INVESTIGATING NURSES LIVED EXPERIENCES TOWARD FAMILY PRESENCE DURING RESUSCITATION TO ENHANCE THE FUTURE OF NURSING CURRICULUM

by

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ABSTRACT

Death is inevitable, but dying alone can be an agonizing prospect for patients and their families. Family presence during resuscitation (FPDR) is a controversial but evidence-based concept that helps relieve some of the fear and anxiety for the family. Sadly, loved ones are often not allowed to be with the patient during resuscitation. FPDR importance is typically taught within the healthcare setting but still lacks implementation. By starting education while healthcare students are in a higher learning setting, this concept has a higher probability of success. To fill the gap concerning FPDR, this researcher interviewed nurses who have witnessed FPDR. The study utilized a qualitative hermeneutic phenomenology with a constructivist lens. The investigation explored themes and patterns as to why FPDR may not be carried out. The emerging themes were permission, support and communication, compromised care, patient/family-centered care, bereavement, and situational dependence. The most common theme was support and communication. Each participant recognized the importance of the concept but also stated it should be considered on a case-by-case basis. The themes matched similar studies on the concept and provided insight into ways to improve policy and practice, as well as positively influencing key stakeholders. Lastly, nurse educators can enhance nursing education in the future based on these findings. These educational changes would include curriculum additions and enhancements that will show future nurses that following evidence-based research will advance nursing knowledge and improve their ability to critically think while providing quality, holistic care for patients and families.

Keywords: curriculum, evidence-based, experiences, family, FPDR, holistic, resuscitation.

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List of Abbreviations

Advanced Life Support (ALS)

American Association of College of Nursing (AACN)

American College of Critical Care Medicine (ACCM)

American Heart Association (AHA)

American Nurses Association (ANA)

Bachelor of Science in Nursing (BSN)

Basic Life Support (BLS)

Cardiopulmonary Resuscitation (CPR)

Continual Education Units (CEU)

Critical Care Unit (CCU)

Do Not Resuscitate (DNR)

Emergency Cardiovascular Care (ECC)

Emergency Nurses Association (ENA)

Emergency Room (ER)

Family Presence during Resuscitation (FPDR)

Institutional Review Board (IRB)

Intensive Care Unit (ICU)

Institute for Patient-and Family-Centered Care (IPFCC)

International Liaison Committee on Resuscitation (ILCOR)

Intravenous (IV)

National League for Nursing (NLN)

Pediatric (PEDS)

Post-Traumatic Stress Disorder (PTSD)

Registered Nurse (RN)

Society of Critical Care Medicine (SCCM)

CHAPTER ONE: INTRODUCTION

Overview

Death is inevitable. While many may fear death, it is often seen as more concerning when someone dies alone. The dying person may be alone, scared, and unable to say goodbye. The same is true for the family of the loved one during the dying experience. Families confronting a loved one's death can feel overwhelmed with anger, denial, sorrow, and guilt due to losing a loved one. The family may feel cheated by not being present a what the family sees as the loved one's last moments. This isolating feeling may further the grieving process for the family when the loved one dies. These negative feelings for the family can be seen with the loss of an adult and pediatric loved ones. Holistic care is needed to ensure families are comforted when facing the loss of their relative. Family presence during resuscitation (FPDR) is an evidence-based concept that assists families with losing a relative (Hassankhani et al., 2017; Joyner, 2018; Lederman, 2019; MacLean et al., 2003; Tennyson, 2019; Twibell, R., Siela, D., Riwitis, C., Neal, A., & Waters, N. , 2018).

Nurses are in a great position to advocate for families during this traumatic time (Gerber, 2018; Hassankhani et al., 2017; MacLean et al., 2003). Much education has occurred within the workplace to support this evidence-based concept (Auerbach et al., 2021). Despite this, FPDR is still underutilized for patients of all ages (Hassankhani et al., 2017; MacLean et al., 2003). By investigating nursing experiences with FPDR, education can begin when nurses are still students, building confident, educated, and supportive nurses who can blossom regarding this controversial concept (Blevins, 2018).

Background

FPDR was presented as a problem in 1982 (Afzali Ruban et al., 2020). Staff have questioned hospital policies that avoid family presence during a family member's resuscitation effort after families have expressed their desire to be present. To the family, it allows for an opportunity to say a final goodbye while knowing the loved one was not alone during this resuscitation process. Since the problem was first analyzed, research has shown how this process is helpful for the grieving cycle, improves acceptance of the loved one's death, and improves outcomes for anxiety and depression for the family members (Afzali Ruban et al., 2020; Powers & Reeve, 2018).

FPDR is a concept that allows the family to be present, whether visually or physically, in the area their loved one is located when receiving resuscitation efforts (Joyner, 2018; Powers & Reeve, 2018). These resuscitation efforts can include cardiopulmonary resuscitation (CPR), defibrillation that shocks the heart, and/or intravenous therapy (Joyner, 2018). These can be disturbing for the family, especially if the loved one was involved in a visually-traumatizing situation (Hassankhani et al., 2017; Imperatrice, 2019; MacLean et al., 2003; Powers & Reeve, 2018). FPDR could negatively impact the family, drawing attention from the patient to the distraught family member (Hassankhani et al., 2017). This perplexing situation could also cause the family member to misunderstand the revival efforts and get in the way of the staff performing their duties. Some healthcare workers have been worried about increased legality issues if the family witnesses such a chaotic situation (Imperatrice, 2019; MacLean et al., 2003; Powers & Reeve, 2018). While studies show healthcare professionals have continued reluctance to allow families in the resuscitation rooms, families have announced that presence is needed and wanted for the family and the loved one (Afzali Ruban et al., 2020; Hassankhani et al., 2017; Joyner,

2018; Lederman, 2019; Powers & Reeve, 2018; Tennyson, 2019; Twibell, R., Siela, D., Riwitis, C., Neal, A., & Waters, N., 2018). Since studies show that there are benefits to the grieving process for the family, it needs to be considered for holistic patient care.

Education of Nursing Professionals

For healthcare professionals, FPDR education is being introduced into practice (Powers, 2018; Tennyson, 2019). There are ongoing training programs and continuing education unit (CEU) requirements for hospital staff demonstrating the benefits of FPDR to the family (Powers, 2018; Powers & Reeve, 2018; Tennyson, 2019). The American Heart Association (AHA; 2014) has even added FPDR to their CPR training. Despite the influx of education to staff and the wishes expressed by the families to be present during the resuscitation process, this concept is still underutilized (Deacon et al., 2021; Powers, 2018; Tennyson, 2019). To advance the process of FPDR, education should start sooner to ensure nurses follow evidence-based practice.

Education of Nursing Students

Higher education for nursing students teaches pupils to develop critical thinking skills and follow evidence-based information for quality, holistic, patient- and family-centered care. To be influential, quality nurses, student nurses need to be taught about controversial topics, such as FPDR, and evidence-based care that encompasses holistic care (Powers, 2018; Powers & Reeve, 2020; Tennyson, 2019). Nurses are vital to making a difference for patients, their families, and the healthcare community. To advance these qualities, education should begin at the student level to enhance the nursing discipline and the nurses who serve (Toronto & LaRocco, 2018; Wei et al., 2018). Since nursing students lack experience with resuscitation efforts, the nursing perspective must be examined. Learning about the nursing experiences of

FPDR will allow nurse educators to develop and enhance student nursing education (Toronto & LaRocco, 2018). These educational changes include enhancing the nursing curriculum to influence this concept.

Philosophical Framework: Hermeneutic Phenomenology through a Constructivism Lens

Phenomenology is a method of study that allows the researcher to look at concepts through human experiences (Creswell & Poth, 2018). This conscious experience allows a situation to be viewed subjectively through various lenses due to how each person sees the same circumstance. These various views are influenced by historical events within the person's life, how a person was raised, emotional attachments to a condition, and various ways humans see a scenario.

Husserl, the father of phenomenology, believed that each person had a different way of experiencing a situation, but the investigator should bracket from the experience to avoid bias (Husserl, 1958; Moran, 2005). Heidegger, Husserl's pupil, felt that a researcher could not suspend their own experiences as their lived experiences drew the investigator to the concept (Heidegger, 1962; Moran, 2005). Heidegger felt that by viewing a concept through several lenses, including the participants and researcher, the concept could be given more profound meaning and have a richer understanding (Heidegger, 1962).

Constructivism allows students and instructors to work together to learn about new concepts (Billings & Halstead, 2016; Candela, 2019; Creswell & Creswell, 2018). This team-building method allows the professor and student to work together and recognize historical events, feelings, or previous experiences that may help or hinder the learning process (Candela, 2019; Tam, 2000). This is vital in the student setting, especially within nursing. Nursing works to see patient care in a holistic light (Powers, 2018). Just as a patient and loved ones can bring in

personal feelings and experiences to healthcare, so can a student bring in the same for learning, and a participant and researcher do the same for a study (Billings & Halstead, 2016; Candela, 2019; Creswell & Creswell, 2018). That is why a nursing study would fit well with a constructivist method and a hermeneutic, phenomenology philosophical framework. Each sees that a situation or person is more than one individual item. Everything consists of expressions, feelings, emotions, and lived experiences. This foundation can be expanded and evolved to better serve the stakeholders while filling gaps to enhance nursing practice and research (Candela, 2019).

Situation to Self

I have witnessed birth and death in a variety of healthcare settings. Most of these have occurred in the ER. Seeing a child's death has touched and haunted me. While these experiences have made me grateful for life, seeing death has also caused some negative feelings. I have seen coworkers argue and complain about how a patient's care was handled, including FPDR. I have also experienced negative emotions from colleagues when suggesting families come and spend a few moments with a dying patient. However, I have seen families in the treatment area during routine care and FPDR where disruptions occurred that prevented the healthcare team from caring for the patient. While I advocate for patients and family, there have been times I would have been reluctant to allow the family in the room, despite what evidence has taught me.

Education of Nursing Students

If I had been introduced to FPDR in my student nursing years using evidence-based methods, lessons could have been adapted to fit the situation and audience. By understanding the epistemology of knowledge, I could have used constructivism to understand how professors and

students work together to develop new skills while recognizing that each brings different experiences to the situation (Creswell & Poth, 2018). Having this background could have assisted me in understanding how to handle such a complex event in a more holistic, beneficial manner.

As someone who has also had the pleasure of being a nursing educator, I understand that the opportunities to experience FPDR are not always available. Using a constructivist method within education, various learning methods could be used to build upon the evidence showing the benefits of such a concept (Creswell & Poth, 2018). I recognize the complexity and unique skills that nursing needs with every patient encounter, especially in difficult situations such as FPDR. This requires developing critical thinking, displaying emotional intelligence, and understanding the importance of evidence-based practice. To accomplish these needed abilities, an instructor and student must work together to fill that gap. Using a constructivist lens within a hermeneutic phenomenology approach to interview nurses on their lived experiences with FPDR, an educator can glean information to help build a student's confidence (Creswell & Creswell, 2018; Creswell & Poth, 2018). The educator can also develop communication and team-building skills through various learning methods. These multiple methods would help the student and teacher work as a team and understand that adaptation of learning skills may be needed since everyone has a different way of addressing harsh circumstances.

Research Paradigm and Assumptions

Hermeneutic phenomenology allows a person to see the same experience through different lenses (Heidegger, 1962). It allows the researcher to recognize their own perceptions within the experience while recognizing other participants' understandings of the same concept. This humanistic ontological view recognizes that the nature of reality is the interpretation of

shared experiences. This is important to this investigator, as my Biblical views show that God is the true reality of the world (Hebrews 4:12; John 1:17; John 14:6). Sadly, through the distortion of people's perceptions, experiences, or the human nature of sin, this reality can have different meanings to different people.

Epistemologically, this research method maintains that knowledge is studied through subjective experiences and feelings (Heidegger, 1962). However, biblically I know that emotions and perceptions can be a desire of the flesh and cause one to sin (Galatians 5: 16-24; Proverbs 16:32). Therefore, it is best to put our strength and understanding on Christ (Isaiah 12:2; John 10:10; Proverbs 29:25). While it may be seen as counterproductive, these biblical principles are helpful when using hermeneutic phenomenology.

Human nature is fickle (Lal & Singh, 2021). This is not only seen by worldview scholars but noted in the Bible (James 1:8; Matthew 6:24; Romans 8:7). This phenomenological approach allowed me to see the axiological assumption that individuals are all a part of other experiences while understanding that outside factors influence their perceptions (Creswell & Poth, 2018). This is vital within nursing using a holistic view and the Biblical worldview I hold dear. While recognizing that each person comes to an experience with their own values and beliefs lets me stay grounded in the foundational belief that Christ is the final truth, and everyone will all come to that resolution at his return (1 Peter 1:3-5; Romans 8:18-21).

Problem Statement

The problem is that FPDR is not being implemented within the healthcare setting despite helping the family's grieving process. This is true for adults and pediatric patients. This problem exists despite education occurring within many healthcare settings (Powers, 2018; Tennyson, 2019). Earlier interventions are needed to impact the long-term stability of nursing and its goal of

holistic, quality, evidence-based care (Powers, 2018; Powers & Reeve, 2018). Since nursing students lack experience with FPDR, nurses need to understand this concept. Understanding the essence of nurses' experiences regarding FPDR will help fill the research gap and allow future nurses to recognize the importance of evidence-based, holistic care when entering the nursing workforce (Powers, 2018; Toronto & LaRocco, 2018; Wei et al., 2018).

Purpose Statement

The purpose of constructivism within a hermeneutic phenomenology study is to understand the essence of nurses' experiences with FPDR. It also acknowledges that everyone has their own truth and that human experiences influence the knowledge of concepts such as FPDR (Pilarska, 2021). Using various nursing experiences and perceptions on FPDR can help nursing faculty educate future nurses. These educational changes can adjust the curriculum to mold future nurses to practice, lead, and advocate for evidence-based care for the patient population (Bates et al., 2019). These curriculum adjustments within the university setting can impact hospital policies and healthcare professionals' conflicting perceptions regarding FPDR (Bates et al., 2019; Billings & Halstead, 2016; Johnson et al., 2012). Addressing this obligation can also address individual, social, and political transformations. The mission to move a student from a preparatory to a novice nurse starts with an appropriate nursing educational program with an up-to-date, evidence-based curriculum (Bates et al., 2019; Johnson et al., 2012; People for Education, 2019). Examining this controversial concept will also furnish the student with the ability to build confidence in their aptness, knowledge, communication, and feelings to provide comprehensive care for all patients, regardless of age (Garbrah et al., 2017; Hassankhani et al., 2017; MacLean et al., 2003; Twibell et al., 2008).

Significance of Study

Nursing began during the 1850s when proper care, advocacy, and education were often not present (Riegel et al., 2021). Florence Nightingale was a pioneer of nursing; Nightingale's contributions to holistic patient care have been critical for developing nursing as an art and science. Nightingale pushed for proper training and education for nurses to ensure that holistic, evidence-based care was provided to the patient. Florence Nightingale's research, advocacy, comprehensive care, and devotion are the foundation for nurses being seen as valuable leaders within healthcare (Matthews et al., 2020; Selanders & Crane, 2012).

Nursing Leaders

Throughout the years, other vital nursing figures, such as Jacqueline Fawcett and Virginia Henderson, paved the way for nurses to help comfort, lead, teach, and advocate for patients and their families. Fawcett believed a patient was more than a physical being (Fawcett, 1984). Fawcett created the nursing metaparadigm that confirms a patient's care involves respect for the person, health, environment, and nursing. This nursing metaparadigm is the basis for student nursing education and curriculum, the nursing discipline, and the mission of holistic family and patient-centered care.

Virginia Henderson, the modern version of Florence Nightingale, believed leadership and advocacy for patient-centered care are critical to nursing (Henderson, 2006; Wagner, 2018). Henderson (2006) stated that nurses should advocate for the patient. Nurses should care for every person, even when the patient cannot advocate or care for themselves. This includes providing care in fragmented situations due to a lack of understanding or education (Henderson, 2006; Salmond & Echevarria, 2017). Nurses can contribute to the positive evolution of healthcare

when evidence-based studies are learned and subsequently implemented into practice (Henderson, 2006).

Evolution of Nursing

When examining nurses implementing the evolutionary nursing process, an example can be seen with fathers in the delivery room and parents' presence during invasive procedures for their children (King, 2017; MacLean et al., 2003). Each of these situations was unthinkable but is now seen as a norm within healthcare. Nurses, in both situations, advocated for the family and patient to allow support, involvement, a sense of purpose, comfort, and care.

COVID

In recent events, COVID-19 stretched the boundaries for nurses and many other team members (Anderson-Shaw & Zar, 2020; Capozzo, 2020; The Ones, 2020; Wakam et al., 2020). Many healthcare professionals lacked the experience or understanding to deal with this pandemic or the emotional toll it would take on the healthcare community and the patient population (Anderson-Shaw & Zar, 2020; Capozzo, 2020; Karimi et al., 2020). Patients were often in life-threatening situations and left alone due to strict quarantine procedures (Wakam et al., 2020). While not optimal, nurses, being innovators, would often use smartphones, or other electronic devices, to allow patients and families to communicate or see each other's faces (Ones, 2020). With approximately one million in the United States dying from COVID, many of these patients died alone (Capozzo, 2020; CDC, 2022; Wakam et al., 2020). Nurses did their best to hold hands and comfort patients and their families (Ones, 2020). Sadly, this often left the patient fearful during their last moments or family that was angry, distraught, or grief-ridden due to how the loss occurred.

Spirituality and Religion

These feelings of fear or anger were often cited by patients and families, in part, due to the lack of spiritual access and performance of cultural or religious rituals when death occurred during COVID-19 (Brazal, 2021; Firouzkouhi et al., 2021; Papazoglou et al., 2021; Willard, 2021). Families and leaders could not be present for customs to help facilitate the passage to the afterlife. This caused concerns about the loved one's soul after death and if the patient moved on to a higher realm. Muslim families could not wrap their loved ones in a shroud or bury the patient as quickly as religious guidelines require (Gabay & Tarabeih, 2022). Catholics could not receive the last rights that involved confession, holy communion, and anointing of the sick (Dobrakowski et al., 2021). Hindu families were not allowed in the room to position the patient properly or chant as their souls left the body (Ghosh & BK, 2022). This exponentially increased the fear for the patient and family and increased stress and resentment by the family (Brazal, 2021; Firouzkouhi et al., 2021; Papazoglou et al., 2021; Willard, 2021).

Family Importance

Families' perceptions of the loved one dying alone, inability to say goodbye, and lack of custom and religious rituals are concerns for the families' mental well-being. Many mental health professionals recognize the impact COVID-19 had on those left behind's mental and spiritual health. There are concerns for the healthcare workers who experienced the loss of the patient and the strain on the family in this isolating situation (Dutheil et al., 2021; Sekowski et al., 2021). Behavioral health experts have cited concerns for prolonged grief recovery, post-traumatic stress disorder (PTSD), depression, anxiety, and suicide from family members due to COVID deaths. This has many in healthcare recognizing what nurses have known for years, that holistic care is vital to the well-being of the patient and those within their circle (Henderson,

2006; Wagner, 2018). Since holistic care was not readily available during COVID, there are fears of another pandemic, but this one would involve mental health (Dutheil et al., 2021; Sekowski et al., 2021).

Education of Nursing Students

According to the American Academy of Colleges of Nursing (AACN; 2021b), proper student nursing education is the best way to ensure nursing meets the demands of evolving health and societal environments. Evidence shows that properly educating student nurses makes the student more confident and better prepared regarding data analysis, quality and safety, starting projects that benefit healthcare, and evidence-based practice. A student nursing program and curriculum must focus on educating students that support new technology, different specialties, and scientific advances to meet the community's healthcare needs (Brussow et al., 2019). A student-centered educational approach, such as a constructivist method, allows students to develop critical thinking abilities and reasoning in complex situations (Brussow et al., 2019; Tam, 2000). This type of educational approach helps meet the needs of critical stakeholders, such as patients, families, interdisciplinary health professionals, universities, and students. By presenting educational moments on various topics while a student is in school, the student often develops into a well-rounded, confident, critically-thinking nurse advocate and leader (AACN, 2020; AACN, 2021b; Brussow et al., 2019; Fawaz et al., 2018; Institute of Medicine (US) Committee on the Robert Wood Johnson Foundation Initiative on the future of nursing, at the Institute of Medicine, 2011; Kavanagh & Sharpnack, 2021; National Academies of Sciences, Engineering, and Medicine [NASEM], 2021; Smith, 2017). This can then influence future nurses' evidence-based care, hospital policies, and legislation. Utilizing these concepts will help close the gap from classroom to clinical and create a rich, research-practice-based environment.

