**BACKGROUND** Increasingly, patients’ families are remaining with them during cardiopulmonary resuscitation and invasive procedures, but this practice remains controversial and little is known about the practices of critical care and emergency nurses related to family presence.

**OBJECTIVE** To identify the policies, preferences, and practices of critical care and emergency nurses for having patients’ families present during resuscitation and invasive procedures.

**METHODS** A 30-item survey was mailed to a random sample of 1500 members of the American Association of Critical-Care Nurses and 1500 members of the Emergency Nurses Association.

**RESULTS** Among the 984 respondents, 5% worked on units with written policies allowing family presence during both resuscitation and invasive procedures and 45% and 51%, respectively, worked on units that allowed it without written policies during resuscitation or during invasive procedures. Some respondents preferred written policies allowing family presence (37% for resuscitation, 35% for invasive procedures), whereas others preferred unwritten policies allowing it (39% for resuscitation, 41% for invasive procedures). Many respondents had taken family members to the bedside (36% for resuscitation, 44% for invasive procedure) or would do so in the future (21% for resuscitation, 18% for invasive procedures), and family members often asked to be present (31% for resuscitation, 61% for invasive procedures).

**CONCLUSIONS** Nearly all respondents have no written policies for family presence yet most have done (or would do) it, prefer it be allowed, and are confronted with requests from family members to be present. Written policies or guidelines for family presence during resuscitation and invasive procedures are recommended. (American Journal of Critical Care. 2003;12:246-257)

Allowing patients’ family members to be present at the bedside (also termed “family presence”) during cardiopulmonary resuscitation (CPR) and invasive procedures is a controversial practice in the United States. In less than a single decade, however, the movement to allow family presence has steadily evolved because of the support of professional organizations, attention of the media, and research on the topic. In 1993, the Emergency Nurses Association (ENA) adopted a resolution to support the option of having patients’ families present during CPR and invasive procedures. Two years later, an educational program for implementing this practice within institutions was developed by the ENA. This program was revised in 2001 to reflect updated guidelines and research. In addition, guidelines on family

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presence have been integrated into the ENA curriculum for the trauma nursing core course* and the emergency nursing pediatric course. The guidelines of the American Heart Association for CPR and emergency cardiovascular care also recommend that providers offer patients’ family members the option of remaining with the patients during resuscitative efforts.

Family presence has attracted considerable interest in publications devoted to healthcare professionals and consumers. This attention ignited debate on the issue among healthcare professionals and heightened awareness of the topic among consumers. Recent research and public opinion polls revealed that most consumers think that patients’ family members would want to be and should be allowed to be present while emergency procedures were performed on the patients and at the time of death. Several studies indicated the multiple benefits of this practice for patients’ family members:

- It reduces doubt about what is happening to the patient and reinforces that everything possible was done;
- It engenders feelings of supporting and helping the patient;
- It sustains patient-family connectedness and bonding; it provides a sense of closure on a life shared together;
- It facilitates the grief process and encourages professional behavioral and conversations at the bedside;
- It removes doubt about what is happening to the patient.

Nearly all families involved in such an experience reported that they would make the same choice again. Despite the fears of healthcare providers that patients’ families might become emotionally upset and interfere with care, researchers found no disruptions in the operations of the healthcare team, no adverse outcomes during events at which patients’ families were present, and no adverse psychological effects among family members who participated at the bedside.

From the patients’ perspective, studies have indicated that almost all children preferred to have their parents present during stressful medical procedures and that the children thought that parental presence was the most beneficial intervention in managing the children’s pain. The experiences of adult patients were considered in only 1 study** and 2 anecdotal accounts. The patients reported that having their family members present provided comfort and help, reminded healthcare providers of the patients’ personhood, and maintained the patient-family bond.

For healthcare providers, allowing the presence of patients’ families is a paradigm shift. Patients’ families traditionally have been excluded from such events because of a myriad of concerns, including fears that the families might lose emotional control and interrupt care, lack of staff to meet families’ needs, increased risk of litigation, family-imposed limitations to the training of medical residents, violation of patients’ confidentiality and privacy rights, and the potential that providers’ technical skills would be affected because the providers were uncomfortable with the families’ presence.

