PARENTAL PRESENCE DURING PEDIATRIC RESUSCITATION: THE USE OF SIMULATION TRAINING FOR CARDIAC INTENSIVE CARE NURSES

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INTRODUCTION

- Transitioning a paediatric cardiac intensive care unit (ICU) from a traditional, strict parental visitation schedule to that of an open atmosphere of family-centered care can create an atmosphere of confusion, uncertainty, and turmoil for all involved.
Introduction

- Nursing staff have vocalized reservation of parental presence at the bedside during paediatric resuscitation
Common questions from the nursing and support staff included:

- Is it okay for family members to witness cardiopulmonary resuscitation?
- What do I say to the parent of the child being resuscitated?
- How do I answer the question, ‘Is my child going to die’?
- How do I support them during this crisis?
LITERATURE REVIEW

Advantages and disadvantages of family-witnessed resuscitation has been a topic in the literature for many years.

Hanson and Strawser (1992) provided an early description of family-witnessed resuscitation that was beneficial and clinically significant with adult patients undergoing CPR in the emergency department (ED).
• Family-witnessed CPR assisted families with the grieving process and was helpful to patients who were survivors (Kidby, 2003).

• Family-witnessed pediatric resuscitation has evolved in different clinical situations such as the ED and the ICU settings (Eppich & Arnold, 2003) & (Maxton, 2008)

• It is an emotionally charged time for the parents of children undergoing resuscitation and for the clinical team attending to the child.
Answers to different questions and scenarios focused on parental-witnessed paediatric resuscitation have been sought to paediatric procedures.

For (Bauchner, Vinci, and Waring, 1989)
The question was:

Do Parents Want to Watch???
Response

- 78% of the participants responded “YES!!”

- The parents felt that their presence helped everyone involved with the procedure, which included the child, themselves, and the physician.
Jarvis (1998)

- Focused on the attitudes of staff in a paediatric ICU and found that the nurses and physicians surveyed felt the advantages outweighed the disadvantages.

- His Recommendations:
  - Giving parents the informed choice to stay at the bedside during resuscitation
  - Providing parental support from a team member for clear explanations
  - Preparing teams for the potential of having the family at the bedside during resuscitation
Maxton (2008) found that the fears of the parents are overridden by the need to be with their child and that the recollection of the resuscitation is scene is blurred not not long lasting.
Boudreaux, Francis, and Loyacano (2002)

Performed a critical literature review on family presence during invasive procedures and resuscitation in the ED

- Families wanted the option of attending the procedure or resuscitation
- Families often stayed during the procedure or resuscitation
- Families reported beneficial and favourable experiences afterward
Boudreaux, Francis, and Loyacano (2002)

- Nurses had more favourable attitudes toward family presence

- Older physicians had more favourable attitudes toward family presence

- There was mixed data from randomized controlled trials of whether the patient actually benefited from the family at the bedside.
GOALS OF THE STUDY

• To improve CPR methods and skills via performance in clinical, unit-based scenarios involving paediatric patients with congenital heart disease (CHD).

• To provide hands-on training in the support of parents at the bedside during paediatric resuscitation.
OBJECTIVES

• Rationale behind parental presence during pediatric resuscitation

• Communication skills and techniques during this emotionally charged clinical situation

• Language skills in describing clinical interventions in laymen’s terms for the parents
OBJECTIVES

- Offering emotional and physical support for the parent(s) during the resuscitation
- Offering the family member(s) referral options for social work or clergy support
- Feedback on how to answer the tough parent questions.

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STUDY SETTING

- Simulation Training Unit at Arkansas Children’s Hospital, USA

- Their pediatric cardiac ICU began utilizing simulation training (ST) in January of 2008
Simulation Training

- It was found that retention of CPR materials and skills obtained in traditional educational settings was poor (Hamilton, 2005)

- Simulation training is a promising educational method to improve teamwork skills and behaviour in the clinical environment (Murray, 2006) and (Kakora-Shiner, 2009).

- It has evolved into a format for medical and nursing education that promotes retention of skills and information
METHODOLOGY

- Institutional review board approval was gotten
- 64 STs were carried out
METHODOLOGY

• Participants
  • Nurses
  • Standardized participants (SPs)
    • Either laymen / women
    • Professional actors from the community
Standardized Participant (SP)

- Simulated parent or grandparent of the patient undergoing resuscitation

- Received information and preparation regarding the specifics of each clinical situation prior to the actual exercise
Standardized Participant (SP)

- The expected actions and emotions of the SP during each of the training exercises were planned prior to the ST event.

- The emotional response provided by the SP varied from quiet and non-demanding to loud yelling, crying, and screaming.
METHODOLOGY

- Debriefing exercise in a classroom format after ST

- Debriefing exercises always conducted in a nonjudgmental and non-punitive manner

- ST exercise videotaped, after prior consent from all participants
Debriefing Exercise

- Facilitator initiated the discussion with the participants
- Initially focus on performance strength – What went well
- Next what you feel needs to change / improve in the next scenario
Debriefing Exercise

- SPs shared their thoughts and feelings and perceived level of support

- SP shared with the group suggestions for improvement focused upon the parental support at the bedside during pediatric resuscitation
METHODOLOGY

- A pre test, post test survey methodology was used to evaluate the simulation experience.

- An instrument was developed to specifically address participants’ self-report of level of comfort using a Likert scale.

- Data were collected at the interval of pre and post-training at the time of the ST event and at 1 year post-ST.

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RESULTS

- Verbal feedback from nursing and support staff experiencing this method of training was positive.

- There was increased awareness and knowledge of effective parental support and communication techniques.
RESULTS

- Post-training, staff more comfortable with parental presence during resuscitation (p value = .00)
RESULTS

Post training, Staff more comfortable communicating with Parent in Crisis
(p value = .001)
Conclusion

- Implementing the concept of family-centered care from admission to discharge requires that nursing and support staff be sufficiently prepared to appropriately support family members should they choose to be present during emotional situations, such as paediatric resuscitation.
Conclusion

- Simulation training to educate nursing staff in support of parents present at the bedside during paediatric resuscitation is an effective technique to increase staff comfort and communication skills in working with families in crisis.
Conclusion

- Successful implementation of a policy change is most effectively accomplished with education as well as provision of context and rationale for the change.

- This educational technique allowed the staff to have an improved grasp of the parent’s perspective and improved empathy for the parent’s experience.
QUESTIONS & DISCUSSION