Research Questions

The essential question for this FPDR study was: What are the lived experiences of nurses with FPDR? Follow-up questions may include: What stood out about FPDR? Tell me more about the experiences with FPDR? Using these foundational questions, several other questions during this investigation were answered to enhance this concept for nursing and nursing students.

Definitions

The following terms were pertinent to this study.

1. *Constructivism* – Constructivism is a teaching-learning method that allows people to actively formulate their knowledge based on previous learning experiences (Bakar et al., 2019; Muhajirah, 2020; Pilarska, 2021; Straughair, 2019; Tam, 2000). It allows for a relationship between a teacher and learner that enhances the education process by building on past experiences through meaningful encounters and team-building approaches (Tam, 2000).
2. *Dasein* – Dasein is exploring individual perceptions and experiences while recognizing that one cannot separate the person from experience (Heidegger, 1962).
3. *Education* – Education is the growth and development of knowledge through learning (DeBoor & Keating, 2018).
4. *Emotional intelligence* – Emotional intelligence is a transformational process where self-awareness, self-regulation, self-motivation, empathy, and social skills such as communication are developed (Jaeger, 2003; Lam & Kirby, 2002; Raghubir, 2018; Salovey & Mayer, 1990).

5. *Experience* – Experience is awareness and response to an event that includes perceptions, actual doing or use of knowledge, or familiarity with the situation (Creswell & Poth, 2018).
6. *Family Presence during Resuscitation* – Family presence during resuscitation is a process that allows families to be present during resuscitation efforts of the family's loved one (Powers & Reeve, 2018). These resuscitation efforts can include CPR, intubation, defibrillation, and/or IV therapy.
7. *Hermeneutic Circle* - Hermeneutic circle is a cyclical process where a person's views are seen as an individual part while recognizing that each part creates a whole process to understand a concept (Heidegger, 1962).
8. *Hermeneutic Phenomenology* – Hermeneutic phenomenology is an interpretive type of phenomenology that allows a concept to be explored through individuals' lived experiences (Heidegger, 1962).
9. *Investigating* – Investigating is researching a concept to develop new theories and ideas that further knowledge (Creswell & Creswell, 2018).
10. *Perception* – Perception is understanding a concept through the eyes of different participants (Creswell & Poth, 2018).
11. *Student nursing curriculum* – Student nursing curriculum is a plan that includes philosophical methods, goals, outcomes, designs, courses, and methods to educate nursing students (Creswell & Creswell, 2018). This process allows the student to go into the healthcare setting and deliver high-quality, holistic, evidence-based patient care.
12. *Thrownness* – Thrownness is a concept where a person is conscious of being in the world and aware of how the world influences their Being (Heidegger, 1962). The person is

thrown into the world, and an individual must use their preconceived thoughts and understanding to shape their own experiences within the world.

Summary

By following the evidence-based practice of FPDR and allowing loved ones to be part of the life cycle from birth to death, nurses can follow the nursing metaparadigm and maintain mental, physical, social, and spiritual well-being. Since the nursing discipline has been voted the most trusted profession for almost 20 years, the public expects nurses to be their voice and practice in their best interest (Gaines, 2021). To meet public expectations, nurses often include family members in patient care to ensure support and advocacy for those seeking care (Auerbach et al., 2021; Lederman, 2019). Quality care is more than pills, radiological procedures, and surgery. It is about seeing the patient as a sum of their pieces and advocating for those that cannot always advocate for individual patient care needs (Gerber, 2018; Wagner, 2018).

Examining nurses' experiences with a loved one's resuscitation process can enhance curriculums for student nurses so the pupils can grow into well-rounded nurses (Twibell et al., 2008). This will allow nurses to demonstrate, lead, and mentor others to incorporate all types of evidence-based concepts (Gerber, 2018; Wagner, 2018). This includes FPDR, a patient and family-centered care concept (Auerbach et al., 2021; Gerber, 2018; MacLean et al., 2003; Tennyson, 2019).

CHAPTER TWO: LITERATURE REVIEW

Overview

According to Powers and Reeve (2018), FPDR is a concept that allows families to be present during the resuscitation of their relatives. This process can occur in various areas, including intensive care units (ICU), emergency rooms (ER), or other patient care areas. Research shows that FPDR is beneficial for families dealing with their grieving process (Goldberger et al., 2015; Hassankhani et al., 2017; Joyner, 2018; Lederman, 2019; MacLean et al., 2003; Tennyson, 2019; Twibell, R., Siela, D., Riwitis, C., Neal, A., & Waters, N., 2018; Vincent & Lederman, 2017).

Many professional organizations, state nursing policies, and foreign countries have recognized the philosophical importance of holistic care. Each establishment has taken a stance on the benefits of offering support to families during resuscitation. Early recognition by the American Heart Association (AHA; 2000) and the Emergency Nurses Association (ENA; 1993) was foundational in recognizing the need for supportive care for the patient and the families that wish to be present and influencing other organizations to follow suit. This procedure was first recognized in the 1980s. One of the first institutions to implement FPDR was the Children's Medical Center (2002) in Dallas and Foote Hospital in Michigan (Doyle et al., 1987). Foote Hospital and Children's Medical Center have offered educational literature on how support could be offered during this life-altering process (Children's Medical Center, 2002; Doyle et al., 1987; Guzzetta & Ratner, n.d.). Sadly, even though this process has been present for forty years, only a handful of United States institutions have taken steps to develop a comprehensive policy and training program that would allow the implementation of such a concept (Guzzetta & Ratner, n.d.). Even with the limited number of institutions with these policies, FPDR still has a negative

stigma from many hospital personnel. According to polls and research studies, families want to be present, but the staff is reluctant to implement FPDR due to legality concerns, family interference, and emotional concerns (Toronto & LaRocco, 2018).

Theoretical Foundation: Hermeneutic Phenomenology with Constructivism Lens

A foundation for the theory of FPDR is constructivist in nature while using the hermeneutic phenomenology worldview. A constructivist approach allows people to actively formulate their knowledge based on previous learning experiences (Bakar et al., 2019; Pilarska, 2021; Muhajirah, 2020; Straughair, 2019; Tam, 2000). The same is true for the hermeneutic phenomenology approach. Ideas can be modified or expanded by building on known past experiences through meaningful encounters and team-building approaches. By learning more about a person's journey, a new concept can grow into a new idea with different views and perceptions. Thus, constructivism and phenomenology allowed this researcher to examine various thoughts and feelings and to better understand current situations in nursing as well as nursing education in the future.

Constructivism

Constructivism allows the learner to add new information to existing knowledge (Mennenga, 2018). This process of meaning is attempted to base that new information on foundational experiences throughout the person's life. This method allows students to see a link between old and new knowledge, and this process allows the teacher to be the facilitator while the student is part of the team and allows for collaborative learning. The faculty members give encouragement and reassurance while allowing the student to take the lead in the learning process. This team approach creates a bond between an educator and student. This allows for trust between the two team members, while the student gains self-assurance and confidence in

the learning process (Tam, 2000). This can flow into the whole student class setting, which allows each student more freedom in their attainments.

History and Premise of Constructivism

According to Triantafyllou (2022), constructivism is grounded in epistemology, the theory of knowledge, and how each person learns. Constructivism focuses on communication skills that enhance the exchange and cooperation of team learning. This theory postulates that people can actively receive information through lived experiences or social interactions. Constructivism constructs new knowledge that builds on individuals' earliest forms of information. The key to learning and building knowledge is motivation. With motivation, individuals can build upon past experiences and enhance their foundation with links to new information.

There are three main types of constructivism: social, cognitive, and radical (Triantafyllou, 2022). Ernst von Galswersfeld, Lev Vygotsky, Jean Piaget, and John Dewey are key theorists of constructivism. Each of these theorists may have various views on knowledge and how a person learns, but each has the foundational belief that knowledge is a versatile action for the learner. This study utilized Dewey's method of constructivism since he used a holistic manner for learning (Boyles, 2020; Dewey, 1960, 1986; Mayer, 2008). His beliefs impacted education by recognizing that social and cognitive values are essential for students. These are important for the findings of FPDR if they are to be used in nursing education in the future.

Ernst von Glasersfeld

von Galswersfeld (1995) is credited with developing radical constructivism. Radical constructivism affirms that reality is subjective and constantly growing. Knowledge is learned based on a person's subjective analysis of their own lived experiences. In education, the student is the only creator of information and meaning. The role of an instructor is not to give the

information to the student but guide them through the experience. The teacher assists the pupil through the theoretical grouping of particular sections of the experience to reach an improved conclusion.

Lev Vygotsky

Like other theories, social constructivism attempts to explain how individuals learn and create meaning (Triantafyllou, 2022). Vygotsky (1962) believed knowledge was generated through social interactions and teamwork. This social constructivism theory focuses on the social and cultural nature of learning. It involves collaboration with others and reflection and discussion to construct an evolved meaning on a topic. Teachers could help students by integrating various groups to discuss a concept so that each can learn from one another.

Jean Piaget

Cognitive constructivism argues that knowledge grows based on the individual's cognitive state of development (Piaget, 1967). Known for his four states of cognitive development, Piaget states that each child goes through sensorimotor, preoperational, concrete operational, and formal operational based on their age. Knowledge is created using functions of memory, attention, and perception. In education, the educator is to present the information but allows the learner to investigate the resources and data to build their understanding.

John Dewey

Dewey is known as the philosophical developer of constructivism (Boyles, 2020; Mayer, 2008). While some of his counterparts believed in social, cognitive, or radical constructivism, Dewey straddled the belief of social and cognitive values within constructivism (Mayer, 2008). Both Dewey and Piaget felt that children learn by doing and encouraged the exploration of thought. Dewey and Vygotsky felt that social interaction was important in the learning process.

However, Dewey had differing ideas about constructivism from his colleagues. Dewey felt that real-life situations impacted a student's ability to advance in critical thinking (Boyles, 2020; Dewey, 1960, 1986). He felt that each person is different and that interactions with others are vital to learning. Dewey felt a hands-on approach is the best way to increase and build upon knowledge (Dewey, 1986). Touching, sensing, seeing, and discussing an action leads to a deeper understanding of the concept. The educator and student can work together to build a relationship where they could learn from one another (Dewey, 1960, 1986). The teacher can provide the student with encounters that are directly relevant to the concept, allowing the student to make further sense of the material in a deeper way.

Constructivism within Nursing Education

Constructivism is also vital within nursing education, where the student and professor build a relationship (Billings & Halstead, 2016; Candela, 2019; Creswell & Creswell, 2018). Each person has a crucial role and brings various backgrounds, feelings, and experiences to the teaching-learning team. Just as holistic care in nursing sees the person as more than their body, the constructivism method fits with the phenomenology theory, which recognizes the student and instructor as individuals with different perceptions (Candela, 2019; Tam, 2000). This constructivist learning method allows students to create ways of understanding situations while using older knowledge and experiences to build and form new knowledge (Billings & Halstead, 2016). The educator is the facilitator in the learning process and works in a team environment. This allows the process to develop, emphasized by Bloom's Taxonomy in the conceptual knowledge category. Knowledge grows and builds upon simpler to more complex skills. This method involves the student and establishes the collaborative learning process. Each member, instructor, and pupil are a team. This team allows for a bond to form and, thus, creates self-

assurance and confidence (Tam, 2000). Self-assurance and confidence often spill over into the class as a whole and show that each person is responsible for their role in the learning process. By taking an active role in the learning process, it can be applied to real-world situations. This will also enhance research, hypothesis, testing, and building upon evidence to fill the gap between nursing research and practice (Candela, 2019). Filling the gap improves educational standards and the art and science of the nursing profession, the patient, and the people in the patient's circle.

Figure 1

Constructivist Learning Method

History and Premise of Hermeneutic Phenomenology

Utilizing a hermeneutic phenomenology approach allows the researcher to understand lived experiences in a particular situation (Heidegger, 1962). Heidegger developed this qualitative research method by expanding on Husserl's transcendental phenomenology. Husserl used his phenomenology to understand human experiences, but Heidegger used the hermeneutic circle to understand that a whole experience comprises its singular parts (Heidegger, 1962; Husserl, 1958). Husserl (1958) felt that understanding a situation or idea was about studying consciousness and individual perceptions, reflections, thoughts, and feelings. Husserl felt that the researcher should bracket or separate from the concept to avoid contaminating the experience. Heidegger (1962) felt similar to Husserl regarding understanding a phenomenon but thought that a researcher needed to understand what outside perceptions each person brings to the study as well. While the investigators' perceptions and experiences need to be recognized, the researcher's own preconceived ideas are what brought that person to the investigation and thus cannot be bracketed.

Heidegger

According to Heidegger (1962), ontologically, human reality is part of the existing world. Unlike his mentor, Husserl, Heidegger felt that a person could understand their own Being while knowing that the Being is inseparable from the world. This concept is what he called Dasein. Epistemologically, Heidegger noted that the knowledge and understanding of a situation, or the world surrounding a person, are influenced by human reality. While ontology and epistemology look at truth, axiology looks at values (Creswell & Poth, 2018). Values influence the way a situation is evaluated epistemologically or ontologically. The axiological assumption for

Heidegger is that each participant Being has its own values brought to the experience. (Heidegger, 1962). Since humans are part of the world, the two cannot be separated.

Heidegger, unlike Husserl, also felt that a person needs to recognize their internal feelings and biases, but each individual must also understand that everyone is made up of unique experiences (Heidegger, 1962). These various perspectives, emotions, and lived experiences can expand on human interests and circumstances within patient care (Candela, 2019). Bracketing is not possible when a researcher is involved with a hermeneutic phenomenology study (Heidegger, 1962). The experiences brought the investigator to the study to begin with; thus, bracketing from the situation would not allow for a further understanding of the concept. The notion would not be able to grow and unfold. However, the researcher does need to avoid biases while conducting the study. To recognize what the investigator brings to the study, the researcher should openly acknowledge their thoughts. Reflexivity should be used to identify these preconceived notions. Reflexivity also demonstrates the importance the investigator's subjectivity plays within the study. This allows the study to provide rich and robust information about the concept using a holistic manner (Creswell & Poth, 2018).

Hermeneutic Circle

To understand the holistic link between how parts play a role in making a situation whole, Heidegger developed the hermeneutic circle (Heidegger, 1962). A hermeneutic circle is used to help recognize the different lenses of the experiences. This circle is not a linear process but a continual cycle of growth. The circle allows the investigator to recognize that thoughts and experiences change. By seeing other participants' views, the researchers' perceptions evolve based on the various ways of seeing the same situation. It is similar to a spiral-like event. This spiral allows the researcher to advance their understanding of the phenomenon in question each

time a new experience is introduced to the study. Heidegger recognized the importance of investigating social beings as a sum of all their parts and how the separation of these lenses is not possible to get the complete picture. Using the hermeneutic circle within hermeneutic phenomenology, the researcher has a study that recognizes the entire holistic essence of the phenomenon, just as social sciences like nurses use holistic care and the nursing metaparadigm (Fawcett, 1984; Heidegger, 1962; Nikfarid et al., 2018).

Figure 2

Hermeneutic Circle

[redacted]

Dasein

According to Heidegger (1962), Dasein is simply being there. For human beings, it is the situation of existence and the experiences the person encounters. The process of the person and Dasein are interlocked and cannot have purpose without the other. Each person comes into the

world with their own experiences, feelings, and emotions. Situations and values are addressed based on these experiences and cannot be separated. This process makes each person a Being within the world. That is why there are wide varieties of feelings and perceptions. Each person's meaningful existence gives different meanings and a rich understanding of the world and the concepts encountered. Heidegger felt that each person needs to embrace different meanings and not conform to protocols or rules that do not allow for freedom of reflective thought and insight.

Throwness

When a person is "thrown" into the world, this individual encounters various social norms, educational guidelines, and cultural differences (Heidegger, 1962). This realm shapes the person's understanding and, if not careful, can be conformed to emotions and behaviors that are not typical of the individual. The person needs to be aware of the world's influence and use reflection to recognize the differences between their Being and the world's norms. People must use their foresight to recognize this and how it will shape their feelings and understanding of the world.

Fusion of a Constructivism Lens with a Hermeneutic Phenomenology Method

While this study utilized hermeneutic phenomenology theory, it also investigated using a constructivist approach. This allowed the lens of the educator and student to be used while using the lenses of different participants in the same experience (Pilarska, 2021). Constructivism and hermeneutic phenomenology allow the researcher to see how different perceptions can evolve a concept to improve understanding, and allows for a bigger picture of the concept. As people learn more, methods and awareness evolve. This improved understanding will improve teaching methods, such as in the educational setting.

Constructivism and hermeneutic phenomenology allows each part to play a role in the process. It also demonstrates that the whole process is a foundation for the various pieces (Peoples, 2020). One must see that each piece plays a role in the experiences everyone lives. This is true for constructivism, where teachers and students work together to learn. It is also noted in the phenomenology process of seeing participants' views to gain the whole essence of the concept.

Using different views is also vital within nursing. The foundation of nursing is the nursing metaparadigm (Nikfarid et al., 2018). The nursing metaparadigm looks at the discipline as a person, environment, health, and nursing (Fawcett, 1984). The person, environment, health, and nursing are interwoven to create a relationship of holistic care that is foundational when enhancing nursing concepts and evidence-based care (Fawcett, 1984; Nikfarid et al., 2018). The same is true for constructivism and the teacher-student relationship as well as phenomenology to understand a concept's entire essence (Pilarska, 2021).

Related Literature

Despite the evidence supporting FPDR, it is a tendentious topic. Many healthcare professionals, including nurses, do not feel that families should be allowed in the treatment area during resuscitation efforts (Imperatrice, 2019; MacLean et al., 2003; Powers & Reeve, 2018). Negative themes include families causing havoc during the resuscitation process, distrust of the resuscitation team, legality concerns, negative mental images for the family, and drawing care away from the patient to care for the family member (Hassankhani et al., 2017). This includes situations with adult and pediatric patients. However, studies show that medical staff is more open to families being present during a pediatric resuscitation than an adult (Joyner, 2018; Oczkowski et al., 2015; Twibell, R.S., Siela, D., Neal, A., Riwitis, C., & Beane, H., 2018;

Twibell, R., Siela, D., Riwitis, C., Neal, A., & Waters, N., 2018; Vincent & Lederman, 2017).

Pediatric Population

For a pediatric patient, most medical staff feels that there are more ethical considerations to FPDR. When examining the ethical principles of autonomy, nonmaleficence, beneficence, and justice, some believe that a pediatric patient is more susceptible than an adult patient (Beauchamp & Childress, 2001; Joyner, 2018). While there are concerns about parents misunderstanding medical actions, feeling anxiety, and interfering with medical procedures, pediatric patients are most vulnerable since a minor cannot advocate for procedures. As their legal guardian, the parents speak on the child's behalf, which is not only as the child's advocate but as an act of beneficence, nonmaleficence, and justice.

For many medical professionals, pediatric patients have not fully lived their lives (Joyner, 2018). The team sees a pediatric death as more traumatic to a family than an adult death (Joyner, 2018; Oczkowski et al., 2015; Twibell et al., 2018; Vincent & Lederman, 2017). There is more acceptance of family presence when a child is involved, as the medical team often sees the parents' situation and feels more empathy. Also, many physicians against FPDR have shown advocacy for a family's presence during a pediatric resuscitation due to the patient's young age (Imperatrice, 2019; Twibell et al., 2018).

Influences on the Patient

While any death can be traumatic to a family, there is evidence showing the physical and psychological importance to the patient. According to Afzali Ruban et al. (2020), three different studies examined how patients that survived resuscitation felt about having a loved one present. While there were some negative concerns that the patient did not want their family to see such a

situation, the positive ones were more significant. A participant in one of the studies stated that having his family member present helped him know that the hospital staff would recognize him as a person with a family and feelings, not just as another patient. While not all the participants stated the same, most themes included feeling comfort, support, personhood, and dignity.

Influence on the Family

Consensus shows that FPDR is helpful to the family (Gouda & Hoehn, 2020). Research also shows that families want the option to be present, regardless of the situation (Gouda & Hoehn, 2020; Hassankhani et al., 2017). When families have not wished to witness the event, family members have stated that being invited meant a lot and made them feel that the staff recognized the importance of the patient and the family (Gouda & Hoehn, 2020; Powers, 2018). Subsequently, the family also feels their emotions and feelings were not dismissed, which made them feel they were a part of the care, even when they were not in the room.