On the other hand, providers with experience with family presence reported that having patients’ families present provided an opportunity to educate the families about the patients’ condition, facilitated family participation in caring for patients (eg, supporting the patient, positioning the patient, translating), reminded staff of patients’ personhood, encouraged professional behavior and conversations at the bedside, and helped parents in thebereavement process. Moreover, the presence of a patient’s family did not increase anxiety levels of healthcare providers during invasive procedures or increase their perceived stress during resuscitations.

On the basis of studies indicating the benefits of family presence for both family members and patients, it has been recommended repeatedly that to meet the needs of patients and their families, programs should be developed to offer patients’ families the option of being at the bedside during CPR and invasive procedures. However, little is known about the practices of critical care and emergency nurses related to family presence. Therefore, the purposes of this study were to determine the following:

- the frequency of formal and informal hospital policies on family presence in critical care units and emergency departments,
- the preferences of critical care and emergency nurses for having patients’ family members present during CPR and invasive procedures,
- the practice of critical care and emergency nurses related to family presence,
- the preferences of patients’ families, and
- the common themes of nurse respondents regarding their experiences with family presence.

**Methods**

**Study Design and Sample**

A survey design was used to determine the family presence practices of critical care and emergency nurses. The survey was mailed to a random sample of 1500 critical care nurses who were members of the American Association of Critical-Care Nurses and 1500 emergency nurses who were members of the ENA. All 3000

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*References 18-20, 29, 30, 33-35, 37, 38
**References 19, 20, 28, 29, 31, 32, 39, 46-52
were registered nurses. The American Association of Critical-Care Nurses, ENA, and the institutional review board at one of the investigators’ (CEG) medical centers approved the study. To maintain the anonymity of the subjects, we included no identifying information on the surveys. Informed consent was implied by the participant’s response to the questions and return of the survey.

**Instrument**

A 30-item survey (see Appendix) was developed. The survey included questions about the demographic characteristics of the respondents (20 items); questions about the respondents’ practices, preferences, and hospital policies related to family presence during CPR and invasive procedures (9 items); and the option to share any comments about the respondents’ personal or professional experiences with family presence. Definitions of family presence developed for the study (Table 1) were sent to all potential participants along with the survey, a cover letter that explained the purpose of the study, a request to return the completed survey, and a guarantee of anonymity. The cover letter contained no value statements about the ENA guidelines on family presence.

To establish the content validity of the tool, a national panel of experts consisting of 3 critical care nurses, 3 emergency nurses, and 1 physician rated the relevance and clarity of the survey. All experts rated 100% of the items and the overall survey as relevant in measuring family presence practices. No items were deleted, but 7 items were revised on the basis of the panel members’ suggestions (e.g., change “permit” to “allow” and “code” to “CPR”). Before the study, the survey was tested on 4 separate occasions, with a total of 113 critical care and emergency nurses. After each pretest, items on the survey were reordered for clarity. The mean time for completing the survey was 15 minutes.

**Procedure**

The final version of the survey was mailed to potential participants. They were asked to return the completed survey in an enclosed postage-paid return envelope. A postcard was sent to potential participants after the initial mailing to remind them to return the surveys.

**Statistical Analyses**

Data analysis was completed by using SPSS Version 10.1 (SPSS Inc, Chicago, Ill). Descriptive statistics were used to characterize the sample and each of the survey items. In addition, \( \chi^2 \) tests were used to determine differences in the effects of actual experience on preferences that support family presence. Significance was set at \( P < .01 \). Written responses and comments were qualitatively analyzed by one of us (SLM) by using content analysis. The constant comparison technique was used; segments of data were coded, grouped, clustered, and linked, and primary themes were identified and interpreted to discern the experiences of respondents. A final document of themes, categories, and direct quotations was sent to each of us for validation.

