Family Presence & Involvement
During Critical Care Transport

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Usual Disclosures & Disclaimers

- I have no conflicts of interest to disclose.
- The views, opinions, and recommendations in this presentation are my own and do not necessarily reflect those of my employer(s).

Objectives

- Primary objective: Facilitate consideration and discussion
  - I don’t have all the answers
  - It’s okay if you leave with more questions than answers
- Secondary objective: Present current evidence surrounding this practice, both in favor and against family presence

Top 3 Rules in EMS

- Rule #1 : Do what is right for the patient
- Rule #2 : Do what is right for the crew
- Rule #3 : Don’t ever confuse rules 1 and 2

Literature Review

- Limited data on family presence for CCT
- Pediatric CCT – some info
- Family presence during *in-hospital* resuscitation & invasive procedures – more info & growing

- Various reasons why this may or may not be done
  - Policy / lack thereof
  - Physical space
  - Local culture

Air Med J 1997;16:38-42
Air Med J 2015; 34:32-6

History of FPDR

- 1982: Foote Hospital, Jackson, MI
  - 2 separate incidents
    - Accompanied family in ambulance
    - Spouse of shot police officer
- Follow-up survey (1980s)
  - **72%** of family (not present) would have liked to be
  - **94%** of family (present) would do again
  - **76%** felt grieving / adjustment to death was helped
  - **64%** felt they were of benefit to their dying loved one

Ann Emerg Med 1987;16:673-5

More Recent Data (*but still in-hospital*)

- Family Members
  - 95% : personally helped & assisted in understanding loved one's condition
  - 86% : right to be there
  - 82% : presence did not affect care loved one received
  - 91% : touched their family member
  - 86% : provided necessary healthcare info
- Staff
  - 97% : family members not disruptive to teamwork or care
  - 89% : unaffected by family presence

J Emerg Nurs 2006;32:225-33

National Guidelines on Family Presence

- Endorsed by ENA, AACN, ACEP, NAEMT, among others
- Family presence on Ped CCT is a quality metric identified by Ohio Neonatal/Pediatric Transport Quality Collaborative

Crit Care Nurse 2016;36:e11-4
Pediatr Crit Care Med 2013;14:518-24

NAEMT / EMSC / DHHS (2000)

Following the group discussions the panel made the following recommendations:

- The safety of all team members, including family members, must remain a primary concern during prehospital care and transportation.
- Family representatives or organizations [members?] should be involved in primary training for prehospital emergency medical responders at all levels.
- Family members should be given the option to be present and to participate in prehospital care on scene, during transport, and during transfer of care to the receiving facility
- Family-centered care practices, including family presence and cultural proficiency, should be integrated into the fabric of prehospital care everyday on every call.
- Programs to better prepare families to deal with emergencies should be developed, assessed and replicated.
- An effective family-centered prehospital care program should include an established critical incident stress management program.

NAEMT 2000

Emergency Nursing Association (2012)

Description of Decision Options / Interventions and the Level of Recommendation:		
Family Presence	There is little or no evidence to indicate that the practice of family member presence is detrimental to the patient, the family or the health care team	B
	There is some evidence from the international literature that acceptance of family presence may have some cultural basis	B
	There is evidence that health care professionals support the assignment of a designated health care professional to family members that are present, in order to provide explanation and comfort	B
	There is some evidence that a policy regarding family member presence provides structure and support to health care professionals involved in this practice	B
	Family member presence during invasive procedures or resuscitation should be offered as an option to appropriate family members and should be based on written institution policy	B
	There is some evidence that patients would prefer to have their family members present during resuscitation	C
	There is evidence that family members wish to be offered the option to be present during invasive procedures and resuscitation of a family member	C
	There is evidence that family member presence does not interfere with patient care during invasive procedures or resuscitation	C

ENA 2012

American Assn. of Critical Care Nurses (2016)

- "Family members of all patients undergoing resuscitation and invasive procedures **should be given the option to be present** at the bedside per the patient's wishes"
- Ensure your unit has a policy, including:
  - Presenting FPDR as an option, no expectation
  - Criteria to assess family coping
  - Contraindications to FPDR
  - Role of the family liaison and support for family throughout process

Crit Care Nurse 2016;26:e11-4

So, How are ***WE*** doing?

Current Practice in Flight / CCT

- Wide variability in Peds CCT
  - Parents present generally felt receptive environment
    - Reduced parental anxiety
  - Parents absent generally felt “unwelcome”
    - Increased anxiety
- Staff views:
  - Generally little to no added stress
  - Little to no difficulty performing needed interventions
  - Parent presence had calming effect on patient
- Very poor data on Adult CCT

Air Med J 2015;34:32-6
Arch Dis Child 2005;90:1270-3

Important Considerations for FPDCCT

- Screening for appropriateness of family presence
  - Physical space and weight/balance considerations?
  - Ability to safely wear safety restraint(s)?
  - Any behaviors that were not controllable by staff?
  - Any sign of drug/alcohol use?
  - Will family be signing out AMA to accompany you?
  - Communication barrier (preventing safety brief)?
  - History of motion sickness, fear of heights, fear of flying?
  - Faintness at sight of blood?
  - History of anxiety or psych disorders?

Air Med J 2009;28:31-6
Crit Care Nurse 2016;36:e11-4

Important Considerations for FPDCCT

- Safety Briefing (and who does this?)
  - Procedure for going to/from vehicle/aircraft
  - Requirement to follow crew instructions
  - Use of seatbelts
  - Emergency egress procedures, PFD use, etc.
  - Personal belongings
  - Comms use and sterile cockpit
    - “A headset must be provided to allow the passenger access to the aircraft communication system and the family member should not be isolated”
  - Notify your comm center of family

Air Med J 2009;28:31-6

Important Considerations for FPDCCT

- Other Considerations
  - Ability to “brief” or “update” family on condition and interventions
    - Designated “Family support person” ??
  - Waiver / release from liability?

Air Med J 2009;28:31-6
J Air Med Transp 1992;11(2):11-3

So, What do we do?

- Advocate for patient
  - Remember the 3 rules?
- Reserve right to say “no”
- Develop / implement policy

- Always strive to be the best part of your patient’s worst day.

- *And as you wish that others would do to you, do so to them.* Luke 6:31 (ESV)

Important take-homes for the bedside nurse

- MULTIPLE factors weigh into this decision
  - Aircraft configuration
  - Weight / balance
    - Varies with temperature, on-board fuel, add'l equipment, etc.
  - Patient condition
  - Family member condition
- **DON'T** promise family they can ride!
  - Advocate for your patient!
  - Encourage family to remain present until CCT *departs*

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