Different studies have offered information from healthcare professionals that there is a concern about traumatizing the family or family interrupting the procedure if they attend (Dutheil et al., 2021; Sekowski et al., 2021). However, family information demonstrates that they wish to be present, not for themselves, but to ensure the patient is not alone (Powers, 2018; Powers & Reeve, 2020; Tennyson, 2019; Toronto & LaRocco, 2018). Families feel that their presence reassures their loved ones and allows them to say goodbye (Powers, 2018; Powers & Reeve, 2018, 2020; Tennyson, 2019; Toronto & LaRocco, 2018). By seeing and possibly touching the patient, families felt relieved that everything was being done to help their relatives. It also allowed them to know their loved one was shown respect and care in this tragic situation.

Studies have cited families' support of a liaison being present during the resuscitation process (Powers & Reeve, 2018, 2020; Tennyson, 2019; Toronto & LaRocco, 2018; Wyckoff, et

al., 2022). A support person can help give vital information to the family if they are not present. However, if the family is present, the support person can help interpret the actions and words of the staff, which would help the family understand the resuscitation process. By having their own individual support person, the family feels valued. Through interpretation, the family can also recognize how the staff's words and actions were helping their loved one.

Families also have cited that during the event, if they felt they were losing control, a support person helped recognize those emotions and assisted them to either understand, maintain composure, or guide them to a safe area where they could be alone (Gouda & Hoehn, 2020; Powers, 2018; Powers & Reeve, 2018; Powers & Reeve, 2020; Tennyson, 2019; Toronto & LaRocco, 2018; Wyckoff, et al., 2022). The support and understanding in this delicate situation helped reduce the family's guilt and even helped them cope better with losing their loved one. Giving the family an option in this tragic setting, allowing them a support person to guide them, and allowing them to say goodbye empowers the family. When nursing takes the active role in these situations, it demonstrates patient/family-centered care, which is crucial to the spiritual, mental, and physical health of all involved (AACN, 2021a; Gouda & Hoehn, 2020; IPFCC, 2023; Labrague, 2021).

Organizational Support

According to several nursing agencies, FPDR is a beneficial concept that should be adopted within the healthcare setting. In the early 1990s, the ENA (1993) recognized the benefits of FPDR. However, in 2014 the ENA officially supported family presence, not only during invasive procedures but during resuscitation efforts (ENA, 2014). According to the ENA, family presence is a right for the family and patient. The ENA also states that family presence is supported to help bring closure for the family members and benefit the holistic care provided to

the patient, even when the patient cannot advocate for certain procedures. While each facility needs to investigate proper ways to introduce family in such a complex situation, it is recommended for both the family and the patient when feasible.

The AHA (2002) advocates for family presence not only within their policy statements but also incorporates it within their Basic Life Support (BLS) and Advanced Life Support (ALS) classes for laypersons and healthcare professionals. These classes teach individuals to perform CPR or other advanced lifesaving procedures, such as oxygenation, intubation, IV medication administration, and defibrillation on adult and pediatric patients (AHA, 2002; AHA, 2014). The AHA recognizes there are circumstances where family presence is not recommended. These situations are usually in trauma conditions. However, the AHA states that the opportunity should be presented when possible and recommends that a liaison be available for the family (AHA, 2002).

The American College of Critical Care Medicine (ACCM) and the Society of Critical Care Medicine (SCCM) encourage FPDR when situations are appropriate for such a concept (American Academy of Pediatrics, 2006; Davidson et al., 2007). Both organizations recognize that healthcare professionals need exposure to the concept to become more familiar with its benefits. However, the organization states that families are assisted with their grief when allowed to be present, and it also allows the family to feel helpful during the loved one's death. The aim of their support for FPDR is to recognize the benefit of the concept while working to put policies in place within various healthcare facilities.

The AACN (2021a) recognizes the importance of a strong foundation for nursing by practicing evidence-based, patient-centered care. While it does not recognize FPDR specifically, there are components that the organization recommends to ensure nurses function in the complex

dynamic within healthcare. These components include evolving the profession to fit current technological and social structures and system-based care, which allows the nurse to use critical thinking to practice patient care in different venues that once may have been taboo. Other components include leadership abilities, interprofessional building, compassionate care, communication, engagement, and experience, allowing the nurse to participate actively in the healthcare community while advocating for the patient.

Worldviews

FPDR is recognized as a valuable concept in other countries as well. In 2021, an International Liaison Committee on Resuscitation (ILCOR) met to determine an International Consensus on Cardiopulmonary Resuscitation (CPR) and Emergency Cardiovascular Care (ECC, Wyckoff et al., 2022). This group conducted a comprehensive analysis that made formal recommendations of evidence-based practice regarding CPR methods, basic life support educational measures, infectious disease resuscitation methods, and the benefit of FPDR. Within the ILCOR, United States agencies were recognized for their policies on FPDR, but it also recognized European healthcare organizations (Fulbrook et al., 2007a; Fulbrook et al., 2007b; Moons & Norekval, 2008; Wyckoff et al., 2022). These organizations included the Neonatal Intensive Care, the European Federation of Critical Care Nurses Association, the European Society of Cardiology Council on Nursing and Allied Professionals, and the European Society of Paediatric and Neonatal Intensive Care. The ILCOR showed that these European organizations recognize that patient rights include having family members present during resuscitation. The organization’s purpose is to recognize patient-centered care and support formal policies that would bolster the use of this concept within healthcare settings.

With many organizations supporting FPDR, especially with official healthcare facility policies, medical teams should hope for its use when encountering this situation (Goldberger et al., 2015; Hassankhani et al., 2017; MacLean et al., 2003). Policies can include using a patient advocate, chaplain, or designated nurse to facilitate the FPDR process. Ironically, hospitals are leery of FPDR due to the healthcare staff's concerns and lack of leadership and advocacy demonstrating the need for this evidence-based practice. This contrariness reflects the evolution of healthcare that shifts the focus from the individual patient to various situations and other individuals that influence the patient's well-being (Franck & O'Brien, 2019; Imperatrice, 2019; Park et al., 2018).

Educational Efforts

Current measures are in place to educate nursing staff on the benefits of FPDR (Powers, 2018; Tennyson, 2019). Despite this, studies show that this concept still lacks stability in healthcare. It is still a subject of conflict and stress that continued education for healthcare professionals has not alleviated.

For nursing students, a handful of studies provide some information about FPDR. A few studies were noted from various areas, including the United Kingdom, the Middle East, and Turkey (Boztepe et al., 2016; Bray et al., 2016; Kenny et al., 2017; Shibily et al., 2021). Using quantitative methods, these studies examined how students completed tasks during FPDR or viewed the concept from the families' views. There were a few studies in the United States (US), but still, the focus was on higher-level nurses such as Clinical Nurse Specialists (CNS), quantitative methods, or investigated links between self-confidence and FPDR (Kantrowitz-Gordon et al., 2013; Norton et al., 2007). Of the studies available within the U.S. or other countries, the majority were over five years old, which can cause concerns about up-to-date

information. Since the studies available did not focus on the U.S., utilize qualitative measures, or lack information on the student's link to FPDR, a gap exists within the research. Since nurses are the key to quality, safe, and holistic patient care, researchers should investigate nurses' experiences with FPDR to help nursing students before the pupil enters the workforce to enhance fundamental change (Wei et al., 2018). Nurses' experiences regarding FPDR could be evaluated to see if higher education could address gaps or negative influences on this concept (Toronto & LaRocco, 2018).

However, to bridge the gap between profession and student, one must understand that education is critical to enhancing most professions and the person's job performance abilities (AACN, 2021b; Ng & Feldman, 2009). For nursing, the Institute of Medicine (IOM, 2011) states that transformations within the nursing profession and education are needed to keep up with the profession's demands. Educational guidelines, core competencies, and curricula must address these changes to ensure nurses are competent and comfortable within the profession. This will allow future nurses to recognize evidence-based practice and the benefits of holistic patient care.

Emotional Intelligence

This transformational step aims to educate students to develop self-awareness, self-regulation, self-motivation, empathy, and social skills such as communication (Jaeger, 2003; Lam & Kirby, 2002; Raghubir, 2018; Salovey & Mayer, 1990). This is called emotional intelligence, and it is essential to nursing practice.

For nursing, emotional intelligence within the profession facilitates a positive environment for the nurse and patient (Raghubir, 2018; Smith, 2017). Nursing is stressful, and emotionally-intelligent nurses recognize their thoughts and feelings before dealing with a patient

so that it does not impact the holistic care delivered to the patient (Smith, 2017). Emotional intelligence can also help the nurse communicate, especially in controversial times, such as with FPDR. This can help facilitate teamwork and communication with interdisciplinary members, administration, legislative branches, and family members (AACN, 2021a; AACN, 2021b; Raghubir, 2018; Smith, 2017). This skill can be developed in nursing school by mentoring the nursing student and leading by example. This can help the student to recognize that everyone has unique perspectives. By allowing the pupil to focus on other individual perspectives and adapt their response to the situation, the pupil can see how others can benefit from the encounter (AACN, 2021a; Browne et al., 2018; Jackson, 2018; Jaeger, 2003; Lam & Kirby, 2002; Mthiyane & Habedi, 2018; Shahbazi et al., 2018; Sharon & Grinberg, 2018; Smith, 2017).

Therefore, since nursing students lack FPDR, examining the experiences and perspectives of nurses are crucial for FPDR. By examining the nurses' lived experiences, their knowledge can help cultivate emotional intelligence within student nursing education. The student nurse can then learn how their thoughts and feelings influence FPDR. The student can understand that each person has unique perceptions on controversial topics. Using a constructivist-hermeneutic phenomenology approach to this study, nurse educators can also use this information to promote and cultivate emotional intelligence for their students regarding FPDR, and more robust decision-making and critical thinking skills can grow (Raghubir, 2018; Salovey & Mayer, 1990; Shahbazi et al., 2018; Sharon & Grinberg, 2018). This will allow the nurse to understand what actions are essential to provide well-rounded, evidence-based care (Brasel et al., 2016; Doyle et al., 1987; Shahbazi et al., 2018; Sharon & Grinberg, 2018; Toronto & LaRocco, 2018).

Figure 3

Emotional Intelligence

Note. [redacted]

Summary

When looking at nursing contributors such as Nightingale, Fawcett, and Henderson, there is a strong relationship between nursing, an individual's holistic health, perspective, proper communication, and the community (Fawcett, 1984; Nikfarid et al., 2018; Wagner, 2018). These foundational beliefs of patient and family-centered care, leadership, emotional intelligence, and advocacy are the basis for the nursing profession to change and grow through evidence-based

practice (Nikfarid et al., 2018; Shahbazi et al., 2018; Sharon & Grinberg, 2018; Wagner, 2018). If nurses are to follow these fundamental concepts, they must be open to growth and change to feel more confident in their abilities (Twibell et al., 2008; Wagner, 2018). This includes controversial topics. Nurses promote holistic quality care for all, no matter their situation or perceptions. This is part of emotional intelligence and is a skill that is often learned through time and experience (Raghubir, 2018; Salovey & Mayer, 1990).

Since change is slow in developing the evidence-based practice of FPDR in healthcare settings despite the support from national organizations, such as the AHA, ENA, and other world agencies, it is imperative to study nurses' experiences regarding this concept (Ng & Feldman, 2009; Powers, 2018; Tennyson, 2019). Using the information from this study, educators can develop methods to teach about FPDR that can benefit the student and help the educated student learn how to handle such delicate situations (AACN, 2021b; IOM, 2011; Ng & Feldman, 2009). This is true for the family, nursing discipline, interdisciplinary team members, hospital administrators, and policymakers. Nursing students educated about FPDR can be instrumental in making a substantial difference in the future of nursing (Powers, 2018). These future nurses can go out into the community in various demographics and settings and demonstrate to healthcare facilities how an established, well-thought-out policy can provide supportive, family-centered care even during tragic events (Toronto & LaRocco, 2018).

CHAPTER THREE: METHODS

Overview

Methods for a study include the theoretical framework, research design, data collection, participants, and setting (Creswell & Creswell, 2018). Hermeneutic phenomenology with a constructivist lens was used to interview nurses about their experiences with FPDR. Selection processes involved nurses in the intensive care units (ICUs) and ER of a level one trauma facility. This selection helped enhance data collection by using open-ended questions to learn the intricate nuances of nurses' views on FPDR. This exploration enhanced the data collection process and helped fill the gap between practice and research for this evidence-based concept. Instruments, research roles, biases, and ethical considerations will also be discussed regarding nurses' experiences within this FPDR investigation.

Design

Hermeneutic phenomenology, a qualitative method, and constructivism, a learning model, are humanist approaches to research (Pilarska, 2021). Both recognize a person's cultural, social, and psychological values and beliefs. A constructivist approach states that there is no one truth. The educator and student are both involved in the process. Each person's experiences, knowledge, and perceptions are a sum of the parts of the individual, and these experiences influence a person's understanding and knowledge of the world. The individual, therefore, constructs new knowledge. Multiple realities within constructivism allow a researcher to utilize hermeneutic phenomenology. This allows for investigating experiences, thoughts, perceptions, and realities that influence FPDR and how it could impact the future of nursing (Creswell & Creswell, 2018; Pilarska, 2021).

Using observations and understanding a person as a complex individual with different lived experiences and perceptions builds and evolves, allowing for this qualitative study. This constructivism-hermeneutic phenomenology study is vital as it enabled the researcher to address the "how" and "why" of concepts, how they occur, and how they can impact higher education (Cleland, 2017, p. 69). This gives a more in-depth understanding of humans since individuals are a complexity of experiences, social contexts, family dynamics, and feelings (Cleland, 2017; Creswell & Creswell, 2018). This allowed for a phenomenology research approach to associate the nurses' perceptions with their lived experiences (Creswell & Creswell, 2018). Since each person sees the world from a different view, this allows for the same scenario to be seen from various viewpoints, increases the study's transferability, and allows higher education to help prepare future nurses for these complex scenarios.

Research Question

The essential question for this FPDR study was: What are the lived experiences of nurses with FPDR? Follow-up questions included: What stands out about FPDR? Can you tell me more about your lived experiences with FPDR? Using these foundational questions, this investigator noted that several other questions during the investigation were answered to enhance this concept for nursing and nursing students.

Setting

The setting of this study was the southeast part of the United States. A level-one trauma facility was used to interview nurses regarding their lived experiences of FPDR. This hospital covers 29 counties in two bordering states (Zippia, 2022). The population within the state that houses the setting is about 2,400,000, and in the bordering state, the population is approximately 208,000 (US Census Bureau, 2021). The ethnic breakdown of the hospital employees is 70%

white, 12% African American, and 7% Hispanic or Latino (Zippia, 2022). Demographics of the population served are similar to the hospital employee ethnic breakdown, with a noted two percent as Asian descent (City Population, 2021).

There are over 5,000 employed in this hospital setting, and 32% of these employees are nurses (Zippia, 2022). Most nurses are at the bachelor's degree level, while the rest are at the associate's or master's degree level. The average employee age is 20-30 at 33% percent, while the second highest is 40 or more years at 32%. Eighty percent of the nurses are female. The average employment length is one to two years at 26%, less than one year at 20%, and over 11 years at 18%.

While there are other hospitals in the area, a level one trauma facility was chosen as it offers the top level of patient care. While a Level I is named as such due to the ability to provide 24-hour availability of trauma physicians, surgeons, and radiological access, these facilities often offer other specialty care. This can include brain surgery, open heart surgery, pediatric disease management, oncology, organ donation and transplantation, and neurologic procedures. This hospital provides patient care to all ages and rural and urban populations. By choosing this setting, this researcher had an opportunity to have various types of nurses from various backgrounds and settings that have experienced FPDR.

FPDR Guidelines in Hospital Policy

Despite the high level of care offered at this hospital and designation as a Level I trauma facility, it does not offer an official policy regarding FPDR. While this hospital strives to follow recommended guidelines from the AHA, AACN, and other evidence-based organizations, it offers no guidance or information on when or if FPDR should be incorporated within a resuscitation effort for an adult or child.

Participants

This study utilized registered nurses at the BSN level from a local, Level I trauma facility who have witnessed FPDR. These nurses are from the ICUs and the ER within this hospital. Online training modules offer education, but none are specific to FPDR. This hospital works with several colleges and universities in the state to give student nurses exposure during their clinical rotations that could lead to witnessing resuscitation efforts, which meets the recommendations of the AACN BSN educational guidelines (AACN, 2021a; AACN, 2021b). These rotations include adult and pediatric populations within critical care, emergency room, cardiac surgery, hospice and palliative, pediatrics, mother/baby, and trauma care units.

The nursing population is local to the researcher and includes nurses that have experience with FPDR. This allowed for a purposeful, convenient sample to be used. This investigator works for a university that uses this hospital for training and research projects. However, this researcher is not part of the hospital and does not have access to any punitive measures that would govern the nurses used in the study.

Confidentiality of the nursing participants was maintained by using a pseudonym for each person (Haddad & Geiger, 2018; Ingham-Broomfield, 2017). Each pseudonym was a randomly-generated name that followed the participant throughout the study.

Table 1

Participant Demographics

Pseudonym	Gender	Ethnicity	Marital Status	Yrs Experience	Work Area	# without FPDR	# with FPDR
John	Male	White/Non-Hispanic	Married	10+	ER- Adult and Ped	6+	6+
Kim	Female	White/Non-Hispanic	Married	10+	ER – Adult and Ped	6+	6+
Rob	Male	White/Non-Hispanic	Single	2-4	ER-Adult	6+	6+
Josh	Male	White/Non-Hispanic	Divorced	10+	ER-Adult and Ped	6+	3-5
Laura	Female	White/Non-Hispanic	Single	5-9	ER-Peds	3-5	2
Emily	Female	White/Non-Hispanic	Married	5-9	ICU-All-Float	2	6+
Mike	Male	White/Non-Hispanic	Divorced	2-4	ICU-Cardiac	2	6+
Jill	Female	White/Non-Hispanic	Married	0-1	ER-Peds	1	1
Dan	Male	White/Non-Hispanic	Single	2-4	ICU-Cardiac	1	2
Walter	Male	White/Non-Hispanic	Single	0-1	ICU-Cardiac	1	2

According to Creswell and Poth (2018), no specific number of participants is needed for a qualitative study. However, data saturation is needed for a reliable and valid study (Creswell & Creswell, 2018; Creswell & Poth, 2018; Guest et al., 2020). For this study, at least 10 participants were expected to be needed. However, meta-themes were noted after the first six interviews. To ensure reliability and validity, four more individuals were interviewed for the study through this volunteer process for nurses who have had experience with FPDR.

Procedures

This study examined nurses' meaning regarding FPDR. The process used for this study followed a hermeneutic phenomenology method for recruitment, interviewing, collecting, analyzing, and storing the research findings.

Participant Recruitment

Before the study began, this researcher contacted and sought approval from the Institutional Review Board (IRB) for the university and the hospital where the study occurred (see Appendices A and B). Assuring that the study obtains IRB approval confirms that participants in the study are protected (Creswell & Poth, 2018). This ensures that the participant's rights and welfare are prioritized during the investigative process. Once the two institutions gave IRB approval, the research began by selecting the participants for the study.

To elicit volunteers, participants were contacted via email by the nurse managers of the ICU and ER units. Flyers were also posted within the ICU and ER break rooms, and the nurse managers made announcements at the unit's regularly-scheduled monthly meeting. To be considered for the study, the participant had to be a registered nurse (RN) at the bachelor's level. The RN must have worked in the ER or ICU and been present or participated in a resuscitation when the family was present. These participants came from this southeast United States, Level I trauma facility with a 43-bed ICU, an adult ER, and a separate pediatric ER (Zippia, 2021). The ICU areas included cardiothoracic, neurological, medical/surgical, and trauma specialty care. Approximately 400 nurses work in the ICU areas, and about 350 nurses work in either the adult or pediatric ER.

Notifications were sent out, announced, and posted at the beginning of the month the study began. Little response was received, so another announcement was made one week later.

Nurses who had been present or participated in resuscitation when a family was present were scheduled for an interview. These meetings continued until data saturation was achieved.

Within the initial email, volunteers were asked to contact the researcher via text or email (see Appendix C). A flyer was also posted in the nurses' break room to elicit volunteers (see Appendix D). The email and flyer stated that nurses were needed to participate in a study about FPDR. It clarified that this was a voluntary process and that participants would be given a $25 Amazon gift card to compensate for their time. The notices informed the participants of the audio recording during the interview. The email and flyer stated that the scheduled dates and times would be lenient due to the complexity of the nurses' schedules. This allowed the study to fit around their time constraints.

