Navigating Parental Presence During Paediatric Resuscitation and Invasive Procedure - Summary of a Critical Review

Sonja Heller, Lorinda Palmer
School of Nursing and Midwifery, University of Newcastle

INTRODUCTION

A family-centered approach to paediatric care has evolved over recent decades, with parents now accepted as being an integral part of the child’s hospital care (Dingeman, Mitchell, Meyer & Curley, 2007). Parental presence during less invasive procedures is now widespread, however controversy surrounds the practice of allowing parents the option to remain with the child during more invasive procedures, such as cardio-pulmonary resuscitation (Dingeman, Mitchell, Meyer & Curley, 2007). A critical review conducted by Dingeman, Mitchell, Meyer & Curley (2007) assessed existing evidence on this issue. This paper is a summary of that review.

Current Practice

Current standard practice is for family members to be asked to leave the room when invasive procedures or resuscitation are initiated. The prevailing view is that witnessing these procedures would generate distress for the family and potentially compromise patient care (Robinson, Mackenzie-Ross, Campbell Hewson, Egleston & Prevost, 1998). The move to a more family-centered approach in paediatric care, combined with the requirement that practice be informed by evidence has resulted in questioning the automatic exclusion of family (Powers & Rubenstein, 1999). This is reflected in current guidelines. For example, the American Heart Association and Emergency Nurses Association have both recently published guidelines endorsing parental presence (Dingeman, Mitchell, Meyer & Curley, 2007). In Australia, the Paediatric Advanced Life Support guidelines recommend that parents be given the option to be present (Australian Resuscitation Council [ARC], 2006).

Furthermore, both the ARC and Australian College of Critical Care Nurses (2008) recommend an experienced staff member accompany the family to provide support and facilitate communication with the resuscitation team. However, despite growing support for parental presence, concerns still exist. Many clinicians are reluctant to implement these recommendations and hospital policies are inconsistent (Dingeman, Mitchell, Meyer & Curley, 2007). In terms of the evidence, current research is predominately from North America and the United Kingdom with no paediatric research undertaken in Australia.

SUMMARY OF REVIEW FINDINGS

Quality of Evidence

The studies reviewed by Dingeman, Mitchell, Meyer & Curley (2007) included one Level II randomised controlled trial (RCT), four Level III-II non-randomised comparative studies with control, and ten Level IV descriptive studies. Limitations of these studies included small sample sizes, convenience sampling and low response rates. A potential bias was identified in that those responding were most likely to have strong opinions about this issue (Dingeman, Mitchell, Meyer & Curley, 2007). The validity of the review is potentially affected by the quality of research currently available, and the feasibility of the practice being investigated is not yet certain. Nevertheless, a degree of consistency is evident in the findings.

Parental Views

Survey findings indicate strong support among parents for presence. In one study, 87% wanted to be present during invasive procedures and 83% during resuscitation (Boie, Moore, Brummelt & Nelson, 1999). In another, 86% believed they had a right to be present (Mangurten, Scott, Guzzetta, Sperry, Vinson, Hicks, Watts & Scott, 2005), and in yet another, 68% of parents requested they be given the choice of being present (Gold, Gorenflo, Schwenk & Bratton, 2006). Parents are becoming more aware of their options, and believe clinicians should not make this decision on their behalf (Boie, Moore, Brummelt & Nelson, 1999).

Parental Behaviour

Studies of parents’ behaviour when they are present during invasive procedures indicate a range of findings. Physical and emotional supportive behaviours have been observed, including touching, kissing, and talking, standing quietly by the bed, assisting in reassuring and settling the child and asking questions (Meyers, Eichhorn, Guzzetta, Clark, Klein, Taliaferro & Calvin, 2000; Sacchetti, Paston & Carraccio, 2005).

Robinson, Mackenzie-Ross, Campbell Hewson, Egleston & Prevost (1988) found parents did not disrupt the resuscitation process or impede the decision to cease treatment. One study reported that a parent had experienced syncope, while another thought her child had inadequate pain relief, which was resolved when sedation effects were explained (Sacchetti, Paston & Carraccio, 2005).