**Results**

**Characteristics of the Sample**

A total of 984 surveys were returned, for a response rate of 33%. Surveys were completed by 473 critical care nurses, 456 emergency nurses, and 55 nurses who either practiced in both areas or who did not provide work information. Nurses practiced in all 50 states and the District of Columbia. The mean age of the respondents was 42 years, 90% of them were women, and 50% had a baccalaureate degree (Table 2).

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<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Option of family presence</td>
<td>Offering the choice to a patient’s family member to be present in a location that affords visual and/or physical contact with the patient during an invasive procedure or cardiopulmonary resuscitation</td>
</tr>
<tr>
<td>Families</td>
<td>Relatives or significant others with whom a patient shares an established relationship</td>
</tr>
<tr>
<td>Invasive procedure</td>
<td>Any intervention that involves manipulation of the body or penetration of the body’s natural barriers to the external environment (e.g., endotracheal intubation, placement of a central catheter, lumbar puncture, insertion of a chest tube, orthopedic reduction)</td>
</tr>
<tr>
<td>Cardiopulmonary resuscitation</td>
<td>Artificial breathing and cardiac chest compression initiated to sustain life</td>
</tr>
<tr>
<td>Emergency Nurses Association’s Presenting the Option for Family Presence</td>
<td>An educational program that includes intervention guidelines to assist professionals in developing and implementing programs to provide patients’ families the option to be present at the bedside during invasive procedures and cardiopulmonary resuscitation</td>
</tr>
</tbody>
</table>

Adapted with permission from the Emergency Nurses Association.\(^1\)
The respondents were experienced registered nurses; 74% had more than 10 years of experience. A total of 74% worked full-time, 80% were staff nurses, and 78% spent more than 75% of their time providing direct care to patients. The characteristics of the respondents’ institutions are given in Table 3. Only 4% of the respondents cared for children; 56% worked with both adults and children. A few (5%) worked at institutions that used the ENA guidelines for the option of family presence, but most (73%) did not know these guidelines were available.

Survey Results

Family Presence Policies. Only 5% of the respondents worked on units that had written policies allowing the option of family presence during CPR (51/969) and invasive procedures (48/961; Figure 1). Written policies prohibiting family presence were rare for CPR (12/953; 1%) and invasive procedures (15/946; 2%). Although their institutions did not have a written policy allowing or prohibiting family presence, 45% (422/943) of the nurses stated that their unit allowed family presence during CPR. Similarly, 51% (483/940) of the nurses worked in units that had no written policy but allowed family presence during invasive procedures (Figure 1). However, about one fourth of the nurses reported that family presence was prohibited for CPR (260/905; 29%) and invasive procedures (224/910; 25%) although their units had no written policy prohibiting the option.

Policy Preferences for Allowing Family Presence. A total of 37% (365/984) of the nurses preferred a written policy allowing the option of family presence during

| Table 2 Demographic characteristics of emergency nurses and critical care nurses |
|-----------------|----------|----------|
| Characteristic* | No.      | %†       |
| Age, years (n=912) |          |          |
| <30             | 66       | 7        |
| 30-39           | 264      | 29       |
| 40-49           | 390      | 43       |
| 50-59           | 173      | 19       |
| ≥60             | 19       | 2        |
| Sex (n=928)     |          |          |
| Female          | 839      | 90       |
| Male            | 89       | 10       |
| Highest degree in nursing (n=927) |          |          |
| Graduate        | 94       | 10       |
| Baccalaureate   | 462      | 50       |
| Diploma/associate | 371     | 40       |
| Years of experience as a registered nurse (n=929) |          |          |
| ≤3              | 43       | 5        |
| 4-5             | 50       | 5        |
| 6-10            | 147      | 16       |
| 11-15           | 183      | 20       |
| 16-20           | 172      | 19       |
| >20             | 334      | 36       |
| Work hours (n=929) |          |          |
| Full-time       | 692      | 74       |
| Part-time (>0.5 full-time equivalents) | 164 | 18 |
| As needed       | 73       | 8        |
| Primary position held (n=929) |          |          |
| Direct care/staff nurse | 741 | 80 |
| Manager/administrator | 130 | 14 |
| Advanced practice nurse | 29 | 3 |
| Other           | 29       | 3        |
| Direct care of patients, % of time (n=928) |          |          |
| >75             | 720      | 78       |
| 25-75           | 112      | 12       |
| <25             | 85       | 9        |
| 0               | 11       | 1        |

*Values for n vary because of missing data.  
†Percentages may not equal 100% because of rounding.