Data Collection Location

The interviews were conducted at this one hospital site. This allowed for flexibility; the nurses could schedule the interview before, after work, or during a break. The IRB Committee Director was contacted to use one of their offices with an interview room within a larger office to ensure adequate space was available. It was planned to use the Educational Department, but due to scheduling issues, the IRB was kind enough to help with the study's needs. The interview room was used for interviews, analysis, and storage of equipment and personal items. The room was in a secure, quiet area where face-to-face interviews occurred. After each interview, transcribed data were reviewed twice, with field notes written down while the thoughts were fresh in the researcher's mind.

The interview area was reserved on an as-needed basis for four weeks. Each day the space was needed, the area was reserved for approximately two hours. This time allowed for set up, orientation to the room, instructional time, interviews, field notes, breaks, and clean

up. Before utilizing the areas, the researcher reviewed all pre-study activities to ensure all goals were accomplished (see Appendix E).

Gathering Data

A reminder was emailed to the participant three to five days before the interview. At the interview, each participant completed the informed consent form (see Appendix F). The participant also completed a demographic questionnaire (see Appendix G). This information asked for age, sex, work area, how many resuscitations the participant has witnessed with and without the family being present, and years of experience.

For this study, the signed informed consent papers are stored in a locked file cabinet away from the other data (Creswell & Poth, 2018). Other information, including demographics, interview comments, emails, texts, and phone numbers, are also secured in the password-protected computer. All information was assigned a randomly-generated name to protect the participant's identity. This procedure followed the ethical principles set forth by the Declaration of Helsinki (Elsevier, 2021). This declaration ensures that each participant is protected and that the study will not jeopardize their rights and interests.

Recording Procedures

Each interview was conducted within the designated conference room using Zoom and Temi. Zoom is a conferencing platform where users can use computers, smartphones or tablets, or mobile apps to communicate with others online (Zoom, 2019). While Zoom's platform allows users to employ secure audio or video recording, this research only used the audio to avoid identifiable data. The audio recording was securely stored via Zoom Cloud and transcribed during the conversation. After saving this audio to the Zoom Cloud, it was later downloaded to a password-protected computer. Each file was given a randomly-generated name that correlated

with the participant's pseudonym demographic questionnaire name that was assigned before the interview process.

Temi is an application on any smartphone that allows the user to get automated transcription services to convert the interview into audio text within a few minutes (Temi, 2023). This researcher found the app very helpful as it gave instantaneous conversation views. This allowed for clarification about any muddy or unclear items to the researcher.

Zoom and Temi's programs allowed the researcher to collect verbal communication. The video portion was turned off. Field notes were added after the interview on things that stood out to the interviewer. By using field notes, distractions were kept to a minimum.

The Researcher's Role

This researcher led the investigation for the FPDR study. Since I have been present when families were present during resuscitation, my interest guided me toward investigating this concept. From this lived experience, I sought a hermeneutic phenomenology study to comprehend the understanding of others in the same situation.

I determined the methods used to collect the data through open-ended questions. I notified the other expert committee members of any pertinent information. I also conducted the interviews, transcribed, set up equipment, sought IRB approval, and compiled the completed data. I also ensured that any identifiable information, besides signature sheets for the informed consent, had been assigned computer-generated, random names. Also, while I had a central role in this study, consulting experts' opinions were sought to help guide the process. Expert guidance reviewed coding and themes, IRB applications, and ways to improve the research process.

Dasein and Role of Hermeneutic Circle

FPDR is a topic of interest for this researcher. The study came from years of resuscitation efforts in prehospital and hospital situations. This includes when families were present and when the family was not allowed. The ER is the area that had the most impact on this investigator. I have seen some painful experiences, and the most heart-wrenching was when a child died without their parents or loved one being present. While most of these patients were deceased upon arrival, there were situations where the child or loved one passed while in the staff's presence. I witnessed verbal altercations when the doctor and nurse disagreed on bringing in the family. In those situations, the nurse would advocate for their presence, but the physician did not feel it was appropriate. There have also been situations I witnessed when the nurses and doctors in the resuscitation did not feel it was right to bring in the family and worried the family would get in the way, despite my advocacy for the family. Through all these experiences, using a hermeneutic phenomenology method for this study was imperative.

Reflexivity and Co-Constitution

A deeper essence to FPDR is allowed when the researcher's own perceptions are utilized. My experiences are my own and must not influence others' perceptions or emotions. Reflexivity within hermeneutic phenomenology allows constant prompting of the researcher's intentions during the study (Dibley et al., 2020). This process was done throughout the research process. To avoid preconceived notions about this concept, the researcher asked: Why am I interested in this concept? What am I learning from the participants? Am I allowing my prior experiences to influence the participant's thoughts and feelings? Is there anything I am doing that will hinder the research? What can I do to prevent any hindrances my actions may bring? The chair

committee expert viewed these questions to clarify the investigator's predetermined views on this topic, which in turn gave the study more validity (Creswell & Poth, 2018).

Recognizing my Being and knowing that my experiences are my own allows for Dasein. It also allows for various interpretations through the hermeneutic circle. The hermeneutic circle gave the conclusions of this study a more profound significance by looking through different lenses used within this qualitative study (Heidegger, 1962; Pilarska, 2021). It also ensured co-constitution, a guide created by Heidegger to understand that each person's experiences and the world influence one another continually (Dibley et al., 2020).

Reflexivity was used outside the interviews to recognize this investigator's preconceived views (Dibley et al., 2020). Journaling was a means of reflexivity; by journaling before each session and discussing the journaled notes with the chair committee member, the researcher had assistance in seeing biases. By recognizing the investigator's perceptions and lived experiences of the concept, data collection, analysis, and interpretation could be made rigorously (Creswell & Poth, 2018; Nicholls, 2019).

This study helped this investigator fill the gap between the evidence-based benefits of FPDR versus why the concept is underutilized within the hospital setting. It will also help nurse educators to advance this evidence-based practice by seeing the perceptions and experiences of nurses with FPDR, and this will help enhance the curriculum for nursing students. Quantitative research gives numerical information but does not dive into a participant's feelings, values, and experiences regarding this concept. A hermeneutic phenomenology study using a constructivist lens helps to understand the perceptions of others. This can also help nurse educators. Since nurse educators play a significant role in developing future nurses, giving instructors the tools to

help evolve student nurses into more confident, emotionally-intelligent, novice nurses is essential.

Data Collection

Demographics and Questions Used

Each participant received a demographic questionnaire before the interview to help determine the population characteristics used in the study. For the interview process, each person was asked an open-ended question that addressed FPDR and the nurses' experiences with this concept (see Appendix H). The researcher asked questions such as, "Can you tell me more…." Or "what stands out about that experience…" when a topic was unclear or needed more probing regarding FPDR (Creswell & Poth, 2018; Moser & Korstjens, 2018). Other ways to encourage dialogue included the investigator asking the participant items such as, "You mentioned…, tell me what that was like for you" or "You mentioned…, describe that in more detail for me, please?"

According to Heidegger (1962), allowing open-ended conversations will help describe the meaning of the central themes of the situation being investigated. Open-ended questions can help minimize bias and allow for free expression from the participant. The researcher also self-evaluated before each interview through journaling (Creswell & Poth, 2018). This helped to recognize any preconceived thoughts or feelings that may be present that could hamper the study's results.

Preliminary Data Development

After each interview, the transcripts were explored and reviewed twice (Creswell & Poth, 2018; Moser & Korstjens, 2018). The transcriptions were surveyed using Moustakas' (1994)

method for phenomenology analysis and representation. This eight-step process moves from transcription statements, horizontalization, codes, themes, and sub-themes.

From each transcribed interview, a review was completed the following weekend by looking for common words or phrases. This was a continual process as each interview added more information (Creswell & Poth, 2018; Moser & Korstjens, 2018; Moustakas, 1994). This moving back-and-forth method after each interview and on the weekend helped determine what themes were emerging. Zoom and Temi were used for audio recording and transcribing the information. Memoing and the primary researcher's handwritten field notes from the interview were also reviewed (Moser & Korstjens, 2018). With the expert committee members' assistance, the investigator could identify codes within the transcripts. The themes were noted from the codes, which showed the researcher the common messages from the nurses about their perceptions and experiences with FPDR.

To keep preliminary and final notes easily interpreted, a computer program called Dedoose was used. This program helped organize information in a neat and organized fashion. It was also used to code and develop themes from the study (Dedoose, 2022; Salmona et al., 2019). Only this researcher inputted the data into the computer program. However, the chair and associate committee experts had access to the transcripts and could have reviewed the information from each participant to ensure common themes were noted (Creswell & Poth, 2018; Guest et al., 2020).

Interviews/Observations

This qualitative study used a hermeneutic phenomenology method with a constructivist lens. This allowed for data collection from nursing participants' lived experiences with FPDR (Creswell & Creswell, 2018). The open-ended questions allowed the nurse participants to lead

the interview. The questions also allowed the investigator to use the questions as a primary source for data collection and significant dialogue to open a new understanding of the concept (Creswell & Poth, 2018; Fuster, 2019; Lauterbach, 2018).

Interview Guide

` 1. What are your experiences regarding FPDR?
2. What stands out about your experiences with FPDR?
3. Tell me more about your experiences regarding FPDR.
4. Think of a time when you experienced FPDR and describe what you saw, felt, and heard in as much detail as possible.
5. You mentioned _____, tell me what that was like for you.
6. You mentioned _____, describe that in more detail for me, please.
7. Do you want to share anything about FPDR during your nursing career?

The interview guide shows that questions one, two, and four allow the nurses to express their understanding of the experiences to the researcher while allowing the investigator to be a part of the hermeneutic circle (see Appendix I, Peoples, 2020; Pilarska, 2021). It allowed the participant and the researcher to reflect on their understanding of the concept since meaning is a human action, intention, or experience to help preserve and understand the foundational belief of holistic nursing care (Powers, 2018; Powers & Reeve, 2018). The third question helped to clarify information already presented about the nurses' lived experiences, beliefs, perceptions, and intentions about FPDR (Creswell & Poth, 2018; Fuster, 2019; Lauterbach, 2018). The fifth and sixth questions asked for further reflection on their experiences, while the seventh allowed the participant to sum up any further thoughts on the concept.

Field Notes/Observations

Since Zoom and Temi allow recording to transcribe the conversations, these two applications were used for each interview (Temi, 2023; Zoom, 2019). After each interview, the Temi-transcribed interview was reviewed to ensure the information was accurate to the participant. Each transcription had all personal identifiers removed. The transcribed information was uploaded to Dedoose (Dedoose, 2022; Salmona et al., 2019). Field notes were taken after the interview to minimize distractions (Creswell & Poth, 2018; Dibley et al., 2020). Field notes included any significant non-verbal cues the investigator felt added richness to the conversation. All field notes cited how these expressions could change the meaning of the interview data to avoid any possible biases (Dibley et al., 2020). The researcher and the chair consulting expert reviewed the transcription and field notes. This process of review of the transcript, as well as examination for codes and then the development of themes, helps to ensure the lived experiences of the nurses are correctly interpreted (Bans-Akutey & Tiimub, 2021; Creswell & Poth, 2018; Fuster, 2019; Moser & Korstjens, 2018).

Follow Up Interviews

While open-ended questions are a great way to examine thoughts and feelings, follow-up information is sometimes needed to clarify misunderstood points (Creswell & Creswell, 2018; Creswell & Poth, 2018). Participants were told that follow-up may be needed. A follow-up interview follows a hermeneutic phenomenology research pattern by allowing for clarification of any misunderstood information (Creswell & Poth, 2018; Heidegger, 1962; Lauterbach, 2018). However, due to the use of Temi and its instant transcription, clarification took place immediately after the interview. This made follow-up interviews unnecessary.

Data Analysis

A constructivist lens within a hermeneutic phenomenology study allowed the researcher to discern meaning from the nursing participants and the investigator (Creswell & Poth, 2018; Fuster, 2019; Lauterbach, 2018). This allowed for appreciation that the investigator brought their own experiences to the study but also allowed for open thoughts and feelings of the other participants to shape not only the study but also the researcher.

This investigator conducted the study but used three advisory members for expert guidance. One of the specialist members was the chair, a PhD expert consultant for qualitative, phenomenology research. One was an expert in qualitative, phenomenology research with a PhD and functioned as a consultant. The third member had a PhD and assisted with coding and theme analysis, ensuring readers could understand the information accurately.

Open-ended questions and field notes were transcribed. This information developed into codes and themes. The investigator utilized the transcribed interviews via Zoom and Temi and read the document twice after each interview to ensure accurate coding (Creswell & Creswell, 2018; Creswell & Poth, 2018; Guest et al., 2020). Each transcript generated from an interview was reviewed the weekend following the interviews. During the review, the researcher examined statements, horizontalization, and codes (Moustakas, 1994). Themes and sub-themes developed from this method. This review was a continual process after new participant information. After every five respondents, the data was reviewed for saturation of the findings, and again after each interview thereafter (Creswell & Poth, 2018). Once data saturation was noted after six interviews, four more interviews were done to ensure accuracy. Then, the interview process ceased.

The researcher worked with the consultant members, who read over the transcripts, statements, horizontalizations, codes, and any developing themes and sub-themes (Moustakas, 1994). Several meetings were held between the investigator and the chair members to discuss the findings and determine the preliminary themes. Once the fundamental themes were noted, the rest of the consultation team helped advance the study. The associate qualitative expert read over the transcripts and reviewed the codes and themes. Meetings continued between the researcher, the chair, and the other qualitative expert. The researcher wrote up this information, and it was sent to all committee experts to review and give their approval.

Data Analysis Software and Security

Dedoose computer software was used to help organize themes and coding of themes (Dedoose, 2022; Salmona et al., 2019). Many researchers at the PhD level use this program. It is touted as user-friendly, allowing a qualitative investigator to manage and organize codes in a broad-to-simple formation. The investigator did not incur any fee due to an introductory offer. This program helped ensure coding was conducted correctly and themes were consistent with the participant's interviews.

The Dedoose program was used after each transcript had all identifying information removed. This program lets the user add field notes after each interview to allow for rich and robust data. Demographics were kept on an Excel spreadsheet but stored in the same computer as the study information from the Dedoose program. Each identifiable piece of information had a randomly-generated name for participant privacy. Items that could not have identifiable information removed, such as informed consent signature forms, were stored in a locked file cabinet.

Trustworthiness

Credibility

Credible and dependable study results show the trustworthiness of a study (Creswell & Poth, 2018). Since numerical information is not used for a qualitative study, interpretations can be challenging to show accuracy. For a hermeneutic phenomenology study, Dasein was identified so that the researcher could interpret the accuracy of findings through reflexivity throughout the data analysis (Heidegger, 1962; Nicholls, 2019). Also, reflexivity was used outside the interview to recognize this investigator's preconceived views. Journaling was a means of reflexivity for the researcher; by journaling before each session and discussing the journaled notes with the chair committee member, the researcher's perceptions and biases could be avoided so that they did not negatively impact the study (Creswell & Poth, 2018; Nicholls, 2019).

Dependability and Confirmability

This researcher conducted interviews and examined the transcripts to code the information. The chair of the consulting team, the qualitative expert, and this researcher reviewed the transcripts and codes to develop themes from the participant's information. With this added input from the consulting team, results are more dependable and verifiable (Creswell & Poth, 2018; Nicholls, 2019). This ensures there is a consensus on the understanding of the data.

Transferability

As part of the hermeneutic phenomenology study, rich interpretations are needed when describing the interview, field notes, and observations of the participant's experiences (Creswell & Poth, 2018; Nicholls, 2019). The researcher needed to repeat the data interpretation process in

this phenomenology study. This continual evaluation of the data and examining the transcriptions was put into the Dedoose computer software program (Dedoose, 2022; Salmona et al., 2019). This process was done the weekend after the interviews were completed. This ensured that the interviews were coded correctly and completed while the information was fresh. This fresh perspective allowed for a comprehensive understanding of the participant's meanings regarding the concept (Fontanella, 2021). This process was then repeated with the chair consulting member to catch any discrepancies or add additional insights into the data (Creswell & Poth, 2018). Follow-up interviews were not done as Temi allowed instant visualization of the transcript. This helped clarify any misunderstood or unclear information, which added to the transferability of the study.

Ethical Considerations

Consent

According to Creswell and Creswell (2018) and Ingham-Broomfield (2017), ethical conduct is essential within nursing and nursing research. Participants need to know that involvement in the study can be stopped for any reason. Coercion is unethical and does not promote a trustworthy relationship. Informed consent, full disclosure, information about the study, confidentiality, anonymity, and avoidance of any conflicts of interest are required when dealing with human subjects (Haddad & Geiger, 2018; Ingham-Broomfield, 2017). Full disclosure must be given to each participant. Ethical consent is often required from each facility, ethical committees from the universities, and the IRB. Facility approval, IRB approval, and informed consent from each participant before the interviews ensures that the study is truthful and accurate.

Data Security

Data security and the accuracy of participants' information were other ethical considerations within this study. Each participant knew that confidentiality was of high importance through data in the consent form. However, all information except the informed consent was stored on a password-protected computer to avoid data breaches.

Two files on the computer contain the Excel demographics on one file, and the other is the transcriptions from Zoom and Temi. The Dedoose program is a software program on this same laptop computer with its login to get into the system (Dedoose, 2022). The computer itself has a separate password. The informed consent documents were locked in a file cabinet away from the computer system. However, the computer was locked in a cabinet when not in use. After completing the study, the information will be downloaded onto a password-protected USB drive. This USB drive will be locked in a file cabinet, along with the informed consent documents, that only the researcher can access. After five years, all information will be destroyed (Creswell & Poth, 2018).

Summary

To prevent bias during this research project, this investigator used multiple methods to ensure credible, transferable, trustworthy, accurate, reliable, and valid results (Creswell & Creswell, 2018; Creswell & Poth, 2018). Since a hermeneutic phenomenology method was used, the investigator acknowledged her own lived experiences regarding the topic (Neubauer et al., 2019). I realized that my thoughts could not be deleted, but making others and myself aware of those feelings helped demonstrate any influence on the study.

To prevent other biases, information was reviewed several times to ensure the accuracy of the codes and theme development (Creswell & Creswell, 2018; Creswell & Poth, 2018; Guest et

al., 2020; Moser & Korstjens, 2018; Moustakas, 1994). This allowed for consistency and agreement between the researcher and committee experts' review of the researcher's work. Open-ended questions were used, and the same script was used for each participant's conference (Creswell & Poth, 2018; Moser & Korstjens, 2018). This ensured continuity. The transcripts were reviewed at the end of each interview to help prepare for proper analysis. Other methods to ensure accuracy and unbiased methods included checking alternative explanations of various data sources, such as field notes, transcription reviews, and multiple coding reviews (Moser & Korstjens, 2018). Lastly, ethical considerations were considered to maintain the trust of the study while following IRB guidelines to protect the participants. By conducting all these steps within a research study, the investigator can be confident that the investigation was conducted ethically and trustworthy (Creswell & Poth, 2018).

CHAPTER FOUR: FINDINGS

Overview

Family presence during resuscitation (FPDR) is a concept that assists families with losing a relative (Hassankhani et al., 2017; Joyner, 2018; Lederman, 2019; MacLean et al., 2003; Tennyson, 2019; Twibell et al., 2018). Since nurses advocate for their patients' holistic care, they are in an esteemed setting to make changes within the healthcare system (Gerber, 2018; Hassankhani et al., 2017; MacLean et al., 2003). This constructivist, hermeneutic phenomenology study helped to understand the quintessence of nurses' experiences with FPDR. By examining nursing experiences with FPDR, learnedness can begin when nurses are still students, building poised, educated, and benevolent nurses who can blossom regarding this contentious concept (Blevins, 2018; Powers, 2018). This will assist in narrowing the research-clinical gap within nursing care (Powers, 2018; Toronto & LaRocco, 2018; Wei et al., 2018).

The results of this investigation showed the participants' demographics and thematic outcomes related to the nurses' experiences with FPDR. The data will also be discussed regarding each theme and subtheme related to the concept. Findings related to the research question are presented, and the points will then be summarized to wrap up the chapter's findings.

Participants

This study used registered nurses at the BSN level from a local, Level I trauma facility with previous experience witnessing FPDR. These nurses were from the ICUs and ERs within this hospital. Online training modules offer education for these nurses, but none are specific to FPDR. There is no official policy regarding FPDR at this hospital.

A purposeful, convenient sample was used since the hospital is local to this investigator. Ten participants met the criteria needed for the study. Data saturation was noted after six

subjects. However, four more were interviewed to ensure the study was reliable and had valid findings (Creswell & Creswell, 2018; Creswell & Poth, 2018; Guest et al., 2020).

