A lesson in listening

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The practice of including family members in the resuscitation or trauma room has been the focus of much debate in current literature, and continues to be controversial in practice settings. Though recent research has shown that most families would like to be given the option to witness invasive procedures and resuscitation (Boudreaux, Francis & Loyacano, 2002), the opinions of health care providers remain mixed (Back & Rooke, 1994; Helmer, Smith, Shapiro & Katan, 2000; Meyers, Eichhorn, Guzzetta, Clark, Klein, Taliaferro & Calvin, 2000; Sacchetti, Lichenstein, Carracio & Harris, 1996). Pediatric emergency nurses are frequently faced with family presence decisions. The following case study demonstrates that, ultimately, family members and patients must be listened to and supported in making the right family presence choices for themselves.

Case study

I was a relatively new nurse in the emergency department of a tertiary care pediatric hospital when a 15-year-old boy named John* was brought into the trauma room. While riding his bike, John had been struck by a car head-on and thrown through the windshield. He sustained a number of injuries, including three severe facial lacerations requiring plastic surgery. Just prior to leaving for the operating room, one of my colleagues informed me that John's mother and 19-year-old sister had arrived and were waiting outside the trauma room door. As it is part of our routine practice to allow family members into the trauma room with a support person, I informed John, who was conscious, that I was going to bring his family in to see him. John cried, "Just bring in my sister. My Mom can't handle this." I reassured John that I would verbally prepare his mother and that she would surely want to see him prior to his surgery. Despite his alert, oriented state, I felt that John may have been confused due to the narcotics he had received, and I brushed off his concerns. I went into the hall and spoke with his mother, Jane*, who was visibly very upset, and his sister. I informed them that John had cuts and bruises, but was able to speak to them. Jane was shaking as I escorted them into the trauma room. Upon seeing her son, Jane burst into tears, screaming, "How can you do this to me?" She collapsed on the floor and another nurse had to guide her from the room in a wheelchair. As we wheeled John up to the operating room, he was shaken and worried about his mother. He informed me that his mother had spent the day in court with her other son, who had been accused of a criminal offence, and that he had not wanted to increase her anxiety further. He went in to surgery crying, expressing feelings of guilt for distressing his mother, while Jane, unable to accompany her son, required added stress reduction care in the emergency department.

Reflection

This difficult situation did not result from a lack of knowledge or good intentions on my part. Rather, it was my failure to really listen to John and his family, and allow them to express their concerns that resulted in increased distress and anxiety. I did not give John or his family the opportunity to express their unique needs, and as such, I could not give them the support they needed to make a truly informed decision. John's request not to see his mother should have prompted me to further investigate the situation. I could have explored alternative plans with John, which might have led to better outcomes for him and his family. I could have also approached his mother and sister and honestly reported John's statement, allowing them to discuss his apprehension and consider the best choice for them under the circumstances.

When I care for children who have sustained traumatic injuries, I often remember John and Jane, and consider the importance of listening in communicating with families. I have learned that listening can make all the difference in the provision of family-centred nursing care. I still advocate for family presence, and believe that families have the right to choose to be with their ill or injured loved ones. I now understand, however, that children have a voice and an ability to share in family presence decisions. Each family has unique needs and we must strive to provide them with all of the information and support necessary to assist them in making their own informed choices about family presence.

**Names have been changed to protect patient confidentiality*

References

Back, D., & Rooke, V. (1994). The presence of relatives in the resuscitation room. **Nursing Times, 90**, 34-35.

Boudreaux, E.D., Francis, J.L., & Loyacano, T. (2002). Family presence during invasive procedures and resuscitations in the emergency department: A critical review and suggestions for future research. **Annals of Emergency Medicine, 40**(2), 193-205.

Helmer, S.D., Smith, R.S., Shapiro, W.M., & Katan, B.S. (2000). Family presence during trauma resuscitation: A survey of AAST and ENA members. **Journal of Trauma, 48**(6), 1015-1024.

Meyers, T.A., Eichhorn, D., Guzzetta, C.E., Clark, A.T., Klein, J.D., Taliaferro, E., & Calvin, A. (2000). Family presence during invasive procedures and resuscitation. **American Journal of Nursing, 100**, 32-43.

Sacchetti, A., Lichenstein, R., Carracio, C., & Harris, R.H. (1996). Family member presence during pediatric emergency department procedures. **Pediatric Emergency Care, 12**(4), 268-271.