<p>| Table 3 Characteristics of institutions where emergency nurses and critical care nurses employed |</p>
<table>
<thead>
<tr>
<th>Characteristic*</th>
<th>No.</th>
<th>%†</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital location (n=920)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rural/suburban</td>
<td>366</td>
<td>40</td>
</tr>
<tr>
<td>Urban/small urban</td>
<td>554</td>
<td>60</td>
</tr>
<tr>
<td>Type of facility (n=919)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Not for profit</td>
<td>717</td>
<td>78</td>
</tr>
<tr>
<td>For profit</td>
<td>202</td>
<td>22</td>
</tr>
<tr>
<td>University affiliation (n=925)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>358</td>
<td>39</td>
</tr>
<tr>
<td>No</td>
<td>567</td>
<td>61</td>
</tr>
<tr>
<td>Physician residents on unit (n=926)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>484</td>
<td>52</td>
</tr>
<tr>
<td>No</td>
<td>442</td>
<td>48</td>
</tr>
<tr>
<td>Type of patients cared for (n=929)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adults</td>
<td>377</td>
<td>41</td>
</tr>
<tr>
<td>Children</td>
<td>33</td>
<td>4</td>
</tr>
<tr>
<td>Both adults and children</td>
<td>519</td>
<td>56</td>
</tr>
<tr>
<td>Use Emergency Nurses Association guidelines for the option of family presence (n=713)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>38</td>
<td>5</td>
</tr>
<tr>
<td>No</td>
<td>152</td>
<td>21</td>
</tr>
<tr>
<td>Did not know about guidelines</td>
<td>523</td>
<td>73</td>
</tr>
</tbody>
</table>

*Values for n vary because of missing data.  
†Percentages may not equal 100% because of rounding.
CPR and 35% (347/984) preferred written policies for family presence during invasive procedures (Figure 2). A total of 39% (386/984) of the nurses preferred allowing the option of family presence for CPR but did not want a written policy (Figure 2). Also, 41% (407/984) preferred allowing the option of family presence during invasive procedures without having a written policy.

**How Often Nurses Bring Patients’ Families to the Bedside.** For CPR, a total of 36% (345/968) of the respondents had taken a patient’s family member to a patient’s bedside (Figure 3) a mean of 3 times (SD 4, range 0-51) in the preceding year. A total of 21% (207/968) said they had not taken family members to the bedside during CPR but would do so in the future if the opportunity arose. For invasive procedures, 44% (423/968) had taken a family member to the bedside (Figure 3) a mean of 9 times (SD 12, range 0-100) in the preceding year. In addition, 18% (176/968) said they had not taken families to the bedside during invasive procedures but would do so if the opportunity arose. The effects of actual experience on preferences that support family presence also were evaluated. A significantly greater percentage of respondents who preferred policies (written or unwritten) allowing family presence during CPR or invasive procedures had experience taking patients’ families to the bedside ($P<.01$; Figure 4).

**How Often Patients’ Family Members Asked to Be Present.** Among the respondents, 31% (296/964) said that patients’ families had asked them whether the families could be present during CPR a mean of 3 times (SD 5, range 0-40) during the preceding year. Likewise, 61% (593/966) indicated that patients’ family members had asked them about being present during invasive procedures a mean of 9 times (SD 13, range 0-100) during the preceding year. As seen in Figure 5, we found striking differences between the percentages of families who asked to be present during CPR and invasive procedures and the number of work settings that have written policies.
allowing the option. Nurses’ preferences for a written policy allowing the option of taking families to the bedside were closer to the percentages of nurses who said families asked to go to the bedside.