Each participant completed a one-on-one interview with the researcher about their experiences with FPDR. Six participants were male, and four were female. All were White/non-Hispanic. Three participants were 20-25 years, two were 26-29 years, one was 30-34 years, two were 40-44 years, and two were 50 or more years. Four subjects were single, four were married, and two were divorced. To ensure anonymity, demographic sheets did not include any real names.

A vast array of experiences and areas of work were noted. Two participants had less than one year of experience, three had two to four years of experience, two had five to nine years, and three had 10 or more years in nursing. One subject worked in the adult ER, two in the pediatric ER, and three in the adult and pediatric ERs. Three participants worked in the Cardiac ICU area. One floated in various ICU settings, including surgical, cardiac, pediatric, and neuro. For resuscitation efforts where a family was present, three participants saw only one each, two saw two, and one saw three to five events. Four subjects accounted for six or more times being part of resuscitation with family present.

Results

Ten participants were used, and each completed informed consent and demographics (see Appendices F and G). Each then sat for an interview using open-ended questions (see Appendix H). Utilizing a constructivist hermeneutic phenomenology process allowed the investigator to determine the meaning behind central themes concerning FPDR. The information was analyzed using Moustakas' (1994) method for phenomenology analysis and representation. The findings were excogitated from the accumulated data from the one-on-one interview. This researcher used

reflexivity before each interview and journaled to avoid bias and allow for free expression from the participant (Creswell & Poth, 2018).

The interviews were audio recorded and then transcribed. The transcriptions were examined, and initial horizontalizations began concerning repeated comments or statements. Several reviews of the transcripts were completed to accurately examine for codes and develop themes regarding the lived experiences of nurses (Bans-Akutey & Tiimub, 2021; Creswell & Poth, 2018; Fuster, 2019; Moser & Korstjens, 2018; Moustakas, 1994). Field notes cited how the participant's nonverbal cues could change the meaning of the interview data (Dibley et al., 2020). The researcher then used a qualitative computer program to organize the information and develop horizontalizations, codes, and emerging themes from the study.

When analyzing the transcripts, significant statements were noted. From this, 29 horizontalizations were ascertained (see Appendix J). From the horizontalizations, 19 codes were recognized (see Table 2). These included: asking the family and staff for permission to be present during the resuscitation event, explaining the situation and avoiding confusion, having a support person present for the family, and using the correct words when discussing with the family. Staff concerns included interruption of tasks, seeing the patient as human, family hindering care, and family disrupting the process. Other codes included providing holistic care, evidence supporting the concept, grief and closure, and situational appropriateness that includes medical versus trauma, pediatric versus adult, and traumatizing for the family. Similarities were noted between codes. They were later linked and sorted together as several had similar meanings, and ones that did not address FPDR were omitted. Themes and sub-themes began to emerge and were notated. These themes included permission, support and communication, compromised care, patient/family-centered care, bereavement, and situational dependent (see Table 2). Sub-

themes that emerged were permission from the family, permission from staff, liaison, clear terms and wording, staff concerns, emotional awareness, humanizing, hindering patient care, evidence-based, grief, closure, trauma versus medical resuscitation, pediatric versus adult resuscitation, and family stability.

Table 2

Codes, Themes, and Sub-themes

Codes from Horizontalization	Frequency	Theme derived from codes	Sub-themes
Asking family/staff before event	10	Permission	Permission from family Permission from staff
Explain/Avoiding	16	Support/Communication	
Support person/Chaplin	19		Liaison
Support and Communication	1		Clear terms and wording
Staff concerns	15	Compromised Care	Staff concern
Focusing on tasks	1		Emotional awareness*
Humanizing	2		Humanizing*
Hindering care/tasks	2		Hindering patient care
Family disruptions/outburst	3		
Practicing nursing holistic care	1	Patient/Family-Centered	
Studies supporting FPDR	1	Care	Evidence-based
Grief and Closure	14	Bereavement	
Trying to help – closure	5		Grief
Waiting on family to give closure	2		Closure
Situation/case-by-case	1	Situational dependence	
Trauma vs. Medical	1		Trauma vs. Medical
Peds vs. Adult	2		Peds vs. Adult
Trauma to family	5		Stability of family

Note. *Seen as a negative comment by the staff concerning the family's presence.

Permission

Permission refers to asking the staff, family, or both for permission before bringing the family into the resuscitation room. Permission is a form of respect (Clark, 2020) and a way of engaging others and showing that their thoughts, feelings, and safety are essential. For this study, permission was established as it was needed to ensure everyone involved with the process, whether staff or family, was ready and felt it was appropriate. Participants for this study expressed frustration not only not asking them for permission but ensuring the family was willing to see what they may encounter. All 10 participants felt it was imperative to get permission from those involved for this concept to perform successfully.

Permission from Family

It is essential to ask the family if they wish to be present when their loved one is being resuscitated. In some situations, the family may wish to be present and fear that their loved one is alone or not being represented appropriately by the healthcare team. Other family members may not wish to remember their loved ones that way. Nine of the 10 participants felt that getting the family's input on their presence was essential if the goal was to help the family emotionally. As Jill put it, “It can be pure shock and unexpected. I think some people are more sensitive to that, especially if they've never been exposed.” However, Laura stated that the family “may wanna be there cause it could be, could, be the last…their last dying breath, and they wouldn't want to miss it.” Kim summed it up by stating, “Sometimes the family doesn't want to be there. They should be given that choice.” She reiterated, “You do not know if you do not ask.” Mike states, “It can be involved. It can be traumatic for the families, uh, family members…you need to make sure they want to be there.”

Permission from Staff

Of the 10 participants that stated that permission was crucial for helping the family, one stated that personnel must not forget to ask the staff. There may be circumstances that are not well known, such as domestic family issues, trauma issues within the family, or other matters surrounding the crisis. By communicating and asking staff permission, personnel can help them feel more comfortable carrying out their duties of caring for the patient. Josh had an experience where the staff was not even told the family was on their way into the resuscitation room.

> A three-year-old had drowned. EMS had worked the code for 30-45 minutes even before they got to us. The family was brought back, and somehow, they beat the patient, but they just brought them back, and there they were at the foot of the bed.

Josh expressed frustration not only with the family standing there even before they got the patient but also that they did not work the code long due to EMS efforts, and the family was confused.

Support and Communication

Support and communication positively impact the patient/family-provider dynamic and allow those involved to have a complete sense of the care received (Labrague, 2021). It can form and enhance a trusting relationship during difficult times, reducing stress and anxiety. In this study, support and communication include explaining procedures, clarifying what is seen and heard to avoid confusion, assisting and comfort during the traumatic event, and avoiding euphemisms. Each individual spoke on the importance of support and communication, and several cited these words numerous times. John said, “When done correctly, I believe it's a good benefit to the families.” Clarification of this statement showed that John understood that with

clear communication and proper support from a trained person, the family showed “better grieving” with the resuscitation process and had better outcomes.

Kim stated:

> Almost everyone knows what code blue means, you know, just from television and movies. And, so, they know that it’s, they know what’s going on and it’s a very high likelihood that they, their family member, could die. It is confusing; they just need to have some clarity, some information.

Liaison

A liaison is a properly-trained individual that creates and maintains communication for a reciprocal partnership and understanding in a particular circumstance (Aued et al., 2019). Within healthcare, the liaison has been shown to improve satisfaction scores and care, clarify misunderstandings, improve trust and understanding, and increase education on the situation (Aued et al., 2019; Lopez-Soto et al., 2021). The importance of a liaison is demonstrated in Walter's comment about a father whose son was being resuscitated. He stated:

> I guess it was at night. There was a lapse when a chaplain, they weren't up there at the time. So, I did go up there and sat with the dad. I did kind of like tell him everything that they were doing, like explain things to him. Um, I did pray with him just cuz the chaplain wasn't up there, and I felt comfortable doing that. That helped him so much. I got to see the dad and the doctor up there interact with each other and talking it through. I was like, this is what we've done and do this for.

Mike stated, “I was more focused on the situation, as opposed to the family. I was zeroed in, with the patient….having someone else there for the family is needed.” Emily said:

> It is good practice when a code, or even a rapid response is called, that chaplains come to the room. Not just, not just medical personnel, but, but the, the chaplains on duty to come. To see if they are, you know, the family needs support. I think that is a good idea.

Kim stated:

> One experience, there wasn't much negative so much as that because we had enough, staff members. Um, it was emotionally negative for them (family), but they were not in the way necessarily, because the staff member, had, had been in the situation a few times and helped them (family) and kind of scooted them off to the side while they talked to 'em.

Clear Terms and Wording

When dealing with healthcare and death, it is imperative to avoid jargon phrases, terms that are not familiar to the individuals involved, or substitutions for situations that may be considered harsh or unpleasant (Herbert, 2016). This is called a euphemism. Euphemisms can distort the meaning of situations when clarity is needed to avoid conflicting communication. As with death, many may use phrases such as passed away, went on, or left. During FPDR, when emotions are high, these phrases can invoke stress, confusion, distrust, and anger. A trained liaison knows how to avoid these words in a healthcare setting. Choosing the proper language in sensitive situations allows the family to make educated, informed decisions and balance openness, trust, respect, and consideration to help make a situation less traumatic. Dan stated:

> There is more concern if nobody is there with the family, to explain cause it is scary. I do think it needs to be explained cause just watching the situation and not knowing what is happening is scary. So, I think it is important that somebody be there to talk with the family.

Walter stated:

> Talking to the family, this is what's going on. If we're doing this rather than just seeing us pumping on their chest and all this stuff. I think that could be better, having a good talk and let them know so we can work on the family members because someone explaining actions and making sure words are used correctly…why it is occurring.

Another example was cited by Jill, who stated she just became a nurse when this situation occurred.

> I remember it was early on, and I was in the room, and the doctor just looked at the family and said your child has died. Not that your child has passed, or moved on, or whatever. He said they died. I thought to myself, was that the best way to do that? I mean, he was so blunt. I thought it was rude. Now, I look back and see that it was direct. If you say moved, it is like, moved where? Or, they left, well, left where? No, they did not pass. He is dead. I am sorry. I know now it was the best thing to do.

As sad as a situation can be, jargon or indirect words could have worsened the situation (Herbert, 2016). This would have further hindered support and communication during FPDR.

Compromised Care

Compromised care involves how the participants perceived that FPDR adversely influences the perceptions of their abilities during a resuscitation effort. Compromised care includes staff concerns for the concept, emotional awareness, humanizing, hindering patient care, and family disruptions. When examining emotional awareness and humanization, these are typically seen as positive aspects of the concept. However, the participants that cited these subthemes stated that they were distractions to patient care. Thus, they compromised care. All 10

participants identified one or more compromised care characteristics as subsiding their ability to perform during FPDR.

Staff Concern

Staff concerns mean a good-faith statement by a healthcare member that an activity, policy, or action can negatively impact the environment, health, quality, or safety of those involved in a situation or concept (Law Insider, n.d.). According to Mike:

> It's hard like for us as healthcare professionals to like to have the family, and it's added pressure like with them looking at us, but it's needed. Like they need to be able to see what, what they're, what's happening to their family member, and like what's happening to their child.

Dan said, "Getting them (family) out, get them out of the room as soon as possible so that we can get in and get the, start doing the job." Rob agreed by stating, "It makes it hard to actually get the job done, then that's gonna overall be, I mean, that's bad for the patient, bad for the family, bad for staff." Neither could state specifics when asking for clarification, but the situation could have been better for the staff.

Emotional Awareness

Emotional awareness during FPDR can be a positive aspect as it allows the nurse to understand their own feelings and the feelings around them (Rasheed et al., 2019). This helps enhance communication and understanding of what can help or hinder a delicate situation. It can be like a pause button for nurses to stop any impulsive behaviors or outbursts and handle situations in an appropriate, mature manner. In this study, two people cited how emotional awareness caused distractions for the staff. Jill stated:

> The hardest instances I've had are when the family begs us not to stop. Yeah.

> Um, but I think overall that's been the worst part of it. They were begging, um, where it was like, oh, you know, this is becoming a problem.

Mike stated:

> They are very emotional. They're like an absolute wreck. They're confused. And even if the patient did, like, have a DNR status, like they'll even be like, please do something, help them. And a lot of times they're yelling and screaming and, or they'll be praying or hollering scripture.

Humanizing

Humanized care is essential to nursing care (Meneses-La-Riva et al., 2021). It allows a strong, supporting, trusting relationship to form between the patient and nurse. It allows for holistic care, which nursing sees as foundational to healthcare. However, in this study, it was seen as a harmful sediment for the staff involved with FPDR. The participants cited this reason for compromised care, stating it distracted their duties. One example is from John. John stated:

> Having them there, it is harder because we actually see the grieving. Cause a lot of times when you just work a code, you go through the motions, and you're like, all right, we'll call it, so now time to go to lunch later. You know? But when you see the family present, you know, you see them grieving for this, and that's always a lot harder. Um, just, it makes it more human.

Mike said:

> Then someone says code blue, it's just like, you just go into action. You don't, you don't really have time to think, you know, you just do. Hey, I'm gonna do compressions, or I'm gonna do, I'm gonna ventilate, or I'm gonna push epi or, you know, whatever. It's, you just take, you think, okay, I've got, somebody's not doing this role, I'm gonna do this

> role and focus on that, you know. So, it's, you know, it's more so, so task driven that it's, you know, not really thinking, you know, about the person.

However, as Mike mentioned in emotional awareness, he cited where a family was emotional and "they'll even be like, please do something, help them. And a lot of times they're yelling and screaming and, or they'll be praying or hollering scripture." It made him more aware that this was a person and not just a duty.

Hindering Patient Care

According to Botes and Mabetshe (2022), nurses should advocate for families and patients despite barriers when patients' health is deteriorating. However, like many other studies, nurses and other healthcare professionals continue to see FPDR as a hindrance to patient care. This can be due to various reasons, including family disruptions and the family needing care when the focus should be on the patient. Dan gave an example when he stated, "It's hard like for us as healthcare professionals to like have the family, and it's added pressure like with them looking at us." Dan later stated, "There is usually always someone there. So, we can focus. They take them aside and get them calm so we can focus on the situation." Mike discussed how the family can disrupt the staff's ability to do their duties. He stated, "They're like an absolute wreck. You cannot focus. And a lot of times they're yelling and screaming and, or they'll be praying or hollering scripture." Rob commented, "Like you need to disassociate emotions until you see somebody wailing and crying up to God and stuff like that. That can be an issue." In another situation, Rob spoke of a husband seeing CPR being performed on his wife. He stated the husband "immediately, like, freaked out. He didn't come all the way into the room, but he freaked out in the hallway. It was, it was a big scene." Walter stated:

> I remember a 30 something years old, really young, just like all of a sudden, like, you know, obviously unexpected to where the mom was screaming and yelling the entire time, and they had to take her even further away from the scene because we couldn't hear to run the code properly.

Patient/Family-Centered Care

According to the Institute for Patient and Family Centered Care (IPFCC, 2023), patient- and family-centered care is when healthcare providers work to plan and deliver care cognizant of a partnership between patients, families, and healthcare members. Such a relationship aims to improve the health and well-being of those within the holistic setting. By building this liaison between patients, family, and medical teams, quality, safe, knowledgeable, and policy-developed healthcare can occur, which will improve outcomes and satisfaction.

Two participants saw that this concept is essential when looking at patient/family-centered care regarding FPDR. The importance was based on their belief in holistic care as well as on research on family presence as an evidence-based practice.

Holistic Care

As cited by IPFCC (2023) and Thornton (2019), patient- and family-centered care involves holistic care that looks at the mind, body, and spirit of a person. Traditional medicine looks at the treatment of diseases, while Florence Nightingale theorized that holistic care sees how a patient or family can be helped in other, non-medicine related measures. Looking at the bigger picture allows the patient and nurse to contribute much more to caring and giving the patient and family some control over their own well-being.

Kim recognized the need for holistic care and how it has changed over the years. She stated, “Medicine has evolved over the years…more and more, we're trying to involve the

families in all aspects of care….it helps the families have some type of closure…I think they (the family) get the opportunity to see…what all is done." Jill reiterated how holistic care is the basis of nursing. She stated, "I feel…it is a good thing for them to be at the bedside…they can…see what's truly going on and how people are actually really trying to save their family members' lives."

Evidence-Based

According to Li et al. (2019), evidence-based refers to applying the best available affirmation to making decisions and providing skilled and competent care based on scientific information. In healthcare, evidence-based has been shown to heighten safety measures and improve patient outcomes.

Research shows that FPDR is an evidence-based practice for families, but lacks use due to staff concerns. Rob stated, "Studies show better grieving and closure with resuscitation process. So, it's better for them, as long as it's done right." Rob recognized the importance of following evidence-based care but also stated that it should be done correctly to have the patient and/or family reap the benefits of such a concept.

Bereavement

Bereavement is losing someone important to another individual (Cherry, 2022). During this process, the person typically experiences grief, including various emotions from sadness, anger, and depression. This loss is profound to the person and can cause intense sorrow. This sorrow can lead to health-related issues and self-inflicted behaviors that can harm the person physically, mentally, or both.

Bereavement includes grief and closure. In this study, one or both of these sub-themes were mentioned by all 10 participants. Each person recognized that death could cause immense loss for the family and that the process could help with their feelings.

Grief

According to Harrop et al. (2020), grief is a response to bereavement. To cope, healthcare providers need to work to support families and offer ways to decrease isolation and the feeling of not knowing. Josh stated, “There comes a point to me where it’s like, it’s good for a patient, for a patient's family to be involved. There is just a certain point there.” When discussing staff concerns with the concept, Mike stated, ‘Like they need to be able to see what, what they’re, what’s happening to their family member and like what’s happening to their child.”

Walter helped a father during his son’s resuscitation. A chaplain was not present, so Walter wanted to help this dad during this process. He stated:

> They (chaplains) weren't up there at the time. So, I did go up there and sat with the dad. I did kind of like tell him everything that they were doing, like explain things to him. Um, I did pray with him just cuz the chaplain wasn’t up there, and I felt comfortable doing that. That helped him so much.

John stated that while it is hard, “it did help with their loss.” John also stated, “It's a good benefit to the families,” and it helped the family with “better grieving.”

Closure

According to Fernández and Gonzalez-Gonzalez (2022), closure will not be reached if the normal sorrow and morning phases are not experienced. When this is done, the person experiencing the loss tends to have guilt. With FPDR, there is often a lack of anticipatory grief, as the loved one is lost suddenly and unexpectedly. When the loss is unanticipated, the family

needs extra support. While full closure may not be attainable in all situations, with support, the family can reach some cessation and work to move on with living their own lives.

Speaking of how being present can benefit closure, Laura, a nurse in the pediatric ER, stated:

> I took the mom in there and like just sat with her over in the other corner and like was trying to explain to her everything that was going on. So, I think that that really does help, especially in pediatric patients. It really helped her to know.

Several participants noted other closure sub-themes. Jill mentioned one that stood out. This was a young pediatric patient, and waiting for the family to arrive was important to closure. She stated:

> You know, we had a situation where the patient is not compatible with life. We just need to stop. But our pediatric provider was like, very adamant about it. He was like y'all can leave the room if you want to, but I vote we continue to keep doing CPR until the family gets here so that they can, like, witness and see that we've done everything for them. So, we did that. I think that helped the family tremendously, seeing that we were still like in the process of trying to help her. For the family, it helped to have some type of closure. Maybe to help cope with that.

In this circumstance, not only did the team vote to continue a process that they knew would not have positive results, but they also prolonged the resuscitation process to benefit the family, which is part of the holistic circle of healthcare.

Situational Dependence

Situational dependence is based on the theory by Joseph Fletcher (1997) called situational ethics. Fletcher believed in biblical principles such as agape (Gill, 2017), which is the belief that

love is given whether or not it is returned. The basic premise of his theory held that any moral judgment should be determined in the context of the situation. The decision should be made lovingly and work to cultivate human existence.

When examining situational dependence as a theme, there were sub-themes noted of trauma versus medical situations, adult versus pediatric patients, and the stability of the family. Nine participants noted the importance of allowing family back based on the situation. In this central theme, Jill stated:

> I think it's mainly just like a case by case. Like I said, I've seen it go really, really well where the family's able to come back and see, and I've seen it go really terrible. So it's like, I don't know how to gauge it or judge if it's an appropriate case, but I feel like it's just case by case.

