STN Position Statement in Support of Family Presence During Pediatric Trauma Resuscitation

Abstract:
There is inconsistency in ensuring family presence during pediatric trauma resuscitation at both adult and pediatric trauma centers, despite strong evidence supporting its positive effects. Literature suggests that family presence has assisted with the grieving process in situations where the patient's injuries are fatal. Failure to provide consistency with family presence during trauma resuscitation can be attributed to variability in institutional protocols and healthcare provider views. Research indicates that institutional protocols supporting family presence during trauma resuscitation have a strong impact on ensuring consistency with this process. These protocols should ensure family members are paired with a support person who does not have clinical responsibilities during the resuscitation process.

Introduction:
Family-centered care has been a cornerstone of healthcare for decades, particularly in the provision of pediatric care. A number of studies and guidelines support and encourage family presence during trauma resuscitation and cite potential benefits for patients, families and the care team.

Discussion:
Family presence during resuscitation was first described in the literature in 1987 as an "option" during emergency department resuscitations. Since that time, numerous studies and clinical guidelines have addressed the possible benefits and potential concerns that family presence may pose to patients, their families, and the resuscitation team.

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Introduction

Traumatic injury is sudden and unexpected, and families may suffer from intense stress and anxiety during resuscitation. Often, due to EMS transport, pediatric patients are separated from loved ones during the initial treatment phase at the hospital. Family presence during pediatric trauma resuscitation has been inconsistently implemented at adult and pediatric trauma centers. Current literature was reviewed to examine how family presence affects families, patients, trauma teams, and resuscitation outcomes, for pediatric trauma patients.

Discussion

Strong evidence supports the positive effects of family presence during pediatric trauma resuscitation. Parents desire to be in the trauma room to witness resuscitation and interact with the trauma team (Dainty et al., 2021; Vandanjani et al., 2021). Being present allows them to offer their child physical comfort and emotional support (Dainty et al., 2021; O'Connell et al., 2017). Family presence permits parents to advocate for their children and reduce fears (O'Connell et al., 2017). Many families felt it was their "right" to be present during treatment, although they trusted staff to provide excellent care to their children if they were not there (O'Connell et al., 2017). Being at the bedside helped parents better understand their child's condition (Vandanjani et al., 2021; Dainty et al., 2021). Parents had a strong positive outlook on the experience of being present during resuscitation; however, they worried that they were physically in the way of the trauma team (O'Connell et al., 2017; Twibell et al., 2015). In cases of severe or fatal injury, being present helped families with grieving, and they recognized that the trauma team had done everything possible for their child (Doyle et al., 1987; O'Connell et al., 2017). Literature from adult trauma resuscitations found that family presence during resuscitation improved family members' psychological and emotional states and did not cause additional anxiety or stress (Leske et al., 2017; Pasquale et al., 2010). Families described their supportive role during resuscitation as one that was distinct from the role of the trauma team (Leske et al., 2013). Families were grateful to be present and share useful information about medical history and allergies with the trauma team. They felt that if they wanted to, they should be allowed to be at the bedside (Doyle et al., 1987; Pasek & Licata, 2016). Some parents removed themselves from the trauma room for personal reasons but expressed gratitude for the opportunity to be there

(O'Connell et al., 2017). Overall, family presence during resuscitation studies demonstrated positive results from family members.

Healthcare provider attitudes towards family presence during resuscitation vary although family presence has not been shown to negatively affect trauma resuscitation outcomes. Centers with the most success in implementing family presence have institution guidelines and educational programs for staff (Auerbach et al., 2021; Meeks, 2009; O'Connell et al., 2007). Senior healthcare providers and staff with previous training on family presence were most comfortable having family at the bedside during resuscitation (Dainty et al., 2021). Staff concerns included parental interference, increased stress or distraction for the trauma team, psychological distress for the family, and the risk of litigation (Meeks, 2009; Dainty et al., 2021; Deacon et al., 2020). Although trauma teams worry that family presence prolongs resuscitation, timing of tasks such as obtaining laboratory studies, emergency procedures, portable radiographs, and time to the CT scanner, did not increase with family presence (Dudley et al., 2009). Advanced Trauma Life Support (ATLS) pediatric trauma patient primary and secondary surveys were not negatively impacted by family presence (O'Connell et al., 2017). ATLS assessments and tasks were completed at similar rates with and without family presence. Trauma team members expressed that family presence did not distract them from medical decisions or the ability to perform procedures (O'Connell et al., 2007). Family presence did not hinder communication among the trauma team; many providers expressed that it improved communication with the family (O'Connell et al., 2007). Family interference with the work of the trauma team was uncommon (O'Connell et al., 2007; O'Connell et al.2017). Family members acknowledged that they positioned themselves in the trauma room and remained calm to prevent interference with the work of healthcare providers (O'Connell et al.,2017; O'Connell et al. 2007). Rarely were family members removed from the trauma room because they were overwhelmed, disruptive or uncooperative (Kingsnorth et al., 2010; O'Connell et al.,2007). In cases of youth violence, healthcare providers worried about safety and security when implementing family presence during resuscitation (Kittle, 2022). The presence of law enforcement and the arrival of large crowds of friends and family may complicate identifying family members during resuscitation (Kittle, 2022). There are few studies of family presence in

victims of violence and institution-specific guidelines should be implemented to ensure patient and staff safety.

Pediatric trauma centers have published best practices for implementing family presence during trauma resuscitation.. The first step for successful implementation is to determine available resources and institutional support for family presence. Guidelines and policies should be developed to ensure standardized care and safety (Kingsnorth et al., 2010). Guidelines should include a trained family support person dedicated to stay with the family during resuscitation (O'Connell et al., 2017). The family support person should not have any additional patient care responsibilities (O'Connell et al.,2017). This role may be given to a social worker, chaplain, nurse, or any other trained healthcare team member (Meeks, 2009). During resuscitation, trauma teams should collaborate and agree on family presence in the trauma room. An announcement to the team should be made upon arrival of family members into the room (Meeks, 2009). Some trauma centers have a pre-screening documentation process to ensure that circumstances are appropriate for family presence (O'Connell et al., 2007). For example, institutions were cautious in recommending family presence in cases with uncooperative or intoxicated family members, simultaneous trauma resuscitations, or suspected child abuse (Kingsnorth et al., 2010; Struckman, 2011). The number of family members may be restricted by the facility and family members may be asked to leave if they interfere with care. Staff training in family presence is essential for successful implementation (Deacon et al., 2020). Overall, institutions with policies and educational staff programs for family presence during resuscitation were most likely to allow family presence during pediatric trauma resuscitation.

<u>The Society of Trauma Nurses position is:</u>

- Family presence during resuscitation is beneficial for families of pediatric trauma patients.
- Family presence does not prolong resuscitation times or decrease communication among trauma team members.
- Family members rarely interfere with care of the injured child.
- An institution-specific policy that supports family presence during resuscitation of a pediatric trauma patient is recommended.
- Staff education and training on your institutions family presence during resuscitation policy and guidelines is highly recommended prior to implementation.

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- The trauma resuscitation team should agree that family members may be present, and an announcement is made when family members enter the room.
- A family support person should be assigned to remain with the family. The support person can be any trained team member such as a nurse, medical resident, social worker, or clergy member. Their role is to comfort and support the family, provide ongoing updates within their scope of practice, escort the family to the trauma room and answer questions.
- Assessing barriers to family presence should be addressed by the multidisciplinary team at your facility.

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