**Nurses’ Comments About Family Presence.** Many respondents (436/984; 44%) wrote about their experiences of bringing families to the bedside in the section for comments on the survey. These comments indicated the following benefits of family presence:

- provides emotional support for patients and patients’ families,
- provides a positive experience for patients’ families, patients, and staff,
- provides guidance and increases family understanding of the patient’s situation,
- helps patients’ families make decisions about resuscitation,
- helps patients’ families know that everything was done to save their loved one, and
- facilitates closure and healing.

A small sample of the nurses’ comments on the benefits of bringing patients’ families to the bedside are presented in the following. Three nurses shared contrasting experiences:

First nurse: I was able to get an ER physician to allow parents in the room during CPR on their child. I received a letter from the parents stating how much they appreciated us allowing them to be with their child in the last minutes of his life. They said they had been with the child since he was born and wanted to be with him at death. They said their grieving process was faster because we allowed them in the room.

Second nurse: I once was traumatized during a pediatric cardiac arrest (during an outpatient procedure) where the father witnessed the arrest (of his daughter) and was not allowed in during CPR. He asked repeatedly to come in and “say goodbye” while she was still alive. He wanted to hold her hand. Not only was he kept from the room, but security was called to keep him out. The child did not survive. She was 6. No one would ever keep me from seeing my child. He just wanted to be with her when she died, and we took that away from him. How unfortunate that written policies are needed in this area.

Third nurse: Prior to becoming a nurse, I was a paramedic for 13 years in NYC. When called to a cardiac arrest in the home, the family was always there before us and I never felt right about asking them to...
leave. I frequently utilized significant others, if reasonably calm, to move furniture or even bag an intubated patient. I never regretted this decision. They frequently thanked me for this opportunity to help. The same opportunity should be an option in the ER.

Many nurses commented on the need to assess each situation, case by case, and described the importance of educating and preparing patients’ families for what the families would experience. The nurses thought that it was important to have a designated staff member with the family to guide, coach, and support the family. The respondents wrote that “the policy would provide equal access to all we serve” and that it was important to “have a policy in place to think and decide ahead of time how to handle requests.”

Several nurses expressed concern about allowing the option of family presence. They raised questions about the following:

- patient-related issues such as privacy and limited benefits;
- family-related issues such as family behaviors, lack of education and understanding, emotional reactions, and family-staff relationships;
- staff-related issues such as staff stress and discomfort, impeding work, extra work and burden, and inadequate staffing;
- environmental issues such as limited space and staff, chaos and confusion, and lack of privacy; and
- legal issues such as lawsuits and family complaints.

One nurse wrote: “My experience tells me that families are not prepared for the traumatic events that are occurring before their eyes. When people learn CPR or view it on TV, we have a tendency to sanitize it as if it were a ‘clean’ procedure.” Another commented: “Unfortunately, it seems that there is never enough time to evaluate education level and sensibilities of families before an invasive procedure. Certainly there isn’t enough support staff to allow for in-depth teaching with those families.”

**Discussion**

To our knowledge, no other studies have been done on the family presence practices of critical care and emergency nurses in the United States. Nearly all of the nurses in our study worked in units that had no written policies addressing the option of family presence during CPR and invasive procedures. Although the units had no written policies, almost half of the
respondents reported that their units allowed the option of family presence. This informal practice may be a result of changes in practice that reflect family-centered care and the desire to meet the holistic needs of patients and patients’ family members, the increasing attention paid to family presence in the professional and public literature, or increases in the assertiveness of patients’ families.