Trauma versus Medical Situations

While resuscitation efforts can be unsightly, trauma can often be more horrid. People may see blunt force trauma, open wounds, brain injuries, or complex fractures in trauma. These can occur in many situations, such as gunshot wounds or car accidents. Seeing these things may be more agonizing to the family if they see their loved one in such a predicament. That is why careful assessment is needed of the situation. One circumstance was cited by John when he stated:

> I had another experience where, um, it was a gunshot wound to the head, self-inflicted, teenager. Um, she came in via EMS. The parents were not with them at the time. Um, so we got 'em into our resuscitation room, we're doing CPR on her and everything. It was traumatic for the family cuz, usually, they don't know what to expect, and it's, it's not pretty. So, I think a lot of people get caught off guard by the fact trauma can be harder.

I think it is based on the circumstances.

Another incident from Kim stated:

> I've seen it go both ways where like they are present. It goes really well. I think it's great closure for the family and everything that I've seen it go where it's like really, really traumatizing for the family to see that. And then I've seen where they were present that it was really great for them. There were times they were glad that they weren't present for that, and they didn't have to see that being done. And then there were also times where it's been more traumatic.

Mike stated:

> Trauma, I think that, might be a different beast in itself because of things like a bedside dichotomy. I don't know if the family wants to see us crack open a chest. Uh, and, you know, it gets messy maybe afterwards.

Pediatric versus Adult

Pediatric patients are often seen as vulnerable (Bagattini, 2019). This is due to their developmental issues, including physical, intellectual, emotional, and social. They are highly dependent on others for their primary care needs. Pediatric patients often need more empathy when providing care because they do not have the experiences as adults do regarding everyday life situations. Due to this, when in resuscitation efforts, healthcare providers often feel the need to have the parents/guardians present more than if it is an adult patient.

Adults may be new to a situation in the healthcare setting, but they have some background to know what to expect from a medical setting. Pediatric patients often have little to no experience in traumatic medical situations, which is often why pediatric patients are seen as unique. They need to gain years of experience to understand the full scope of life and living.

This makes healthcare workers have a different perception of their lives compared to adult patients. Kim stated, “Ped codes typically have the parents present, even in the early days.”

As cited earlier from Laura, regarding closure, she stated how she involved the mom in the resuscitation of her child. She stated, “…trying to explain to her everything that was going on. So, I think that that really does help, especially in pediatric patients.” Josh stated, “With pediatrics, there is a push to have the family there and not adults.” Rob stated:

> One experience, there was a child, and the mom did not want to come back, but the dad did. There wasn't much negative, so much as they had enough. We had a staff member assisting and letting them know what was happening... It was obviously emotional, but the staff member helped and been in a situation like that a few times….the dad was appreciative later.

Stability of the Family

In resuscitation efforts, healthcare providers must be able to read the situation, which includes the family's demeanor. If they are not acting in a manner where the staff feels they can perform their duties safely, then concern is raised about the suitability of the family being present. Walter followed up on his remarks to a liaison needing to be present. In one situation, Walter recognized that the dad needed to be present. He stated:

> What stands out to me the most is the actual happening on the unit cause I was the charge nurse down here that day. I had seen a guy come in down in the ER multiple times, and he coded upstairs. They didn't really need me down here, so I went up there to help. The chaplain was not there. Seeing the dad sitting there, by himself, and then helping him. That was important.

Kim cited an incident where a mom was accused of abusing her child. This is the child they were working to resuscitate, and the mom was off to the side. No one was talking to her, and that included the staff and the other family members. Kim felt the need to communicate with the mother, even if it was outside the room. Kim stated, “It was a case where the mom likely caused the issue, and some felt it could have been an issue with the other family there. I thought that I just needed to at least let her know what was happening, even in that situation.”

Mike discussed compromised care but also recognized that a family’s stability can be problematic. Mike admitted that with a resuscitation, he stated, “They're like an absolute wreck…And a lot of times they’re yelling and screaming and, or they’ll be praying or hollering scripture.” Rob commented, “Like you need to disassociate emotions until you see somebody wailing and crying up to God and stuff like that. That can be an issue.” Rob also mentioned another prominent experience where:

> A younger woman who was pretty, uh, chronically ill just to begin with. Um, and her husband, the doctor, wanted to bring the husband back. Um, he came back and immediately, like, freaked out. He didn’t come all the way into the room, but he like freaked out in the hallway. It was, it was a big scene. And then afterwards, once everything was said and done, it was, I don’t know if it did any, I don’t know if it was a more of a neutral situation, but I feel like in that instance, like it didn’t really help him. It may have hurt him a little bit, if anything.

Part of the importance of recognizing family stability is reading the room. Walter, Mike, and Rob recognized that understanding families’ emotions is vital in a sensitive situation. According to Klitzman et al. (2023), reading a room is being aware of the opinion and attitudes of individuals, which can involve verbal and nonverbal cues. By using critical thinking skills and

emotional intelligence, nurses can read the room for cues, energy, and moods in the room, and they can help understand how to involve families in the resuscitation process appropriately.

Research Question

Examining themes and sub-themes from this constructivist, hermeneutic phenomenology study is vital as it enabled the researcher to address the "how" and "why" of concepts, how it occurs, and how it can impact higher education (Cleland, 2017, p. 69). Examining the participants' views gave an in-depth understanding of these nurses' experiences regarding FPDR. Some of the responses were surprising but gave insight into how the nurse sees the concept. This section will answer questions surrounding the central question about FPDR.

Central Research Question-What Are Your Experiences Regarding FPDR?

There were six themes noted when questioning nurses about their lived experiences with FPDR. These included permission, support and communication, compromised care, patient/family-centered care, bereavement, and situational dependence. The themes demonstrate how each subject had their own thoughts, values, and perceptions on the concept. The participants considered the family and the staff in each situation and looked at the circumstances as unique and special.

There were a few subjects that felt the family could be chaotic and get in the way of care. This is seen when Dan stated that having the family present is "hard like for us as healthcare professionals to like have the family." Mike stated how one family was "an absolute wreck. You cannot focus. A lot of times they're yelling and screaming…" Rob stated that the staff need to "disassociate emotions" when "you see somebody walking and crying up to God and stuff like that." Rob also stated that in one instance a husband "freaked out" and caused "a big scene." Walter stated that a mom was "yelling the entire time, and they had to take her even further away

from the scene because we couldn't hear…" However, one felt the FPDR was disruptive to the staff but also felt that when addressed correctly, it can be managed in a manner suitable to all. Dan stated when discussing the pressure on the staff that "there is usually always someone there. So, we can focus." John reiterated this by stating that it allows the family to have "better grieving….when done correctly." John also stated that FPDR can allow the staff to see the situation in a more humanizing way. He stated that seeing "the grieving…makes it more human."

Jill, Walter, Emily, Laura, and Kim verbalized the need to have the family present, or at least consider the option to help with bereavement for the family. Emily cited that FPDR is a "good idea" with proper support "from the chaplains on duty." In one situation, Jill's team continued CPR until the family arrived, despite the traumatic situation. In another, Walter communicated with a father when his child was being resuscitated.

Laura noted the importance of reading the family as some may not feel the need to be present, while others may wish to be with their loved one for their "last dying breath." Josh, who expressed frustration with the family being brought back in a drowning situation, concluded by stating, "There comes a point to me where it's like, it's good for a patient, for a patient's family to be involved. There is just a certain point there."

Summary

The purpose of this research was to investigate the lived experiences of nurses regarding FPDR. Open-ended questions were used during a one-on-one interview. Ten participants were interviewed. Each consultation was analyzed and inputted into a computer program. From this data, horizontalizations were noted. Codes then evolved and culminated into six themes. These themes included permission, support and communication, compromised care, patient/family-centered care, bereavement, and situational dependence. Subthemes included were permission

from the family, permission from staff, liaison, clear terms and wording, staff concerns, emotional awareness, humanizing, hindering patient care, evidence-based, grief, closure, trauma versus medical resuscitation, pediatric versus adult resuscitation, and family stability. Support and communication was the most pronounced theme with each participant. This included using a liaison to help with communication, reading the situation to see if it is appropriate to involve the family, and clarifying any misunderstandings.

CHAPTER FIVE: CONCLUSION

Overview

Family presence during resuscitation (FPDR) is an evidence-based concept that assists families with losing a relative (Hassankhani et al., 2017; Joyner, 2018; Lederman, 2019; MacLean et al., 2003; Tennyson, 2019; Twibell et al., 2018). Nurses are essential within this concept, as they practice holistic care using the nursing metaparadigm (Fawcett, 1984; Powers, 2018). Even though education has occurred within the workplace to support this evidence-based concept, it is still not widely used (Auerbach et al., 2021).

This study scrutinized nursing's lived experiences with FPDR to learn from them to enhance future education for student nurses. A summary of the thematic data is furnished with interpretations of crucial thoughts from the collected evidence. Implications for key stakeholders and policy and practice updates are recognized. Limitations and delimitations of this qualitative study and recommendations for future research are examined. Using these findings to educate nursing students, these individuals can evolve from pupils to confident, educated, competent, and supportive novice nurses about this controversial concept (Blevins, 2018).

Discussion

This research study investigated nurses' experiences with FPDR. The investigation utilized open-ended questions during each interview. Information from 10 interviews came from BSN ICU or ER nurses. The central question for this study was, what are your experiences regarding FPDR? Follow-up questions enhanced the primary query, allowing the nurses to express their feelings, thoughts, or perceptions on FPDR.

The factors expressed by the nursing participants developed into 29 horizontalizations. From these horizontalizations, 19 codes developed into six themes. Each theme had sub-themes

that allowed for a deeper understanding of the findings. Ultimately, each nurse cited efforts answering the central question about their lived experiences on FPDR. They also discussed how each theme demonstrates holistic care using the nursing process and entails critical aspects of the AACN (2021a) guide for qualified, competent care (Schmieding, 1993; Toney-Butler & Thayer, 2022).

Interpretation of the Findings

A constructivist, hermeneutic phenomenology method was used to explore the lived experiences of nurses about FPDR. Through interviews, information was gathered and analyzed. Themes were developed through horizontalization, and codes and themes evolved. While the themes will be used to show how they can influence nursing, they will also be used to show how they can impact key stakeholders and improve patient care in the future.

Findings Related to Philosophical Framework: Hermeneutic Phenomenology through a Constructivist Lens

This study investigated the lived experiences of nurses regarding FPDR and utilized the theory of hermeneutic phenomenology through a constructivist lens. A constructivist approach uses active communication and teamwork to add to foundational knowledge that evolved from their previous learning experiences (Bakar et al., 2019; Pilarska, 2021; Muhajirah, 2020; Straughair, 2019; Tam, 2000). A key developer in this theory was John Dewey (1960), who felt that exploration of ideas and real-world experiences was needed to advance a student's critical thinking (Dewey, 1960, 1986; Mayer, 2008). The student takes an active role in their learning, and the teacher provides the student with encounters directly relevant to the material, allowing the student to make further sense of the information. This constructivist method lets students construct ways of understanding situations while using older knowledge and experiences to build

and form new knowledge (Billings & Halstead, 2016). By allowing the educator to facilitate the learning within this team approach, knowledge and learning evolve, emphasized by Bloom's taxonomy in the conceptual knowledge category (Bakar et al., 2019; Billings & Halstead, 2016; Dewey, 1986; Mayer, 2008; Pilarska, 2021; Muhajirah, 2020). Information sprouts and forms from basic to more dynamic skills. This technique allows the student to see they are responsible for their role in learning and make necessary changes to develop their skills and knowledge.

Hermeneutic phenomenology allowed this researcher to understand lived experiences within FPDR (Heidegger, 1962). Heidegger developed this theoretical method using the hermeneutic circle to understand human emotions, perceptions, and lived experiences. This circle, which is more spiral in nature, allows the researcher to advance their understanding of the phenomenon each time a new experience is introduced to the study. Heidegger recognized the importance of investigating social beings as a sum of all their parts and how separating these lenses is impossible to see the complete picture. Heidegger noted that the knowledge and understanding of a situation, or the world surrounding a person, are influenced by human reality. Heidegger also saw that a person could understand their own Being while understanding that the Being is not indivisible from the world. Each person has their own values called Dasein. He noted that understanding a situation, or the world surrounding a person, is influenced by a person's values, which influence how situations are viewed. A person is "thrown," or thrownness into the world. Each person encounters different situations, values, cultures, and beliefs, and these shape the person. Thus, values are part of the experience, and the person cannot be separated from the world around them.

Heidegger felt that a researcher needs to recognize their biases while understanding that each person has unique experiences (Heidegger, 1962). These various perspectives, emotions, and

lived experiences can expand on human interests and circumstances within patient care (Candela, 2019). Bracketing is impossible when a researcher conducts a hermeneutic phenomenology study (Heidegger, 1962). The experiences brought the investigator to the study to begin with; thus, bracketing from the situation would not allow for a further understanding of the concept. The researcher should openly acknowledge their thoughts to recognize what the investigator brings to the study. Reflexivity should be used to identify these preconceived notions. Reflexivity will also demonstrate the investigator's subjectivity's importance in the study. This allows the study to provide rich and robust information about the concept using a holistic manner (Creswell & Poth, 2018)

Constructivism and hermeneutic phenomenology allowed this researcher to see how different perceptions can evolve a concept to improve knowledge and understanding. Each person has a crucial role and brings various traditions, cultures, emotions, and experiences to the teaching-learning team. Like the holistic nursing model, constructivism and phenomenology see a person as more than their body and recognize the student and instructor as separate entities with varying perceptions (Candela, 2019; Tam, 2000).

These two methods allowed for a broader view of FPDR. As people learn more, methods and awareness evolve. This can narrow the gap between clinical practice and research. This can also improve future teaching methods while following the nursing models of the nursing metaparadigm and holistic care (Fawcett, 1984; Heidegger, 1962; Nikfarid et al., 2018).

A familiar mantra cited by nursing's historical leaders and the American Association of Colleges of Nursing is that nurses are to provide competent, evidence-based care while recognizing the individuality of everyone involved, and recognizing individuality is the foundation for constructivism and hermeneutic phenomenology (AACN, 2021a; Fawcett, 1984;

Nikfarid et al., 2018; Schmieding, 1993; Wagner, 2018). Nursing care is done while using research, advocacy, comprehensive, compassionate care, critical thinking, emotional intelligence, and devotion as the foundation for the profession (Nikfarid et al., 2018; Schmieding, 1993; Selanders & Crane, 2012; Shahbazi et al., 2018; Sharon & Grinberg, 2018; Wagner, 2018). These nursing characteristics enhance the profession to grow and evolve through the nurse's leadership. The nursing profession is an art and science (Rogers, 1988); the nurse uses their heart, soul, and mind to care for each patient based on their individualized needs.

Walter recognized that a dad needed help when his son was being resuscitated and prayed with him. Jill recognized that the family could be in shock and need time to absorb the situation. John voiced concern about family presence in a gunshot wound and how trauma can negatively impact the family. Laura recognized that some families wish to be with their loved ones at the end. Mike verbalized that resuscitation can be traumatic for all involved. Lastly, Rob stated that a husband "freaked out," and the visualization of the resuscitation likely caused the husband harm.

This study demonstrated how each participant recognized and understood how each person uses their own perceptions to understand their lived experiences. The uniqueness of each situation and the family's and staffs' feelings on FPDR helped enhance the participant's ability to meet the person's needs. Using these findings, the information can be passed on to nurse educators to educate student nurses using a constructivist method of individuality when teaching.

Thematic Findings

According to Christianson (2020), critical thinking and emotional intelligence are vital components of nursing. These two items include a process that uses skill and empathy to reach a decision (Christianson, 2020; Papathanasiou et al., 2014). It is a system of cognitive thinking that

examines and comprehends parts of a situation completely. The findings are interpreted by what is said, heard, seen, and felt. This interchange comprehends how emotions can help or hinder a situation. In nursing, this perception validation allows nurses to use the nursing process to better meet the needs of a patient and/or family (Schmieding, 1993). It also recognizes how these characteristics are vital to meeting the competencies of being a qualified nurse (AACN, 2021a). The participants demonstrated these steps of the nursing process and AACN (2021a) nursing competencies when evaluating their lived experiences regarding FPDR for comprehensive, quality patient/family-centered care (Papathanasiou et al., 2014).

Nursing Process. The nursing process is an ongoing, evolving activity of assessing, diagnosing, planning, implementing, and evaluating a patient or situation to improve patient care outcomes (Schmieding, 1993). It bolsters nurses' critical thinking abilities while using emotional intelligence to solve problems and make appropriate decisions (Schmieding, 1993; Toney-Butler & Thayer, 2022). This process allows the nurse to use stimuli around him or her to develop a plan to improve patient outcomes and satisfaction.

Assessing is the first step where the nurse uses critical thinking and emotional intelligence (Toney-Butler & Thayer, 2022). This phase collects subjective and objective data. Kim demonstrated this by stating, "Sometimes the family doesn't want to be there. They should be given that choice…You do not know if you do not ask." Laura talked about a pediatric patient and how the mom was sitting alone, and she could see that the mom needed some assistance. Laura stated, "I took the mom in there and like just sat with her over in the other corner and like was trying to explain to her everything that was going on…It really helped her to know." Each took verbal and non-verbal cues to assess the situation.

Diagnosing uses clinical judgment about stimuli or responses to problems that are present or may present themselves (Toney-Butler & Thayer, 2022). This diagnosis phase is built upon Maslow's (1943) hierarchy of needs (cited in Toney-Butler & Thayer, 2022), which examines a pyramid of patient/family-centered requirements that will improve healthcare outcomes. These necessities build upon the foundation of basic needs to a higher level of needs that move from safety and security to love and belonging. From these, the pyramid includes higher self-esteem and self-actualization requirements. This step of the nursing process was noted by Dan, Mike, Rob, and Walter. Each tells a story of when the family was emotional or chaotic. Even though it was hard, they each had to focus on the basic patient needs while maintaining safety for the scene and the family. They also recognized that a liaison or support person was needed to meet the family's needs during this desperate situation. Dan stated that having the family present is "hard like for us as healthcare professionals." Mike stated how one family was "an absolute wreck. You cannot focus. A lot of times, they're yelling and screaming…" Rob stated that the staff needs to "disassociate emotions" when "you see somebody walking and crying up to God and stuff like that." Rob also stated that in one instance, a husband "freaked out" and caused "a big scene." Walter stated that a mom was "yelling the entire time, and they had to take her even further away from the scene because we couldn't hear…" However, Rob later stated that "letting the family know what was occurring was necessary, even when the emotions were high," or Walter, who acted as a support person so that the resuscitation team could perform their duties and care for the patient.

Planning is the step in developing goals and outcomes that impact patient/family-centered care (Toney-Butler & Thayer, 2022). These goals are set to ensure a positive outcome. Rob recognized that FPDR is an evidence-based concept and is important when providing holistic

care. He stated, “Studies show better grieving and closure with resuscitation process. So, it’s better for them, as long as it’s done right.” Kim recognized the need for holistic care and how healthcare has grown. She stated, “Medicine has evolved over the years…we’re trying to involve the families in all aspects of care….it helps the families have some type of closure.”
Jill reiterated how holistic care, including the family, is the basis of nursing. “I feel like that that it is a good thing…people (the staff) are actually really trying to save their family members’ lives.” These individuals noted that while the resuscitation process was occurring, each recognized the importance of including the family, which was the logical next phase of holistic care. By setting goals of family inclusion, the nurses worked to improve outcomes for the patients’ loved ones.

Despite the lack of policy on FPDR at this hospital and the participants’ recognition of the chaos the family can cause during such an event, the participants stated that FPDR is still an important concept for the family. Each participant reiterated the most recognized theme of support and communication. Having a support person there to assist is vital to making FPDR successful. The plan, while difficult at times, needs to be carried out for the betterment of the family. Walter took it upon himself to act as the liaison since the chaplain was unavailable. Emily noted that chaplains are vital to have a successful concept for the family. Josh stated, “There comes a point to me where it’s like, it’s good for a patient, for a patient’s family to be involved. There is just a certain point there.” Mike stated, “Like they need to be able to see what, what they’re, what’s happening to their family member and like what’s happening to their child.” John stated that while it is hard, “it did help with their loss” and “it’s a good benefit to the families,” and it helped the family with “better grieving.”

Implementation is where the nurse puts the plan into action (Toney-Butler & Thayer, 2022). This is where they meet standard care protocols and follow evidence-based practice. This was seen through Laura talking to a mom sitting alone, Kim intervening and communicating with the parent, or Rob and Walter, who have encountered emotional families and still worked to include the family in the process.

