

Family presence during resuscitation in the intensive care unit

Strategies for implementing this policy change.

By Carolyn Bradley, MSN, RN, CCRN; Janet Parkosewich, DNSc, RN, FAHA; Bertie Chuong, DNP, RN, CCRN

Most people know that resuscitation efforts aren't always successful. Armed with this knowledge, family presence during resuscitation (FPDR) can be a comfort to patients who are fearful of dying alone without the support and advocacy of their loved ones. In addition, patients have a sense of relief knowing that their family will see that the resuscitation team did everything possible to save their lives. FPDR benefits the family as well by promoting transparency about life-saving measures. Witnessing resuscitation efforts reduces family members' anxiety, minimizes feelings of patient abandonment, and provides comfort when they see the efforts made to revive their loved ones. However, not all patients want FPDR because of concern for family members and worry that they might distract the resuscitation team. Conversations with patients and families about FPDR will help allay concerns and highlight the potential benefits.

Implementing FPDR

FPDR is a patient- and family-centered care practice endorsed by the American Association of Critical-Care Nurses (AACN) and the Emergency Nurses Association (ENA). However, not all hospitals sanction it. And in settings that do offer FPDR, it's not always fully implemented or practiced consistently.

The key to successful implementation of FPDR in the intensive care



unit (ICU) is adopting a proven organizational model for change. Many models are available, but the one described by Kurt Lewin, a social psychologist, may be of interest to clinicians because it's time-tested and easily applied in clinical settings. (See *Lewin's 3-step change model*.) Change agents, who in the case of FPDR, are respected clinical experts, provide the leadership for this dynamic process.

The process begins with the *unfreezing stage*, which disrupts the status quo and highlights the need for change. As a change agent, you'll need to develop strategies to help people let go of sacred cows. When it comes to FPDR, nurses and other clinicians must recognize that sending families to the waiting room at the first sign of their loved one's

clinical deterioration is no longer acceptable.

One critical aspect of unfreezing is force field analysis—a thoughtful critique of the current internal and external environments. (See *FPDR force field analysis*.) This analysis weighs the driving forces that will facilitate acceptance of a new practice, such as FPDR, against restraining forces that will undermine or impede the change. Overcoming restraining forces can be challenging because perceptions and beliefs may be embedded in the setting's culture.

The *moving stage* involves planning, implementing, and managing the practice change, which can be introduced on a small scale and then refined based on feedback and evaluation. Most practice changes involve introducing new policies or practice guidelines, redesigning staff members' roles and responsibilities, and providing education and skills training. Be persistent, keep a close eye on how well staff adhere to the new practice, engage those who embrace this change, and work to remove barriers.

The last step is the *refreezing stage*, which represents a shift in culture that wholeheartedly endorses the new practice and ensures that it's applied consistently. You'll need to work hard to realign the new policy with practice expectations, so establish processes for measuring adherence to the new practice and for providing clinicians with performance feedback.

Lewin's 3-step change model in action

Use the following example of Lewin's 3-step change model to integrate FPDR into your organization.

Unfreezing stage

First, confirm senior leadership support for FPDR. Key constituents include providers, nurse leaders, and others who make practice decisions. After support is confirmed, implement strategies to disrupt the status quo. The goal is to call attention to the need for FPDR in your ICU. Plant the seed for change by introducing the topic with clinical nurses, the nurse manager, other nurse leaders, and providers.

Disrupt the status quo

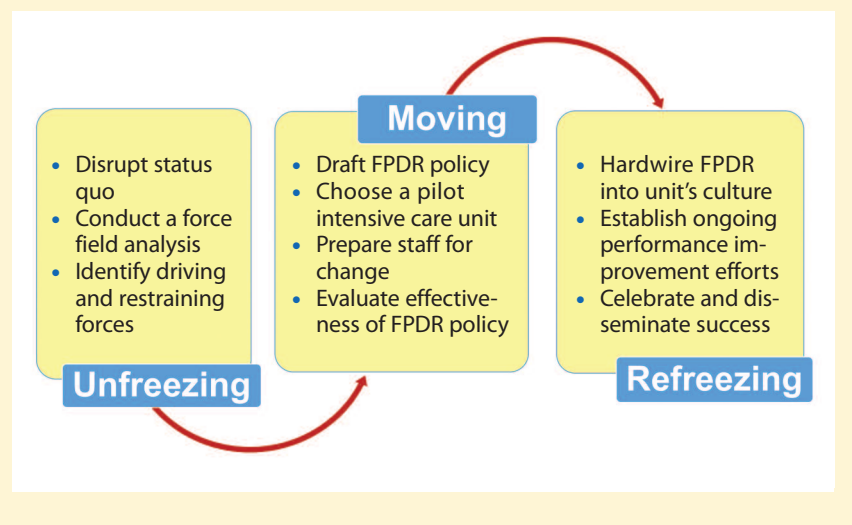
- Visit the ENA website with fellow clinicians to review the *Clinical Practice Guideline for Family Presence during Invasive Procedures and Resuscitation*. Review the AACN Practice Alert: *Family Presence During Resuscitation and Invasive Procedures* and other valuable resources.
- If your unit has a journal club, select a recent FPDR article for discussion.
- Use a recently published FPDR article, the ENA guideline, or AACN resources to have an informal conversation with colleagues so you can learn what they think about this practice.
- Use meeting time to invite guests from other units or hospitals that have successfully implemented FPDR.