Most critical care and emergency nurses in our study supported family presence. The large number of written comments supplied by the respondents further validates this finding. More than one third of the respondents preferred a written policy allowing family presence during CPR and invasive procedures (37% and 35%, respectively), and more than one third preferred an unwritten policy (39% and 41%, respectively). Thus, nearly 75% of the respondents favored some type of option for allowing family presence. This percentage is lower than but consistent with the percentages found by Meyers et al., who reported that 96% of emergency nurses supported family presence during CPR and 88% supported it during invasive procedures. In addition, nurses are more likely than physicians to support family presence. In a survey by McClenathan et al., 43% of nurses and 20% of physicians favored family presence during CPR, and in a study by Meyers et al., 96% of the nurses and 79% of the attending physicians supported family presence. Likewise, the degree of invasiveness of the procedure may influence the provider’s level of support for family presence. In a study of more than 600 emergency nurses and physicians, for example, nearly all of the respondents thought that the parents of children being treated should be present for procedures such as insertion of intravenous catheters and repair of lacerations, but when CPR was available, the respondents preferred a written policy allowing family presence. An important finding in our study was that patients’ family members often ask to be present during invasive procedures (reported by 61% of the respondents), although the request to be present is lower for CPR (reported by 31% of respondents). Although it is unclear why families ask to be present less during CPR than during invasive procedures, families may be influenced by the invasiveness of the interventions involved in CPR or they may not know to ask. Our findings differ from those of Helmer et al., who reported that 66% of 818 emergency nurses and 40% of 140 trauma surgeons had encountered requests from family members to be present during a trauma resuscitation. In addition, in that study, significantly more nurses than physicians had experience with family presence and with being asked by patients’ family members if the families could be present (P<.01 for both analyses), suggesting that family presence is often driven by nurses rather than physicians.

In the study by Meyers et al., the intervention protocol for family presence used the ENA guidelines, and after the study, this protocol was approved for hospital-wide use. The impact of this standardized protocol suggests the benefits of a formal family presence program in heightening awareness and changing clinical practice. However, 73% of our respondents did not know that this ENA resource was available. Moreover, our data revealed a large disparity between the number of written policies on family presence and the number of requests by patients’ families to be present. Consequently, nurses who work in units that do not support family presence or do not have clearly delineated protocols for the practice may be in a difficult position when confronted with a request by a patient’s family to be at the patient’s bedside.

**Implications for Practice and Research**

Our findings have several important implications for practice and research. Because many nurses receive requests from patients’ families to be present...
during CPR and invasive procedures and because nurses often facilitate the families’ presence, critical care units and emergency departments need to decide where they stand on the issue. Most units probably do not have formal policies on family presence because it is a controversial practice and historically families have always been banned from the bedside during such events. Soon, however, other professional organizations most likely will join with the ENA and the American Heart Association in recommending family presence during CPR and invasive procedures. As a result of the influence exerted by both consumers and professional organizations, most critical care and emergency departments will need to determine whether the departments support the practice and whether formal or informal guidelines are needed.

Because our results indicate that nearly all critical care and emergency departments have no written policies or guidelines for family presence, research is needed to explore the implications of these findings. For example, studies are needed to compare institutions with and without formal, written policies on family presence to determine differences in provider support for family presence, how often patients’ families are brought to the bedside, and desired outcomes of family presence such as uninterrupted care for patients and meeting the needs of patients’ families (eg, satisfaction, comfort, and closure). Practitioners need to consider and researchers need to explore differences between formal and informal policies in promoting a family-centered care environment or in supporting a delivery of care that focuses on what works best for the institution. To date, we do not know if formal or informal policies provide stability to work units and promote consistent approaches in carrying out family presence practices. For example, what are the effects of informal versus formal policies on both staff and patients’ families?

The implications of nurses’ differences about whether a written policy is needed may reflect discomfort with family presence or resistance to changing long-standing practice. A policy on family presence could be beneficial if it detailed the responsibilities of nurses during family presence. Nevertheless, researchers should explore the reasons nurses support formal or informal policies on family presence and what the nurses think are the benefits and problems with each approach.

