Winnipeg Regional Health Authority / Office régional de la santé de Winnipeg Caring for Health / À l'écoute de notre santé **CLINICAL PRACTICE GUIDELINE**	**Practice Guideline:** Family Presence during Resuscitation in the NICU	
	Approval Date: June 2020 **Approved By:** NICU Patient Care Teams, SBH & HSC; Child Health Standards Committee; WRHA PAC	**Pages:** 1 of 5 **Supercedes:** N/A

1. PURPOSE AND INTENT

1.1. To provide patients and families with care consistent with the family centered care philosophy and evidence-informed practice during infant resuscitation in the Neonatal Intensive Care Unit (NICU).

Note: All recommendations are approximate guidelines only and practitioners must take into account individual patient and family characteristics and situation. Concerns regarding appropriate treatment must be discussed with the attending neonatologist.

2. DEFINITIONS

2.1. **Resuscitation:** Events, including invasive procedures, initiated to sustain life or prevent further deterioration of the patient's condition.

2.2. **Family (Family member):** Parent, relative, legal guardian, or any person with an established relationship.

2.3. **Family Facilitator (FF):** A member of the healthcare team acting as a resource and support person for a family during the resuscitation of their infant. This staff member is **not** involved in the direct care of the patient during the time of resuscitation and may be a nurse, social worker, supervisor, spiritual health specialist, family support coordinator, or other member of the health care team. The FF is ideally someone aware of and has received education in family presence in resuscitation and is responsible for liaising with the family and facilitating communication between the healthcare team and family.

3. PRACTICE OUTCOME

3.1. To ensure family is offered the opportunity to be present at the bedside with their infant during resuscitation should they wish to do so, to ensure family is supported by a designated member of the healthcare team during the resuscitation regardless of their decision to be present at the bedside or not, and to ensure family have adequate support after medical events have occurred.

4. BACKGROUND

4.1. There is a growing body of evidence to support family presence during a child's resuscitation across various healthcare settings that can be applied to the context of the NICU. Overall, the opportunity to be present for a child's resuscitation is viewed by family members as being valuable (Davidson et al., 2017; Ferreira, Balbino, Balieiro, & Mandetta, 2014; Smith McAlvin &

Carew-Lyons, 2014; Stewart, 2019), and parents have reported the importance of communication with and support from the healthcare team during these instances (Ferreira et al., 2014; Smith McAlvin & Carew-Lyons, 2014; Stewart, 2019). In order to ensure family members receive necessary support, information, and timely communication with the healthcare team, it is recommended that an assigned staff member be solely dedicated to attending to family needs during the resuscitation of their child (Davidson et al., 2017; Ferreira et al., 2014; Oczkowski, Mazzetti, Cupido, & Fox-Robichaud, 2015; Smith McAlvin & Carew-Lyons, 2014; Stewart, 2019).

5. GUIDELINES

5.1. When a situation is identified involving clinical deterioration requiring medical intervention including invasive procedures and resuscitation, the charge nurse or designate determines if the family is present in the NICU or in the hospital and notifies the family of the circumstance (Refer to Appendix A).

5.1.1. If the family is not in the NICU or in hospital, a charge nurse or designate can contact the family by telephone.

5.2. The charge nurse or designate identifies a family facilitator (FF) to liaise with the resuscitation team and the family and to provide family centered and supportive care during a resuscitation.

5.3. The FF is responsible for:

5.3.1. Continuously assessing the family for their readiness, willingness, and suitability to be present during resuscitation.

Note: Indications for not being present include intoxication or escalating aggressive behaviors that may compromise the safety of those present.

5.3.2. Inviting the family to be present at the bedside.

Note: Some procedures may pose a risk to the family (e.g., portable x-ray), or close presence may pose a risk to the integrity of a particular procedure being performed (e.g., those requiring a sterile field). In these instances ensure the safety of the family and integrity of the procedure are promoted by maintaining a safe distance and/or ensuring necessary precautions are in place for the duration required.

5.3.3. Accompanying family at bedside, or to a quiet area away from the bedside depending on the family's decision and/or their suitability to be present.

Note: the family may come and go from the bedside as needed and the family facilitator can accompany them.

5.3.4. Preparing family to be present at the bedside by sharing information relating to the:

- Best place for them to sit or stand during the resuscitation
- Appearance of the child
- Procedures being carried out
- Equipment in use
- Number and roles of people present

- Family behavior expectations

5.3.5. Ensuring the family is able to be close to their infant if at the bedside, but not in impeding the ability of team members to conduct necessary assessments and attend to necessary tasks during resuscitation.

5.4. If a family member is not suitable to be present at the bedside (e.g., is increasingly agitated and exhibiting aggressive behaviors, fainting, disruptive etc..), the FF should, if safe to do so, accompany the family to a quiet area and remain available and supportive. If concerns about safety arise, the FF or delegate can contact security or other supportive services.

5.4.1. The FF should reassess the family readiness and willingness to be present at the bedside should their temperament change with support and more information.

5.5. After resuscitation the FF should remain available to initiate and participate in a family focused debrief with the family about the experience with other members of the healthcare team. The focus of this debrief should be on the family needs and experience highlighting opportunities to answer any questions they may have and connecting them with further support or services as required. This is family focused debrief is distinct from a medical debrief which would focus on the experiences and perceptions of members of the healthcare team.

5.6. The FF may be well positioned to identify whether any members of the healthcare team may benefit from support beyond what is readily available on the unit and can follow up with (or refer to) the appropriate services such as those provided by the Critical Incident Stress Management Program. Contact the program team manager or designate who can arrange support for those in need.

6. DOCUMENTATION

6.1. Documentation by the FF should occur after facilitating family presence during resuscitation in a progress note in the medical record and could include:

- Time of arrival of family members
- Specific questions, concerns, or impressions perceived by the family during the resuscitation
- Family decision to be present
- Family response
- Support provided, including whether a family focused debrief occurred
- Follow up required, or referral(s) made

7. REFERENCES

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Appendix A

Flow Chart for Family Presence during Clinical Deterioration or Resuscitation of a Neonate