The evaluation step is when the nurse works to gain a positive patient/family outcome (Toney-Butler & Thayer, 2022). One that touches this researcher is when Jill is part of a resuscitation team where they know there is no hope of survival. Despite this, the team continues working on the pediatric patient until the family arrives to help give them closure. Jill stated, "We just need to stop…we continue to keep doing CPR until the family gets here…see that we've done everything for them…I think that helped the family tremendously…it helped to have some type of closure."

AACN Nursing Competencies. The AACN (2021a) recognizes the importance of developing a nurse built on evidence-based, patient/family-centered care. The six themes of this study included permission, support and communication, compromised care, patient/family-centered care, bereavement, and situational dependence. Each of these themes revolves around competent, evidence-based, emotionally-intelligent care. The AACN (2021a) lists eight competencies for nurses to practice competent care. These include clinical judgment (critical thinking/professionalism), communication, compassionate care, DEI (diversity, equity, and inclusion), ethics (principles of bioethics of autonomy, beneficence, non-maleficence, and justice), evidence-based care, health policy, and social determinants of health. Based on the question, "what are your experiences regarding FPDR?", participants described multiple factors about the concept of FPDR that demonstrated AACN's guide for competent care.

Competent care was noted in the case of Jill and the resuscitation team. The team continued CPR on a pediatric patient until the family arrived, despite there being no chance of survival for the patient. It was demonstrated by Walter, who took it upon himself to act as a liaison between the code team and the father. It was also demonstrated by Laura, who recognized that the family might wish to be present since it may be their "last dying breath," and Kim, who felt the family should always be given a choice, even if they do not wish to be present. Kim communicated with the mother outside the room to ensure the mom knew what was going on without causing strive with the other family members. Walter and Dan recognized the value of a support person to communicate with the family. Alternatively, Josh, upset that the family was brought back before the patient even arrived, felt that communication and decision-making skills were important for everyone when having the family present. Each participant demonstrates critical thinking, communication skills, compassionate care, and ethical decision-making (AACN, 2021a).

Emotional intelligence is the ability to be aware of, express, and control one's emotions (Raghubir, 2018). Despite the participants' difficulty in seeing the family and having to see the patient as a person, they continued their duties and still cared for the family during that difficult time. This was seen when Laura was "…trying to explain to her (the mom) everything that was going on" or when Rob stated that "letting the family know what was occurring was necessary, even when the emotions were high." It was also noted when Josh stated that despite the difficulties, "there is a push to have the family there" or when Walter acted as a support person so that the resuscitation team could perform their duties and care for the patient. While each theme overlaps in many areas, it is important to recognize that during FPDR, each nurse

demonstrated the competencies and emotional intelligence as a qualified, proficient nurse (AACN, 2021a).

When examining evidence-based care, this researcher was eager to hear the participants' comments on how studies show that it benefits the family when they are present. This was seen when John supported the idea of FPDR “when done correctly.” Also, John added that the family has “better grieving” when they are present.

However, a few responses surprised this investigator. Some participants recognized that everyone is special and needs ethical treatment and dignified respect. This is humanizing the patient and family; the humanization of the resuscitation process was noted but seen as negative for the participants. John cited that it was difficult for the team to function “because we actually see the grieving…it makes it more human.” Mike reiterated by stating that the team often goes through the motions and does their tasks and is “not really thinking…about the person.” While surprising that such a humanizing, empathic action is seen as unfavorable, it was reassuring when reviewing the qualities of a competent nurse.

The six themes developed from the interviews demonstrate AACN's (2021a) competencies of qualified nurses. Support and communication were the most voiced theme; all themes provided the foundation for the nurse's experience regarding FPDR. The themes, individually and collectively, demonstrate the importance of careful consideration by the nurse for this concept to succeed. It is a case-by-case situation that recognizes the need for a support person to be present for a successful process. Each nurse showed qualifications grounded in critical thinking and emotional intelligence, vital in the core nursing competencies and the nursing process (AACN, 2021a; Schmieding, 1993; Toney-Butler & Thayer, 2022).

Implications

Results from this study on FPDR demonstrate an impact on nurses, patients, families, and healthcare as a whole. Despite their own misgivings, these participants work hard to practice as qualified, competent nurses. Each participant endeavored to pursue evidence-based care despite any obstacles. However, a support person was voiced as vital to help avoid obstacles. The participants followed the nursing process to practice holistic, patient/family-centered quality care. While it cannot be assumed that all nurses practice this way, it behooves stakeholders to consider the results and determine how to address such a forgotten concept within other healthcare settings. The way that these can positively impact healthcare is through policy and practice.

Implications for Policy

Organizations such as the ENA (2014), AHA (2002), ACCM, and SCCM recognize the importance of FPDR and have policies or statements that support the concept in appropriate situations (American Academy of Pediatrics, 2006; Davidson et al., 2007). Worldwide organizations like ILCOR, the European Federation of Critical Care Nurses Association, the European Society of Cardiology Council on Nursing and Allied Professionals, and the European Society of Paediatric and Neonatal Intensive Care also offer policies and guidance regarding FPDR (Fulbrook et al., 2007a; Fulbrook et al., 2007b; Moons & Norekval, 2008; Wyckoff et al., 2022). While it is great to see such establishments recognize the importance of the concept, this needs to be improved within the American nursing arena.

American Nurses Association

According to the ANA (2023), its organization works to represent over four million registered nurses and works to improve quality care for nurses, patients, and families. With this

as their primary goal, this organization is a key stakeholder in improving nursing care and the individual nurses that serve within the healthcare community. While the ANA offers guidelines and state information on nursing practice, ethics, safety, and holistic care, it does not offer an official statement on FPDR (ANA, 2015). This study shows how Walter, John, Emily, Mike, and Josh voiced the benefits of FPDR, how it helps with bereavement and can be used in certain situations, as well as the importance of a support person to guide the family. Issuing a position statement about the benefits of FPDR could give guidance to clinical nurses as well as nurses in leadership roles. It also could help set standards that the public could understand if faced with such a concept, such as understanding that family involvement is a case-by-case situation.

National League for Nursing

Another organization with no position or educational information on FPDR is the National League for Nursing (NLN, 2022). This organization promotes excellence within nursing education to develop a nursing workforce that can evolve as healthcare changes. Rob and Josh commented on the benefits of FPDR and how it is an evidence-based concept. Changes within the NLN demonstrating educational guidelines and organizational statements would provide further guidance for higher learning institutions and national policies concerning FPDR.

American Association of College of Nurses

The AACN (2021a) does not acknowledge FPDR specifically; however, it does recognize the importance of educating students on holistic nursing within every individualized care setting (AACN, 2021b). According to the AACN, its goal is to set principles that allow students to excel within the nursing profession while assisting nursing educators in developing excellence in higher learning standards. These will improve the nursing discipline, healthcare, and community support by filling the gap between nursing research and clinical practice. It would beseem the

AACN to recognize the study results and issue statements or guidance on this concept. This would help nurse educators holistically guide students and demonstrate evidence-based care.

Implications for Practice

Patients and families, nurses, employers, and nurse educators are key stakeholders when examining FPDR. This research study demonstrated that FPDR is an evidence-based practice that benefits the family. However, it can have some hindrances for the staff when implemented. The participants of the study voiced the need for a case-by-case decision as well as having a support person for the family to help with the process. Even though the study demonstrated how the participants followed the competencies set by the AACN (2021a) and the nursing process, further exploration is needed to improve patient/family-centered care, nursing, employers, and nursing education (Toney-Butler & Thayer, 2022).

Patient and Family

Patient and family as stakeholders include their need for patient/family-centered care. Patient/family-centered care is seen throughout parent presence during invasive pediatric procedures or when fathers are allowed in the delivery room (King, 2017; MacLean et al., 2003). In recent years, this type of care was seen when nurses worked tirelessly to ensure patients and families were supported and not alone during COVID-19 (Anderson-Shaw & Zar, 2020; Capozzo, 2020; Karimi et al., 2020; Wakam et al., 2020).

Families have expressed their desire to be with their loved ones to say goodbye. During COVID-19, families often experienced prolonged grief, anxiety, or depression due to the lack of contact between the loved one and the family (Dutheil et al., 2021; Sekowski et al., 2021). Families that include parents have even stressed the need for their presence during pediatric procedures to ensure their child's needs are met (Beauchamp & Childress, 2001; Joyner, 2018).

Patients that have survived resuscitation efforts verbalized the desire to have the family present so that they would be seen as a human-being (Afzali Ruban et al., 2020). The patient also stated they felt comforted by having their family present. Patients also felt valued and respected by having their loved ones with them.

When looking at this study, Josh recognized that FPDR benefits the family to be present, and Mike stated that parents can feel better by knowing what is happening to their child. Walter showed how he helped a father understand the process with his support, and John and Laura stated that the family has better grieving and closure with FPDR. Jill even stated how continuing a futile resuscitation was done to benefit the family.

By using the results of this study, parents' and families' wishes can be considered. The nurse can recognize that not all situations are the same and decisions regarding their presence should be made on a case-by-case basis. Every effort should be made to allow for FPDR, especially if a support person is available.

Nursing

Nurses are an essential element within healthcare. From the 19th century Florence Nightingale pushing for fresh air and clean linens for proper patient care to the 20th century when fathers were allowed in the delivery room, nurses have been instrumental in improving healthcare for the patient and their families (King, 2017; MacLean et al., 2003; Riegel et al., 2021). The participants of this study showed that despite emotional outbursts from family and the troubling dynamics they can pose for the staff, it is part of holistic care to include the family in this process.

Rob recognized the need for nurses to follow evidence-based care. Mike mentioned that the family would yell for them to help their loved one, but it made him realize that it is part of

being a nurse, helping the family and patients in their deepest moments. Dan stated that seeing the family can be difficult for the team, but typically there is a support person present, and this is important for the staff and helping the family with their grief. Kim recognized how nurses are vital within holistic care and how it has evolved over the years, especially involving pediatric patients. Jill voiced the same when discussing the importance of having the family at the bedside so they can see the team is trying to help their loved one.

FPDR is an evidence-based concept that still needs clinical practice usage (Powers, 2018; Tennyson, 2019). Despite ongoing education for nurses, there still needs to be clearer guidance on how or when to use FPDR (Powers & Reeve, 2018). Very few hospitals have policies on the topic; by using the information in this study, nurses can see the benefits of its use, not only for patients and families but also for the nursing discipline. Nurses can become more confident in their abilities and push for changes in hospital policies.

Employers

Employers are essential stakeholders when examining FPDR. However, their direct benefit may be through an association with nursing and the family. The employer looks for qualified nurses to care for patients; hiring a new or experienced nurse with critical thinking and emotional intelligence will ensure that patients are cared for competently. Using this study will ensure that patients and families are provided excellent care, which will help increase satisfaction scores. This will ensure continued use of their healthcare facilities and increase the employer's revenue.

Nurse Educators

Examining lived experiences of nurses regarding FPDR can help the nurse educator cultivate emotional intelligence and critical thinking skills within student nurses (AACN, 2021a;

Schmieding, 1993; Toney-Butler & Thayer, 2022). Educators can develop methods to teach about FPDR to benefit the student and help the educated student learn how to handle such delicate situations (AACN, 2021b; IOM, 2011; Ng & Feldman, 2009). Students educated about FPDR can be instrumental in making a substantial difference in the future of nursing (Powers, 2018). These future nurses can go out into the community in various demographics and settings and demonstrate to healthcare facilities how an established, well-thought-out policy can provide supportive, family-centered care, even during tragic events (Toronto & LaRocco, 2018).

Limitations and Delimitations

Having a small sample size was a limitation of this study. While 10 participants can be an appropriate number for a qualitative study if data saturation is obtained, more participants could have improved the validity of the data or opened a door for other various experiences. Recruitment was an issue as many nurse managers only wanted the staff to do the interviews during certain hours, which often interfered with their break times or ability to wrap up their documentation. The researcher brought food when visiting the units, which may have made the participants feel obligated to perform the interviews.

Baccalaureate nurses were used in the study, and it was determined later that many of the nurses employed at this facility were associate-level nurses. Associate versus bachelor’s degree nurses may vary in their values, beliefs, and perceptions on FPDR or other complex topics. Also, all the nurses worked for the same hospital. A small geographic area (Northeast Tennessee) was used as a convenient sample for the researcher. Interviewing nurses from other geographic areas or hospital cultures may influence their views on the concept. Discussing the participants' background, such as where they may have grown up or lived in previous years, may have also influenced how this concept is implemented or participants’ beliefs on the topic.

The diversity of the participant group was limited. All were white/non-Hispanic. There were male participants, but having different views regarding culture or ethnicity could impact the studies' perceptions. There are further limitations in the generalizable results of the study. BSN nurses from the ER and ICU settings were interviewed. While the findings can be applied to other hospital settings, interviewing nurses from the floor, operating room, or palliative/hospice settings may have changed the information.

Delimitations utilize conceptual boundaries to narrow the scope of the research to enhance the validity and credibility of the work completed (Coker, 2022). For the study on nurses' lived experiences with FPDR, BSN nurses and ICU and ER units were used. BSN nurses were utilized as they completed four years of college versus two years for the associates level. Associates level nurses complete their degrees sooner and focus more on clinical skills within nursing (AACN, 2021b). BSN nurses tend to include the same clinical aspects but include more diverse learning within the classroom. Classroom topics include leadership, interdisciplinary care, management, communication, and research at the BSN level. This level of nurses tends to have education in more complex situations, allowing them to have a higher exposure to diverse topics, including FPDR. Also, while resuscitations can happen anywhere or in any hospital unit, ICUs and ERs tend to have more resuscitations than other areas of the hospital settings. This allowed this researcher to reach a wider audience of nurses that could have experienced this concept.

Lastly, this investigator did come into the study with biases. This researcher also worked in the ER for years. She has seen the good and bad of family presence. This writer's perception was that while difficult, FPDR benefited the family. To minimize these biases, journalling and reflection were done before the sessions. Participants could have picked up on the researcher's

body language or tone of voice that the researcher was unaware of and thus, it could have influenced the study's findings.

Recommendations for Future Research

At present, there needs to be more research that explores the lived experiences of nurses regarding FPDR. This study demonstrated how thoughts and feelings are foundational to the use of this concept. While this study shows that the concept of FPDR is still in its infancy, further hermeneutic phenomenology studies are needed for the validity and reliability of the data.

The study investigated ER and ICU BSN nurses that had witnessed FPDR. Future research should explore the lived experiences of all RN levels in various areas of work and a variety of geographic locations. This will allow for comparative information to see if the values, perceptions, and beliefs are related to the findings of this study. Diversity should be considered as different ethnic and cultural groups can see death and dying differently and offer insight into different beliefs.

Conducting quantitative research would also help identify scales regarding the level of discomfort the staff had about the experience and their level of encouragement based on situations of a support person versus no support person. Also, contriving interventions to assist with applying this concept could provide more in-depth ways that nurses can use FPDR successfully and guide nurse educators in teaching nursing students.

Summary

Change is slow in developing FPDR in healthcare settings despite the support from some national organizations (Powers, 2018; Tennyson, 2019). It is important to understand nurses' experiences regarding this concept so that patient/family-centered care can occur and ways to educate future nurses properly are determined (Ng & Feldman, 2009; Powers, 2018; Tennyson,

2019). A hermeneutic phenomenology through a constructivist lens was used for this study. The six themes allowed for a deeper understanding of the meaning behind the nurses' lived experiences. The most voiced theme was support and communication, which felt critical if this concept was to be successful. Each situation is different, and allowing the family should be done on a case-by-case basis. Ultimately, the participants recognized the benefit of the concept but stressed that a support person is imperative for this success as well as communication with all those involved. Each participant demonstrated the competencies needed to be a competent nurse, which was reassuring when using the information to educate future nurses (AACN, 2021b).

With the information from this study, educators can develop methods to teach about FPDR through a constructivist lens that can benefit the student and help the educated student learn how to handle such delicate situations (AACN, 2021b; IOM, 2011; Ng & Feldman, 2009). Nursing students educated about FPDR can be instrumental in making a substantial difference in the future of nursing (Powers, 2018). These future nurses can benefit major stakeholders by understanding this concept. Nurses can also go out into the community and provide competent, emotionally-intelligent, holistic care and be instrumental in improving clinical practice and establishing well-thought-out policies that allow patients and families to receive supportive care (Toronto & LaRocco, 2018).

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APPENDICES

Appendix A: IRB Approval-Liberty

LIBERTY UNIVERSITY

INSTITUTIONAL REVIEW BOARD

February 9, 2023

Laurie Stone
[redacted]

Re: IRB Exemption - IRB-FY22-23-666 INVESTIGATING NURSES LIVED EXPERIENCES TOWARD FAMILY PRESENCE DURING RESUSCITATION TO ENHANCE THE FUTURE OF NURSING CURRICULUM

Dear Laurie Stone, [redacted],

The Liberty University Institutional Review Board (IRB) has reviewed your application in accordance with the Office for Human Research Protections (OHRP) and Food and Drug Administration (FDA) regulations and finds your study to be exempt from further IRB review. This means you may begin your research with the data safeguarding methods mentioned in your approved application, and no further IRB oversight is required.

Your study falls under the following exemption category, which identifies specific situations in which human participants research is exempt from the policy set forth in 45 CFR 46: 1 04(d):

Category 2.(iii). Research that only includes interactions involving educational tests (cognitive, diagnostic, aptitude, achievement), survey procedures, interview procedures, or observation of public behavior (including visual or auditory recording) if at least one of the following criteria is met:

The information obtained is recorded by the investigator in such a manner that the identity of the human subjects can readily be ascertained, directly or through identifiers linked to the subjects, and an IRB conducts a limited IRB review to make the determination required by 546.1 1 1 (a)(7).

Your stamped consent form(s) and final versions of your study documents can be found under

 the Attachments tab within the Submission Details section of your study on Cayuse IRB. Your stamped consent form(s) should be copied and used to gain the consent of your research participants .If you plan to provide your consent information electronically, the contents of the attached consent document(s) should be made available without alteration.

Please note that this exemption only applies to your current research application, and any modifications to your protocol must be reported to the Liberty University IRB for verification of continued exemption status. You may report these changes by completing a modification submission through your Cayuse IRB account.

If you have any questions about this exemption or need assistance in determining whether possible modifications to your protocol would change your exemption status, please email us at irb@liberty.edu.

Sincerely,

[redacted]

Administrative Chair of
Institutional Research Ethic
Office

Appendix B: IRB Approval-Ballad

[redacted] Road
[redacted]
[redacted]
www.[redacted]

DATE: March 17, 2023

TO: Laurie Stone
FROM: [redacted] Health System Institutional Review Board
FWA#: 00004221; IRB #: 00003204

STUDY TITLE: [2021056-1] INVESTIGATING NURSES LIVED EXPERIENCES TOWARD FAMILY PRESENCE DURING RESUSCITATION TO ENHANCE THE FUTURE OF NURSING CURRICULUM
IRB REFERENCE #:
SUBMISSION TYPE: New Project

ACTION: APPROVED
APPROVAL DATE: March 14, 2023
PROJECT EXPIRATION DATE: March 13, 2024
REVIEW TYPE: Full Committee Review

REVIEW CATEGORY: Expedited review category # N/A FULL BOARD REVIEW

Thank you for your submission of New Project materials for this research study. The [redacted] Health System Institutional Review Board has APPROVED your submission. This approval is based on an appropriate risk/benefit ratio and a study design wherein the risks have been minimized. All research must be conducted in accordance with this approved submission.

This submission has received Full Committee Review based on the applicable federal regulation.