Conduct a force field analysis

- Convene an FPDR steering committee to involve others in the change process. Interdisciplinary members can include nurses, providers, respiratory therapists, chaplains, social workers, child life specialists, patient and family advisors, and nursing assistants. Consider inviting individuals who support FPDR and those who resist.
- Schedule regular meetings that encourage open, respectful dia-

Lewin's 3-step change model

Use this change model to develop a family presence during resuscitation (FPDR) policy.



logue about the positive and negative perceptions of FPDR. At the first meeting, discuss personal and professional discomfort about the practice.

- Review the current evidence with the committee. Consider presenting case studies with FPDR best practices.
- Identify potential strategies to enhance driving forces and minimize restraining forces.

Moving stage

This phase involves interdisciplinary planning, piloting the new FPDR policy, and revising it as needed based on feedback.

Draft the FPDR policy

- Ensure that the policy provides clear guidelines and defines the roles of staff during FPDR, which includes details about the family facilitator role. (See *Role of the FPDR family facilitator*.)
- Delineate the process for documenting FPDR on the resuscitation electronic health record (EHR) flowsheet. The nurse's role should include documenting whether FPDR was offered, if the family chose to be present, and if the family facilitator was present. This information will be useful for tracking policy adherence.

Choose a pilot ICU and prepare staff

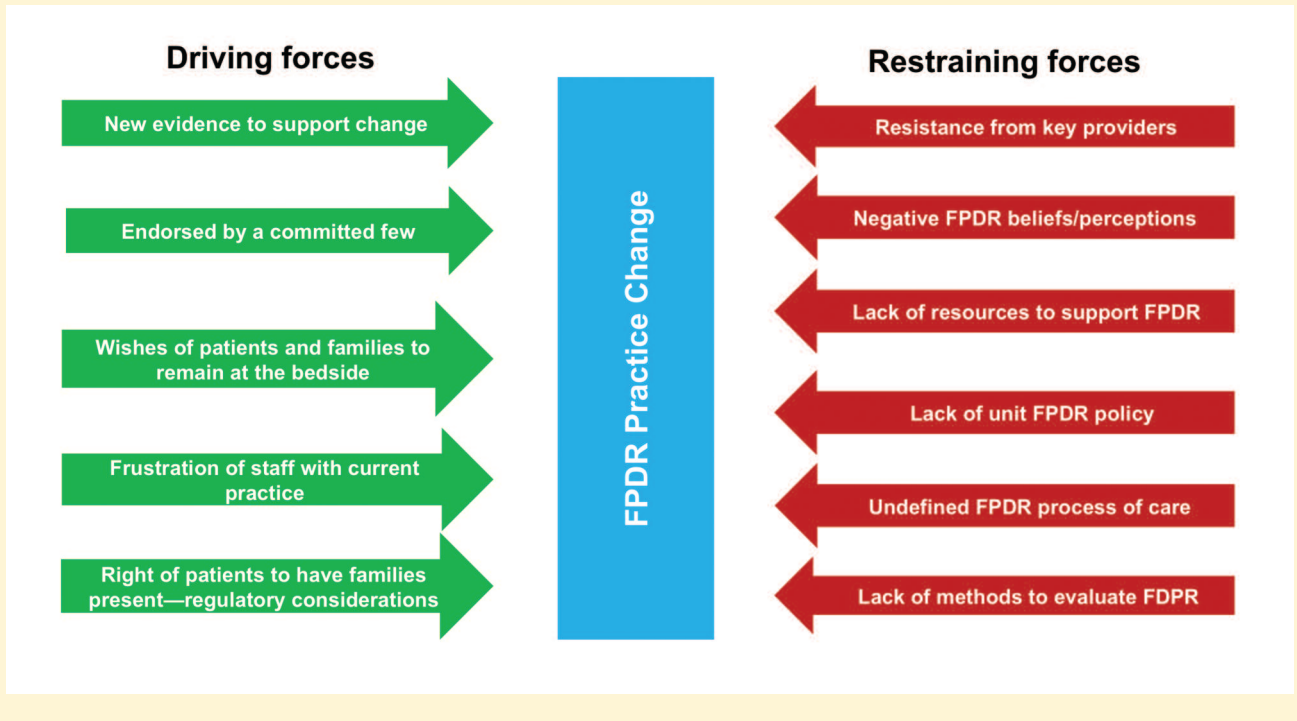
- Identify a pilot unit that's eager to lead the practice change. Unit leaders, providers, and clinical staff are all important stakeholders in deciding where the new practice will be piloted.
- Select FPDR champions from those who truly endorse the practice. You want to choose individuals who will help to drive the change, and who are tenacious and uncompromising in their efforts to facilitate FPDR. They will assist in preparing the interdisciplinary team by providing FPDR education, training family facilitators, and communicating clinicians' experiences with the steering committee.
- Set a date to begin FPDR implementation.