Other benefits expressed by parents included that they felt their presence helped their child and themselves, gave them peace of mind, assisted them with the grieving process, provided them with time to tell their child they loved them and enabled them to appreciate and accept the efforts of clinicians knowing all possible efforts were being made (Mangurten et al., 2005).

Clinician Practices and Perceptions

Practice across the studies reviewed were found to vary widely between clinicians with between 39% and 90% allowing the
option of parental presence and 22% and 93% respecting the parent’s request to be present (Dingeman, Mitchell, Meyer & Curley, 2007, p. 844).

Gold, Gorenflo, Schwenk & Bratton, (2006) indicated that nurses were more supportive and more likely to facilitate parental presence than other health professionals, and frequently acted as a support person. Nurses’ views have a significant effect in determining whether they facilitate or impede parental presence, and ultimately determine the implementation of the practice (Jarvis, 1998).

Several studies reviewed noted increased concern about the potential legal implication of parental presence, staff stress and anxiety about being observed by parents decreased the teaching opportunities for clinicians, the need for additional staff and resources to facilitate parental presence, apprehension of parental hostility, and the possibility of obstruction or interference from parents (Dingeman, Mitchell, Meyer & Curley, 2007).

Not all perceptions were negative, however. One study found parental presence enabled a greater rapport between parents and clinicians (Fein, Ganesh & Alpern, 2004). In another, a majority of Paediatric Intensive Care Unit (PICU) clinicians believed parents witnessing their child’s unsuccessful resuscitation facilitated the grieving process and that legal concerns may actually decrease as parents gain a practical understanding of the resuscitation (Jarvis, 1998). A majority of clinicians across several studies reviewed indicated that parental presence did not influence their performance or disrupt care (Dingeman, Mitchell, Meyer & Curley, 2007).

**Facilitating Parental Presence**

One of the main reasons cited by staff for not allowing parental presence was the lack of a designated support person to accompany them (Booth, Woolrich & Kinsella, 2004). A support person was identified as an experienced nurse, medical staff or a chaplain (Robinson, Mackenzie-Ross, Campbell Hewson, Egleston & Prevost, 1998).

Their role was to prepare the parent for what procedures and treatments will be seen during the resuscitation, provide comfort, supply explanations, answer questions and offer psychosocial support (Mangurten et al., 2005). When support staff were used, care was not disrupted and the experiences of clinicians and parents were positive (Mangurten et al., 2005).

**DISCUSSION**

Controversy surrounds the practice of parental presence and clinicians are divided about the appropriateness and feasibility of implementing the practice (Dingeman, Mitchell, Meyer & Curley, 2007). The majority of parents want to be
given the option to remain. However despite this, parents frequently are not given the option (Dingeman, Mitchell, Meyer & Curley, 2007).

Current practice appears to be largely dependent on the clinician’s discretion and views. It is apparent that perceived negative perceptions underlie much of the decision-making in this area (Dingeman, Mitchell, Meyer & Curley, 2007). However this review shows that these concerns are not substantially supported by research findings, and there is evidence that parental presence, properly supported, can confer significant benefits.

RESEARCH

Further research is needed to assess children’s preferences and experiences, the use of support staff, methods of education of parents about being present, and costs (Dingeman, Mitchell, Meyer & Curley, 2007). Additional research would enable clinicians to gain an understanding of the emotional and physiological needs of parents and children about this very difficult issue and how to provide better support to parents who stay during treatment (Dingeman, Mitchell, Meyer & Curley, 2007).

Dingeman, Mitchell, Meyer & Curley, (2007) indicate further research is warranted before rejecting or implementing the practice due to the quality of the research currently available. Nevertheless, consistency in the findings suggests support for parental presence should be considered.

CONCLUSION

As a result of this review the following considerations reflect a way forward.

1. Parental presence during invasive procedures and/or resuscitation should be an option;
2. Clinicians should support parental decisions to remain present during resuscitation and/or invasive procedures;
3. An experienced staff member should facilitate parental presence by accompanying parents and providing support and explanations throughout the process;
4. Policies to be developed to assist clinicians in implementing and facilitating parental presence.

References


