionate expressions of grief (Othman et al., 2020). Moreover, a qualitative study from the Basque region in Spain found family members were fearful and resistant to being present during resuscitation, which led to the authors recommending healthcare workers assess each case independently, and that families must be integrated into decision-making (Tíscar-González et al., 2019). It is impossible to know each family's culture and preferences, thus each family should be approached individually, respecting their unique perspectives and preferences.

Another aspect of family context is the patient's goals for their care, quality of life and prognosis. In some settings, ED nurses can lead goals of care conversations, in others ED nurses advocate for and facilitate these discussions. Research supports the premise that families want the natural end of life to be respected (Cole et al., 2021; Schmidt & Harrahill, 1995). Resuscitation should not be the default action, nor should protocols and laws make resuscitation mandatory (Cole et al., 2021). In some cases, families involved in resuscitation research have identified that the best care for their family member was holding hands and telling them they are loved, especially in light of futile resuscitation procedures (Mawer, 2019).

## 6. Debrief and summarize events

A valuable tool for emergency department staff is patient and family debriefing. It can be combined with a bedside handover when the patient is transferred, admitted, or has died in the emergency department. The debriefing is not an operational one, (not to reflect on the care processes and identify opportunities for improvement); instead, the purpose of the debriefing is three-fold: i) to address information needs; ii) to address the psycho-emotional needs of the patient and family, and express empathy; and iii) to conclude the care experience with compassion while promoting family self-care. Families have credited debriefing with helping them process the care received (Jang & Choe, 2019).

The debriefing does not need to be lengthy or onerous. The treating nurse and physician can recap what happened to the patient, what is known about the diagnosis, what was done in the emergency department, and what happens next (Redley et al., 2019). In concluding the debriefing, the care team should identify where the family can go for more information or any additional care needs. Receiving important information in written format may help improve recall, considering the brevity of interactions and the potential for misunderstanding during an emergency (Hoek et al., 2020). Resources developed by patient representative organizations are often well received and valued by patients and families (Steffen et al., 2020).

## 7. Future care needs, empowering self-care, and follow-up

If the patient is admitted to the hospital or transferred to another facility, there may be no follow-up care needs to address by ED staff. However, if the patient dies in the ED, staff should identify to whom the family can turn for additional support. This can be communicated through formal discharge summaries, instructions to follow up with a family physician, or suggesting resources such as Canadian Heart and Stroke Caregiver Support Resources (Heart and Stroke, 2022), the Sudden Cardiac Arrest Foundation (Jampel, 2020), or [www.mygrief.ca](http://www.mygrief.ca), depending upon the reason for seeking care. Staff should endeavour to empower self-care. Emergency departments should identify local grief, trauma, and bereavement resources in their community, to which they can point patients' families.

## 8. Supportive policies and procedures

Clinical governance documents, such as policies and procedures, that support family-centred care are required. (McGahey-Oakland et al., 2007; Twibell et al., 2015) Directives that support family-centred care help prevent staff and family conflict about visitation, presence, and expectations of care. They help clarify the expectations of staff and families, while simultaneously supporting both parties to achieve their goals.

## Conclusion

Providing family-centred care during resuscitative procedures and cardiac arrest is essential for improving patient outcomes and addressing the psychosocial and emotional needs of patients

and their families. Emergency nurses and ED staff can provide compassionate and comprehensive care by focusing on patient care, supporting family presence/absence, involving families in decision-making, addressing their needs, and implementing supportive policies/procedures. It is crucial to recognize that each family's needs and preferences may differ and that a tailored approach will lead to the most successful outcomes. By adopting these evidence-based strategies, EDs can create an environment that fosters both patient and family satisfaction and improves overall care experiences.

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Matthew J. Douma conceptualized the manuscript topic and completed the first draft.

Christopher T Picard – substantial edits, second draft preparation

Kar Lin Su – editing

Calah Myhre – editing

Katherine E Smith – multidisciplinary team focused editing

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