Evaluate FPDR effectiveness during steering committee meetings

- Set standing agenda items that include FPDR champions' feedback.
- Invite nurses, providers, and others to share their experiences.
- Conduct a balanced assessment of progress by examining barriers and highlighting examples of positive experiences.

FPDR force field analysis

Force field analysis helps determine the driving forces that will facilitate a family presence during resuscitation (FPDR) practice change and the restraining forces that may impede it.



- Establish communication processes to give positive feedback to team members who use FPDR and to find out why others have not routinely incorporated it into their practice.
- Implement plans to manage any barriers to effective FPDR.
- Revise the policy, as needed, while maintaining evidence-based standards.

Refreezing stage

The refreezing stage sets in when FPDR becomes part of the ICU culture and clinicians no longer question its value. However, you'll need to take actions during this stage to guarantee that FPDR is offered to every patient and family during every resuscitation. You, as the change agent, and FPDR champions should continue to drive this practice innovation and stay involved in all aspects of the refreezing stage.

Hardwiring FPDR into the unit culture

- Explore opportunities for senior

leadership to demonstrate visible support for FPDR.

- Provide FPDR content during orientation of all appropriate new employees.
- Offer ongoing FPDR training and education.
- Establish a process that aligns employees' performance evaluations with the FPDR unit initiative.

Ongoing performance improvement efforts

- Lead a performance improvement team to evaluate ongoing policy success.
- Establish process goals that measure how often: FPDR is offered to families, family members agree to participate at the bedside, and a staff member served as a family facilitator. Analyze EHR data to track these measures of success.
- Share stories from family members who experienced FPDR.
- Implement processes for timely performance data feedback to the FPDR steering committee,

resuscitation team, and FPDR champions.

- Engage FPDR champions in providing performance data feedback to unit staff.

Celebrate and disseminate success

- Create a process for ongoing recognition of those who consistently demonstrate FPDR best practices.
- Disseminate your work to inspire others to embrace FPDR. Consider submitting abstracts for poster and podium presentations at local and national conferences. Work as a team to draft a manuscript for publication to share your FPDR journey.

Be the change

Changing your ICU's culture to embrace FPDR requires a strategic plan, based on a proven theoretical approach. Visible senior leadership support, a committed change agent, focused FPDR champions, and engaged steering committee members keep the change process

Role of the FPDR family facilitator

The family presence during resuscitation (FPDR) family facilitator ensures that the family is fully supported throughout the resuscitation efforts. This facilitator:

- acts as a collaborative liaison between family and the code team
- screens the family's readiness to participate in FPDR, including the need for interpreter services
- describes sights and sounds associated with the resuscitation efforts to the family before entering the room
- announces to the team that a family member is in the room
- remains with the family at all times
- uses layperson terms when explaining resuscitation efforts to the family, repeats information as needed, and clarifies misperceptions about the resuscitation efforts
- reinforces with the family that the team is doing everything possible to help the patient
- anticipates ushering the family safely out of the room
- at the end of the code, continues supporting the family members and helps them meet their immediate needs.

on track because they all share a common vision for the new policy. These strategies will methodically unfreeze current practice by disrupting the status quo, moving clinicians into accepting the need to pilot FPDR, and refreezing the ICU

culture in which FPDR becomes a practice expectation. ★

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Optimizing the ABCDEF bundle

Tips for overcoming challenges

By Amy Shay, PhD, RN, APRN-CNS

The ABCDEF bundle is an evidence-based set of processes designed to address postintensive care syndrome (PICS). This syndrome of negative long-term consequences of critical illness continues to be a significant health concern for intensive care unit (ICU) patients and their families, yet adoption of the ABCDEF bundle is inconsistent, even more than a decade after it was launched.