We found that 40% of our respondents had not taken patients’ family members to the bedside. Because of the current mandate for partnership with patients and their families in an environment of family-centered care, our data suggest that the discrepancy between the requests of patients’ families to be present at the patients’ bedside and the actions of nurses who are not facilitating these requests should be explored. Researchers should target this group of nurses to better understand the nurses’ reasons for not taking patients’ families to the bedside; reasons may include personal preference, comfort level in dealing with patients’ families, lack of formal guidelines to direct the process, and peer pressure in an environment that does not support family presence. If the culture of a unit or department does not support family presence, for example, dissension among staff members is likely when the practice is supported and implemented by a minority of the healthcare providers. In our study, the respondents reported that twice as many patients’ families requested to be taken to the patients’ bedside for invasive procedures than for CPR. Invasive procedures and CPR are 2 extremely different experiences for all involved. Our results suggest that practitioners and researchers need to identify the most effective interventions and explore difference in preparing and supporting patients’ family members during CPR and invasive procedures. Differences in the families’ perceptions and concerns during these 2 events, the families’ needs during the experience, and what helps and what does not help during CPR and during invasive procedures need to be better understood.

**Limitations**

Our study has several limitations. Although the survey was evaluated by a panel of content experts and underwent extensive pilot testing, it did not undergo reliability testing and has no established construct validity. In addition, because only one third of the sample returned surveys, the generalizability of the findings is limited to this group. Possibly, those nurses who did not respond have different preferences for and experiences with family presence. Only members of the American Association of Critical-Care Nurses and ENA were surveyed, and their responses may not represent the preferences and experiences of critical care and emergency nurses across the United States. We did not directly examine the preferences of patients’ families for being present during CPR and invasive procedures; rather, we relied on the memory and reports of the respondents.

**Conclusions**

Nearly all of the respondents to our survey worked on units that had no written policy on family presence, yet three quarters of the respondents preferred that family presence be allowed. Despite the lack of writ-
ten policies to support the practice, nearly half of the respondents worked on units that allow family presence, more than half have brought (or would bring) patients’ families to patients’ bedside during CPR and invasive procedures, and many have been confronted with requests from patients’ families to be present. Because of these findings and those of previously published studies indicating the multiple benefits of family presence for both patients and families, nurses working in critical care and emergency departments should consider developing written policies or guidelines on family presence to meet the needs of patients and their families and provide consistent, safe, and caring practices for patients, patients’ families, and staff.

Appendix A  Family presence practice survey

WRITTEN POLICIES

1. Does your unit have a written policy that allows the option of family presence during
   a. CPR?  ___Yes  ___No  ___Do not know
   b. an invasive procedure?  ___Yes  ___No  ___Do not know
      ⇒ if “Yes” to a and b, then skip to question 5

2. Does your unit have a written policy that prohibits the option of family presence during
   a. CPR?  ___Yes  ___No  ___Do not know
   b. an invasive procedure?  ___Yes  ___No  ___Do not know
      ⇒ if “Yes” to a and b, then skip to question 5

NO WRITTEN POLICIES

3. Does your unit allow (but has no written policy) the option of family member presence during
   a. CPR?  ___Yes  ___No  ___Do not know
   b. an invasive procedure?  ___Yes  ___No  ___Do not know
      ⇒ if “Yes” to a and b, then skip to question 5

4. Does your unit prohibit (but has no written policy) the option of family presence during
   a. CPR?  ___Yes  ___No  ___Do not know
   b. an invasive procedure?  ___Yes  ___No  ___Do not know

BRINGING FAMILY TO THE BEDSIDE

5. In the past year, have you ever taken a family member to the patient’s bedside during
   a. CPR?  ___Yes  ___No  ___No, but would do so if the opportunity arose
      ⇒ How many times? _________
   b. an invasive procedure?  ___Yes  ___No  ___No, but would do so if the opportunity arose
      ⇒ How many times? _________

6. In the past year, if you have taken family members to the bedside during a CPR or invasive procedure, did you use the intervention guidelines developed by the Emergency Nurses Association based on their education program “Presenting the Option for Family Presence”?
   ___Yes  ___No  ___Do not know about these ENA intervention guidelines

Continued
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REFERENCES

10. Davis R. Bedside in the ER: hospitals allowing family member access. USA Today. March 7, 2000:1A-2A.


