Research Review

Attitudes toward and beliefs about family presence: a survey of healthcare providers, patients' families, and patients.

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Duran CR, Oman KS, Abel JJ, Koziel VM, Szymanski D. Attitudes toward and beliefs about family presence: a survey of healthcare providers, patients' families, and patients. Am J of Crit Care 2007; 16(3):270-9.

Introduction

Family-centered care within a critical care environment strives to meet the needs of patients and their families and includes the need for information, support and the ability to be physically close to the patient. Paediatric critical care health care providers (HCPs) and emergency nurses are leading the way with family involvement with protocols for family presence. The nature of critical care areas sees patients and their families confronted with invasive procedures and at times, resuscitation interventions. The term "family presence" in Duran et al.'s article refers to families' attendance during invasive and resuscitation procedures.

The purpose of Duran et al.'s study " …was to describe and compare the attitudes towards and beliefs about family presence of healthcare providers, patients' family members, and patients regardless of previous experience with family presence." (p 273)

Method

The researchers used a mixed methods approach with qualitative and quantitative surveys using open ended questions. This descriptive study drew its sample from HCPs (nurses, physicians and respiratory therapists), patients and family members from the emergency department, neonatal and adult intensive care units of a university hospital in Colorado, U.S.A.. Individuals were excluded if they were under the age of 18 years, non-English speaking, haemodynamically unstable or cognitively impaired, as assessed by the bed-side nurse.

Two methods of recruitment were used. Patients and their family members were individually approached and invited to participate whereas the HCPs were sent a survey via an internal mailing system. All participants were asked to complete the survey and return it by the supplied return envelope.

There were three questionnaires which were adapted from Meyers et al. Parkland surveys which followed an interview style. These were altered and a self reporting survey method was used. The original surveys were intended for participants who had previous

experience with family presence and this was broadened to include participants with no prior experience. The surveys varied in length from 52 items for patients to 74 items for HCPs. A four point Likert response scale was used for the forced responses and open ended questions provided opportunities for additional qualitative data. The researchers established content validity and internal consistency was assessed and found to be high for all three surveys.

Results

Of the 1095 surveys mailed to HCPs, 202 responded (18% response rate) of which there were 98 nurses, 98 physicians and six respiratory therapists. The majority were white, female, with a mean age of 40 years (SD 11.22) and 13 years (SD 10.42) experience. Over half (66%) had prior experience of having family-witnessed resuscitation and 86% with invasive procedures.

Generally HCPs had a positive attitude about family presence. Where the HCPs had prior experience of family presence with resuscitation, the scores were highly significant ($p < .001$) when compared with those with no prior experience. Those HCPs who support the notion of family presence scored significantly higher with their attitudes and beliefs ($p<.001$). Nurses were significantly more positive than physicians and the nurses thought that the development of a policy on family presence would be beneficial.

Three themes emerged from the qualitative data from the HCPs and these included concerns on safety for both patients and families when family members were present; concerns regarding family members' emotional responses; and the potential for HCP's performance anxiety.

The family members' results saw that nearly one third of the family members had prior experience of being present during either resuscitation or an invasive procedure. These respondents scored significantly higher attitude and belief scores than those with no prior experience (($p=.05$) and 89% wrote that it helped them to be with their loved one and 95% said they would do the same again. As was the case with the patient group, family members considered it was their right to witness these procedures and would like to be offered the option. Patients felt it would be of comfort to them to have a family member present.

Conclusion

The investigators found that family members' presence is becoming more acceptable practice with potential benefits for both patients and families. Barriers (both perceived and real) exist but the development of policies may provide the support HCPs need to increase this practice.

Critique

This area of study focuses on the attitudes and beliefs of how and where we include families in critical care. In adult critical care areas the concept of family inclusion during resuscitation and invasive procedures is still relatively new in some areas and this research evidence is therefore clinically interesting and relevant. The study builds on

previous work and adds another dimension by the inclusion of the three perspectives (HCPs, patients and their families). This adds strength and completeness to the study.

The provision of a clear link between the concepts of attitudes, beliefs and behaviour could have been argued as this would have provided a clearer link to practice outcomes. This relationship is currently merely implied and left to the reader to extrapolate. Conceptually, a behavioural component would have added the potential for future interventional research with behaviour an outcome measure. After all it is our behaviour or actions that are important rather than our thoughts.

Although there were over 200 HCPs respondents, the response rate was low (18%). As the authors rightly highlight, this has the potential for sampling bias. There is no indication of any follow up procedures which may have elicited more responses. Another time face-to-face recruitment could be considered and/or other avenues for recruitment such as during in-service education and staff meetings may provide a higher uptake. The excellent recruitment of patients and families support the personal approach strategy. The authors suggest that the length of the survey may have been a cause for non return by HCPs but as it was the same length as the family surveys this reason appears dubious.

The tables are presented clearly and add relevant information to the textual content. Demographic details add depth and highlight the lack of ethnic diversity in the sample. The collection of qualitative data via open-ended self reporting surveys appeared problematic for the patients and family members as few wrote any comments. Short interviews of a random sample may be a better way to captured information from these groups and thus provide depth to the quantitative data. If the researchers had piloted all the surveys this limitation may have emerged giving them the ability to adjust the data collection method.

The authors conclude that family presence is becoming more acceptable and it is noted in this study that those with previous experience with family involvement scored significantly more positive attitudes and beliefs to the practice. It is important to move progressively in this direction of inclusion as policies alone will not be sufficient as they need the support of ICU nurses and HCPs to work effectively. Nurses' attitudes and beliefs are clearly linked to meeting the psychological needs of patients effectively (Price, 2004) and have the potential to make the difference between patient's positive and negative patterns of psychological adjustment.

Price AM. (2004). Intensive care nurses' experiences of assessing and dealing with patients' psychological needs. *Nursing in Critical Care*, *9*(3), 134-142.