The bundle's complexity makes implementation challenging, and its dynamic design requires you to stay up-to-date with changing components as new scientific evidence emerges. Here is an overview of what you need to know.

The problem

PICS is a combination of debilitating symptoms related to mechanical ventilation, heavy sedation, and immobility. It results in significant physical, cognitive, and mental impairment long after patients are discharged. Physical consequences of PICS include ICU-acquired weakness of peripheral and respiratory muscles. This severe myopathy and polyneuropathy is characterized by symmetric extremity weakness and contributes to increased mortality. It occurs in up to 80% of mechanically ventilated patients, and symptoms may persist for years.

PICS also includes critical illness-related brain injury that causes long-term cognitive impairment. Up to 80% of patients may experience cognitive impairment, including deficits in memory, processing, and problem-solving. These cognitive changes can have long-lasting effects on a patient's quality of life. Psychological aspects of PICS in-



clude depression, anxiety, and sleep disorders, and up to 50% of patients report symptoms of post-traumatic stress disorder (PTSD) that last months or years. The debilitating physical and mental effects of PICS mean that many patients experience loss of function that requires prolonged assistance with activities of daily living.

The strategy

The ABCDEF bundle elements aim to break the cycle of oversedation and prolonged mechanical ventilation that leads to ICU-acquired weakness, delirium, and cognitive impairment. The bundle also can improve interdisciplinary communication and cooperation among team members.

The original bundle acronym—ABCDE—stood for **A**wakening and

Breathing trial Coordination, **D**elirium assessment and management, and **E**arly exercise and progressive mobility. Subsequent studies of the original bundle showed consistently improved patient outcomes, and the Society of Critical Care Medicine started the ICU Liberation project to further refine the bundle and disseminate its practice.

The current bundle acronym (ABCDEF) stands for: **A**ssess, prevent, and manage pain; **B**oth spontaneous awakening trials and spontaneous breathing trials; **C**hoice of analgesia and sedation; **D**elirium: assess, prevent, and manage; **E**arly mobility and exercise; and **F**amily engagement and empowerment. (See *ABCDEF bundle*.)

Family (F) is the newest addition to the bundle. Studies show that PICS occurs not only in ICU pa-

tients but also in their family members. Long-term physical, social, and psychological consequences occur in about 75% of families, and many experience anxiety and symptoms of PTSD. Evidence suggests that flexible visitation for families increases satisfaction, improves communication, and allows more opportunities for teaching.

Unrestricted family visitation benefits patients by decreasing anxiety, agitation, and confusion. In addition, family presence improves patient safety and satisfaction while decreasing length of stay. The goal of adding “Family” to the bundle is to promote family presence, engagement, and empowerment.

Family presence

Some myths (such as infection risk, care interference, and patient tiring) exist about the presence of family members in the ICU, but no research supports them. On the contrary, the Society of Critical Care Medicine and the American Association of Critical-Care Nurses recommend unrestricted access for a designated family support person, with no discrimination on the hospital’s part about who is chosen. Unrestricted access can help prevent the patient from feeling isolated from his or her family, provide insight into the patient’s cognitive function, and help decrease agitation and falls. Ideally, the ICU should provide amenities for family comfort and sleep. To help enforce rules in the event of a difficult family member, develop a written visitation policy.

To learn about family presence during resuscitation, read the article on page 18.

Family engagement

Family engagement strategies include inviting family members to participate in some simple aspects of care, such as holding the patient’s hand, applying skin lotion, reading to the patient, placing a cloth on the patient’s forehead, or helping with range-of-motion exercises. Develop brochures that ex-

ABCDEF bundle

Family (F) was added to the ABCDE bundle in response to research that shows family members of patients in the intensive care unit may also suffer from post-intensive care syndrome.

Bundle element	Tools	Key points
A Assess, prevent, manage pain	<ul style="list-style-type: none"> Numerical Rating Scale Behavioral Pain Scale Critical Care Pain Observation Tool 	<ul style="list-style-type: none"> Assess pain using valid tool Treat pain first, then sedate Patient self-report is gold standard I.V. opioids are first drug class of choice for non-neuropathic pain Don’t use vital signs alone to assess pain Implement preprocedural pain treatment
B Both spontaneous awakening trials and spontaneous breathing trials	<ul style="list-style-type: none"> Wake Up and Breathe Protocol 	<ul style="list-style-type: none"> Coordinate the trials and closely observe responses.
C Choice of analgesia and sedation	<ul style="list-style-type: none"> Richmond Agitation-Sedation Scale Sedation-Agitation Scale 	<ul style="list-style-type: none"> Use a valid sedation/agitation assessment tool Titrate medication to light level of sedation Interrupt sedation daily; if needed, restart at half dose Consider non-opioids to decrease number of opioids used Nonbenzodiazepines preferred for sedation
D Delirium: Assess, prevent, and manage	<ul style="list-style-type: none"> Confusion Assessment Method for ICU Intensive Care Delirium Screening Checklist 	<ul style="list-style-type: none"> Monitor for delirium Promote early mobility Provide sleep enhancement Reduce unnecessary and deliriogenic medications Provide structured reorientation Ensure adequate oxygenation
E Early mobility and exercise	<ul style="list-style-type: none"> American Association of Critical-Care Nurses website (aacn.org) contains multiple tools. Search term: early mobility 	<ul style="list-style-type: none"> Accommodate and secure lines, catheters, and drains Assess patient activity tolerance daily Gradually increase activity with adequate rest and recovery Refer for physical therapy as necessary
F Family engagement and empowerment	<ul style="list-style-type: none"> Unrestricted access for primary support person Policies to prohibit discrimination related to the support person Written practice document to limit visitors who infringe on the rights of others 	<ul style="list-style-type: none"> Family presence Family engagement Family empowerment

Implementation resources

Tap into these resources to help your organization successfully implement the ABCDEF bundle.

American Association of Critical Care Nurses (aacn.org/education/webinar-series/wb0027/adding-f-integrating-family-throughout-the-abcde-bundle)—The “Adding ‘F’: Integrating family throughout the ABCDE bundle” webinar identifies strategies for engaging and empowering the families of patients in the intensive care unit.

ICU Delirium and Cognitive Impairment Study Group (icudelirium.org)—You’ll find educational resources and tools for each component of the ABCDEF bundle.

Society of Critical Care Medicine (iculiberation.org/Guidelines/Pages/default.aspx)—The *Clinical Practice Guidelines for the Management of Pain, Agitation, and Delirium in Adult Patients in the Intensive Care Unit* are updated every 3 to 4 years.

plain how family members can be involved in care and participate in bedside rounds.

Provide ICU diaries so families can record events while the patient is sedated and on mechanical ventilation. This documentation may reduce symptoms of PTSD by helping patients understand what happened them. You can find more information about ICU diaries at icu-diary.org/diary/Diary.html.

Family empowerment

Family members are the patient’s primary advocates and should feel comfortable and safe enough to ask questions. Let them know that they can speak up if they see something unsafe and that they can hold staff accountable. Family members and the ICU team should collaborate on palliative care, future care, and the resolution of ethical dilemmas. Remember, families know the patient best and can help staff better understand his or her cultural beliefs and views about illness.

The implementation

A recent survey of ICUs showed that ABCDEF bundle implementation varies by region and individual bundle component. Implementation and compliance was particularly lacking with regard to sedation management, delirium assessment, and early mobility. Recent research has demonstrated the importance of full implementation of the bundle

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and all of its components. A 2017 study of 6,064 patients showed that even partial bundle compliance is effective. For every 10% increase in partial bundle compliance, there was a 15% higher hospital survival rate among patients. In addition, higher bundle compliance was associated with fewer days of delirium, after adjusting for age, illness severity, and mechanical ventilation. (See *Implementation resources*.)

The complex, interacting elements of the ABCDEF bundle make it challenging to implement and maintain. For success:

- involve interprofessional teams and champions
- monitor compliance and outcomes and share on a performance dashboard
- start implementation with one patient to establish an early success and work out process kinks.

Nurses’ role

The ABCDEF bundle is recommended critical care practice, but evidence

suggests that it’s not used consistently. Nurses are critical to successful implementation of every element of the bundle, but they face several barriers. For example, Boehm and colleagues found that nurses cited complexity of the ABCDEF bundle as a reason for nonadherence. Improving knowledge of the bundle will help nurses manage its complexity and facilitate efforts to translate this strategy to the bedside. ★

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