The following items were included for review and acknowledged:

- cv with signature.pdf
- BHS FCOI Disclosure Form filled out 2.11.23.docx
- QUERIED_Informed Consent for [redacted]_Families Present During Resusitation_Stone 2021056.1 corrected.docx

- Waiver Request HIPAA Auth for research.pdf
- Waiver Request HIPAA Auth for research additional information.docx
- certification of investigator responsibility SIGNED.pdf
- Participant Demographics.docx
- Liberty University IRB approval email.pdf
- Human Subjects Protocol Submission Application.docx
- Submission Memo for IRB [redacted].docx
- preview irb approved liberty university.pdf
- QUERIED_UPDATED Jan 21 [redacted] IRB-process for approval 01.06.2023 and 02.11.2023.docx
- citiCompletionCertificate_12059480_54583717 [redacted].pdf
- citiCompletionReport_12059480_54583717 [redacted].pdf
- citiCompletionCertificate_12059480_54583720 [redacted].pdf
- citiCompletionReport_12059480_54583720 [redacted].pdf
- citiCompletionCertificate_12059480_54583719 [redacted].pdf
- citiCompletionReport_12059480_54583719 [redacted].pdf
- citiCompletionCertificate_12059480_54583718 for [redacted].pdf
- citiCompletionReport_12059480_54583718 for [redacted].pdf
- citiCompletionReport_10683406_53442155 from liberty.pdf
- RN licensure tenn.pdf
- state of tenn np licensure.pdf

The following documents were approved:

- QUERIED_Informed Consent for [redacted]_Families Present During Resusitation_Stone 2021056.1 corrected.docx
- Participant Demographics.docx
- Waiver Request HIPAA Auth for research.pdf
- Waiver Request HIPAA Auth for research additional information.docx
- Human Subjects Protocol Submission Application.docx
- QUERIED_UPDATED Jan 21 [redacted] IRB-process for approval 01.06.2023 and 02.11.2023.docx

Please remember that informed consent is a process beginning with a description of the study and insurance of participant understanding followed by a signed consent form. Informed consent must continue throughout the study via a dialogue between the researcher and research

participant. Federal regulations require each participant receive a copy of the signed consent document.

Please note that any revision to previously approved materials must be approved by this office prior to initiation. Please use the appropriate revision forms for this procedure.

All SERIOUS and UNEXPECTED adverse events must be reported to this office. Please use the appropriate adverse event forms for this procedure. All FDA and sponsor reporting requirements should also be followed.

Please report all NON-COMPLIANCE issues or COMPLAINTS regarding this study to this office.

Please note that all research records must be retained for a minimum of three years.

Based on the risks, this project requires Continuing Review by this office on an annual basis. Please use the appropriate renewal forms for this procedure.

If you have any questions, please contact [redacted] at ([redacted]) [redacted] or [redacted]. Please include your study title and reference number in all correspondence with this office. cc:

Appendix C: Invitation E-mail

Dear _____,

As a Ph.D. student at Liberty University in the Nursing Education department, I am asking for your assistance with a research study. The purpose of the study is to explore nurses' experiences with Family Presence during Resuscitation (FPDR). The study will utilize nurses in the ICU or ER areas, within all age groups and levels of experience that have witnessed or experienced FPDR. The goal of this study will work to improve how nursing students are taught about this topic and improve evidence-based practice within the nursing profession.

If you decide to take part in the study, this researcher will get in touch with you by email, phone call, or text. The study will occur at a time and date convenient for you. If you have any concerns about availability, please know it is my goal to make this as convenient for the participants as possible.

This study is not timed, and the length will depend on your input. Your participation is voluntary and will be kept confidential. This research study and researcher are not affiliated with the hospital. At no time will this information be used as part of any evaluation or seniority process.

If you are willing to participate, the following will be asked:

1. Schedule a time with the investigator to meet for an interview.
2. Complete a demographics form (5-10 minutes).
3. Participate in a face-to-face interview with audio/ recorded (60-90 minutes).
4. If needed, participate in a follow up interview to clarify any information. This can be done in person (15-30 minutes).
5. Review the data analysis results and give feedback to the researcher if needed (15-30 minutes).

If you wish to partake in this study, please email me, call, or text at the information below. Participants will be contacted to see if criteria are met for involvement in the study. A consent document will be provided at the time of the interview, along with the demographics form if you take part in the study.

All identifying information will remain confidential. Participants will receive a $25 Amazon gift card for their time.

Yours sincerely,

Laurie A. Stone
PhD Graduate Student
[redacted]

Appendix D: Flyer

PARTICIPANTS NEEDED FOR A STUDY INVESTIGATING

FAMILY PRESENCE DURING RESUSCITATION (FPDR)

WHO IS NEEDED?

-Registered Nurse (RN)
-Working in an ICU or ER (Adult or Pediatric) at [redacted] Health-[redacted] Medical Center
-Has experienced the concept of Family Presence during Resuscitation (FPDR)

The purpose is to gain knowledge from RNs about their perceptions about this concept. This information will be used for curriculum development to help future nursing students. Participants will be asked to complete a demographics form (5 – 10 minutes), participate in a face-to-face, audio-recorded interview (60 – 90 minutes), participate in a follow-up, in-person interview (15 – 30 minutes), and review data analysis results (15 – 30 minutes).

Consent information provided at the time of the interview. All information is confidential. The research and researcher are not affiliated with [redacted] Health-[redacted] Medical Center. Participants will be compensated with a $25 Amazon gift card for their time.

DATE/TIME/LOCATION:
-Flexibility is offered for dates and times
-One visit will be needed for interview
-Any follow-up can be done in person at your convenience
-Interview in a predesignated room on hospital site convenient to your work schedule

CONTACT INFORMATION:
-Laurie Stone-Nursing Education Doctoral candidate at Liberty University
-[redacted]

Appendix E: Pre-Study Planning

Pre-Study Planning	
Research Team Members	Principal Investigator: Laurie Stone Research Sponsors/Liberty Faculty Members: ---------- (----expert in Methodology, -------expert in Qualitative Research)
Checklist:	-Each member has been: -Oriented to the study -Goals of the study -Procedures used during the study
Role of Principal Researcher:	-Author of this study -Establish objectives, outcomes, questions, and follow up criteria -Ensure there is a link between the questions and the study's goal -Write introduction, open-ended questions, overview of the collection of data, and analysis -Purchase gift cards with my own funds -Complete the IRB approval for college and hospital -Print and post flyers -Send out emails for participation -Reach out to nurse managers to allow for announcements during staff meetings -Collect paperwork and flyers and store -Purchase supplies/food/drinks -Purchase computer software programs Dedoose and Zoom if needed -Ensure computer equipment and software programs are in working order before using

	-Make sure rooms for interview room is reserved -Make sure the rooms for the interviews are appropriate for the interview, free from distractions, at a comfortable temperature, and are clean and odor free. -Ensure there are storage areas available within the interview area for storage, and analysis process -Utensils such as pens, pencils, paper, highlighters, extension cords if needed, and other equipment is available before the interview process begins -Will practice interview skills and style to ensure open communication is done to avoid influencing the participants, or make the participant feel uncomfortable -Send and ensure nurses have received emails and follow up -Ensure demographics and informed consents are given to participants at interview -Ensure all informed consents and demographics are completed -Ensure all informed consents are locked in the secure file cabinet for security -Make sure all identifiable information will be removed and replaced with random generated numbers for confidentiality -Perform interviews, coding, themes, and computer input of the information. -Practice reflexivity on regular basis to ensure views and perceptions do not adversely influence the research process -Updates and changes of procedures are done if needed -Notifying research sponsors with any challenges, changes, or updates -Answer questions from perspective or actual participants when appropriate, or needed, regarding the research study.
Role of the Research Sponsors:	-Ensure that the primary researcher conducts the research in a valid, reliable, and proper manner -Will monitor the research process as well as the researchers' actions.

	-Correction will occur if needed

Appendix F: Consent

Title of the Study: Investigating Nurses Lived Experiences Toward Family Presence during Resuscitation (FPDR) to Enhance the Future of Nursing Curriculum

Principal Researcher: Laurie Stone, RN, MSN, bc-NP

Invitation

I am excited to invite you to be a part of this investigative study. To participate, you must have experienced the concept of Family Presence during Resuscitation (FPDR). To participate, you must be actively employed at the hospital where the study is conducted. You must also be a registered nurse that works in an ICU or ER environment. You will need to meet for a face-to-face interview. Your participation in this study is strictly voluntary and you may leave the study at any time.

Please read the entire consent form and contact the researcher if you have any questions or concerns.

What is the intent and expected use of the information of this study?

The intent of this study is to examine the meaning of the experiences of nurses' with FPDR. This will be a hermeneutic phenomenology study that will utilize a constructivism lens so that information can be utilized in the future to help prepare nursing students about this concept. It will also be used in the future to enrich nursing curriculums to equip students to provide holistic, evidence-based care when encountering stressful situations as seen with the family and resuscitation efforts.

What is expected if you participate in this study?

By agreeing to this study, you will do the following:

1. Schedule a time that is convenient for you with the researcher to meet for an interview.
2. Complete a demographic questionnaire (5-10 minutes).
3. A face-to-face interview will take place with audio/video recorded (60-90 minutes).
4. If clarification is needed, the participant will partake in a follow up interview that can occur in person, via online communication, phone, email, or text. This will be recorded and saved via Zoom, along with the face-to-face interview (15-30 minutes).
5. After the research is analyzed, the participant may review the results and give feedback if needed to the researcher (15-30 minutes).

How is this study beneficial?

Participants that partake in the study will be allowed to express their feelings, perceptions, and experiences about this concept. This action will allow the participant to reflect on their own journey about FPDR and allow for a wider understanding of the experience.

Long term benefits will allow student nurses to develop confidence and emotional intelligence when learning about uncomfortable situations. It will enhance their abilities to communicate and increase family, patient, and interdisciplinary healthcare team members satisfaction. Job satisfaction can be better addressed by lowering stress and burn out when dealing with complex situations.

What are the risks associated with this study for me?

Participants may experience stress when discussing potentially emotional information. However, if this does occur, counseling contacts will be available.

Injury or Illness: Disclaimer: This researcher or Liberty University will not provide any medical treatment or financial compensation if injury or illness occurs during this research study. This does not waive any of your legal rights nor release any claim you might have based on negligence.

Will my personal information and feedback be safe?

All information from participants, or about the participants will be kept secure and confidential. Information within the reports will contain pseudonyms and will not offer any information where a subject can be identified. Interviews will be done in a secure location where conversations are not overheard. All research information, documentation, interviews, analysis, and conclusion will be stored securely where only the researcher has access. Interviews will be done in a secure location where conversations are not overheard.

- Zoom will be used by the research for recording. This will be password protected. Once the recording has concluded, the password protected, encrypted interview information will be available to the researcher only. Any recordings from Zoom that were saved on the Cloud will be deleted at the conclusion of the study.
- Zoom offers a feature where transcripts are completed from the interview. This information will be saved on a password protected computer and the software program, Dedoose, will be used to download pertinent information for the study. Each participant's study information will be saved using a random number generator to identify the participant without any recognizable information. An Excel spreadsheet will be used for demographic information, and this will be saved on the same password protected, secure computer for the other collected data.
- Participants consents will be stored in a locked cabinet at the researcher's office. This will ensure that identifying information is not noted. Only the researcher will have access to these items. Signed consents, as well as interview information, study results, and demographics will be stored for five years. However, digital recording information will be destroyed at the study's completion.
- Since a purposeful convenience sample is being used, there are limits to confidentiality that can occur. This is noted if the participant works in the same area as another participant or was present for the same resuscitation event.

Will there be compensation if I participate in the study?

To compensate for the participants time, an Amazon gift card for $25 gift card will be given to the participants of this investigation.

Are there costs that I will incur to be a part of the study?

While the participant may need to drive to the interview and pay for their gas, the interview will be located on hospital grounds. This is being done so that it is convenient for the subject when going to or getting off work. Thus, there should not be any expense to the participant.

Are there any conflicts of interest for the researcher?

There are no conflicts of interests to disclose.

Do I have to do or complete the study?

Your participation in this study is strictly voluntary. While we hope that you can participate, it is your decision to participate or complete the study. This will in no way influence your work environment, your relationship with anyone, or relationships with the hospital or Liberty University.

What do I need to do if I need to leave the study before it is done?

It is voluntary for you to complete the study. If you wish to leave the study, please contact the principal investigator with your intentions. Please use email or phone to contact the researcher. Any information that you may have given at the time of your withdrawal will be destroyed and will not be part of the study.

If I have questions or concerns, who do I contact?

Laurie Stone is the principal investigator of this study. You may reach out to Laurie if needed. You may reach Laurie via cell or text at [redacted] or email [redacted] However, if you have questions later, you may contact the researchers sponsor Dr. [redacted] at [redacted]

If there are questions about the rights of the research participant, who do I contact?

While the researcher, Laurie Stone, is happy to assist, you are welcome to contact the Institutional Review Board at Liberty University at 1971 University Blvd., Green Hall Ste. 2845, Lynchburg, VA 24515 or email at irb@liberty.edu. If needed, **you are also encouraged** to contact the Institutional Review Board with [redacted] at [redacted] Road, [redacted], or email at [redacted]

Disclaimer: The Institutional Review Board (IRB) is tasked with ensuring that human subjects research will be conducted in an ethical manner as defined and required by federal regulations. The topics covered and viewpoints expressed or alluded to by student and faculty researchers are those of the researchers and do not necessarily reflect the official policies or positions of Liberty University or [redacted].

Your Consent

By signing this document, you agree to be in this study. Make sure you understand what the study is about before you sign. You will be given a copy of this document for your records. The researcher will keep a copy of the study records. If you have any questions about the study after you sign this document, you can contact the study team using the information provided above.

I have read and understood the above information. I have asked questions and have received answers. I consent to participate in the study.

☐ The researcher has my permission to audio-record/video-record me as part of my participation in this study.

_____

Printed Subject Name

_____

Signature & Date

Appendix G: Demographics Questionnaire

Participant Demographics	
Gender	• Male • Female
Race/Ethnicity	• White/Non-Hispanic • Black/African American • Hispanic/Latino-a • Asian/Asian American • Pacifica Islander or Native Hawaiian • Native American • Other (please specify)
Current Age	• 20-25 • 26-29 • 30-34 • 35-39 • 40-44 • 45-49 • 50+
Marital Status	• Single • Divorced • Married • Widow/Widower
Years of Experience as a Nurse	• 0-1 • 2-4 • 5-9 • 10+
Current area of Employment	• Intensive Care Unit (Type: Surgical, Cardiac, Neuro, Peds, Other): _____ • Emergency Department (Type: Adult, Peds): • Other (please specify) _____
Numbers of Resuscitations Witnessed with Family Present	• 1 • 2 • 3-5 • 6 +
Number of Resuscitations Witnessed without Family Present	• 1 • 2 • 3-5 • 6+

Appendix H: Family Presence during Resuscitation Questions/Interview Guide

1. What are your experiences regarding FPDR?
2. What stands out about your experiences with FPDR?
3. Tell me more about your experiences regarding FPDR?
4. Think of a time when you experienced FPDR and describe what you saw, felt, and heard in as much detail as possible?
5. You mentioned _____, tell me what that was like for you?
6. You mentioned _____, describe that in more detail for me please?
7. Is there anything else you would like to share regarding FPDR during your nursing career?

Appendix I: Qualitative Interview Guide

General Information Questions			
Date	Month:	Day:	Year:
Time	Start time:	End time:	
Location			
Method	Face-to-face (with audio recorded through Zoom)		
Researcher Name/Email			
Participant			
Notes			

Appendix J: Statements and Horizontalizations

Horizontalizations	Significant Statement-Paraphrased
Done correctly-helps families	If done correctly, helps families
Studies show it helps with grief	Studies about FPDR show it helps family's grief
Peds have families more than adult	Ped codes typically have parents present
	FPDR different with ped than adult and family often brought back
	Even in earlier days family was present for peds
	FPDR tends to be pushed with peds and not so much for adults
FPDR lets families see we are trying to help	FPDR helps family see we did everything we could
	Code not compatible for life but continued for family to arrive-see we tried
	FPDR helps families to see what was done to help
	Family see that we are really trying to help their loved one
	Family admit it was hard but glad it was offered
Certain situations can make it traumatic for families	Patient with gunshot to head-traumatic for all
	Dad was alone and no one with him to help explain
	Trauma worse than medical-cracking open chests, etc.
	Some FPDR can be traumatic for the family
	Seeing a code can be scary for the family
	Family can cause distraction if they

	cannot handle it
	Chaplains help assess if the family needs to be there or not
	Assessing if the family should come back or not
	FPDR can be emotional for family
	Some people can handle witnessing it better than others
	Case by case-not all are the same
Waiting for family to arrive to help them	Code not compatible for life but continued for family to arrive- see we tried
	Family admit it was hard but glad it was offered
Explaining helped family and their grief	Dad was alone and no one with him to help explain
	Chaplain not available, so staff explained-Dad was grateful
	Explaining to family helped them with their grief
	Family appreciated support and explanation from staff
	Interaction between staff and family better with explanation
	A support person is always needed to help explain
	Staff members explaining helped family understand
	Family often confused if the situation is not explained
	Communication with the family helps avoid distraction
	Supporting and explaining helps the family
	With communication, the family was appreciative

	Family admit it was hard but glad it was offered
Support person to help	Dad was alone and no one with him to help explain
	Chaplain not available, so staff explained-Dad was grateful
	A support person is always needed to help explain
	Support person there for the family so the staff can focus on the patient
	Sometimes family needs to be removed to avoid hindering care
	Chaplains support the family so the team can do their job
	Staff members explaining helped family understand
	Chaplains help assess if the family needs to be there or not
	Assessing if the family should come back or not
	A support person helps family understand it better
	Someone needs to be present to help family
	Communication with the family helps avoid distraction
	Supporting and explaining helps the family
FPDR tends to be pushed with peds and not so much for adult	Ped codes typically have parents present
	FPDR different with ped than adult and family brought back
	Even in earlier days family was present for peds
	FPDR tends to be pushed with peds

	and not so much for adults
FPDR helps them say goodbye	Code not compatible for life but continued for family to arrive-see we tried
	FPDR allows family to say goodbye
	A lot of good experiences with FPDR
	Family admit it was hard but glad it was offered
Family begging and yelling can be hard	Calming family is important
	Staff seeing family can make it hard
	Family begging and yelling can be hard
	Distractions from yelling are hard for the staff
	Hearing family grieve can be a distraction from your task
	Everyone has a role/task in a code-family can get in the way of that
	Seeing patient as a human when the family is there can distract from care
	Family can cause distraction if they cannot handle it
	Chaplains help assess if the family needs to be there or not
	Assessing if the family should come back or not
	Family needs to be stable to avoid hindering care
	Someone needs to be present to help family
	If family are emotional, it can distract the team
	Family making a scene and hard

	to concentrate
Family appreciates support and communication	Dad was alone and no one with him to help explain
	Chaplain not available, so staff explained-Dad was grateful
	Explaining to family helped them with their grief
	Family appreciated support and explanation from staff
	Interaction between staff and family better with explanation
	Even when resuscitation is hard it needs to be explained to family
	Allowing family to be present, they expressed their gratitude
	Support person there for the family so the staff can focus on the patient
	Staff members explaining helped family understand
	A support person helps family understand it better
	Family often confused if the situation is not explained
	Someone needs to be present to help family
	Supporting and explaining helps the family
	With communication, the family was appreciative
	Family admit it was hard but glad it was offered
Asking. Family or staff. Some may want to and some not	Asking staff first-not just bringing family back
	Asking family members-May or may not want to come back
	Seeing a code can be scary for

	the family
	Assessing if the family should come back or not
	Some people can handle witnessing it better than others
	Family admit it was hard but glad it was offered
	Case by case-not all are the same
	Family not even there yet and brought back without asking staff
Bluntness in word of dead/ Communicate	Bluntness of doctor and using word dead
	Use words the family understands-avoid confusion
Using proper words helps avoid confusion	Bluntness of doctor and using word dead
	Use words the family understands-avoid confusion
Trauma can be worse than medical	Patient with gunshot to head-traumatic for all
	Trauma worse than medical-cracking open chests, etc.
	Case by case-not all are the same
Calming down family	Calming family is important
	Family begging and yelling can be hard
	Distractions from yelling are hard for the staff
	Family think it is like what they see on TV and get confused
	Family hears code blue and freak out

	Sometimes family needs to be removed to avoid hindering care
	Hearing family grieve can be a distraction from your task
	Everyone has a role/task in a code-family can get in the way of that
	Chaplains support the family so the team can do their job
	Family can cause distraction if they cannot handle it
	Chaplains help assess if the family needs to be there or not
	Assessing if the family should come back or not
	Family needs to be stable to avoid hindering care
	A support person helps family understand it better
	FPDR can be emotional for family
	Family often confused if the situation is not explained
	Someone needs to be present to help family
	If family are emotional, it can distract the team
	Communication with the family helps avoid distraction
	Some people can handle witnessing it better than others
	Supporting and explaining helps the family
	Family making a scene and hard to concentrate
Staff seeing family can be hard	Asking staff first-not just bringing family back
	Staff seeing family can make it

	hard
	Even when resuscitation is hard it needs to be explained to family
	Family begging and yelling can be hard
	Distractions from yelling are hard for the staff
	Staff seeing the family's grief can be hard for staff
	Hearing family grieve can be a distraction from your task
	Everyone has a role/task in a code- family can get in the way of that
	Seeing patient as a human when the family is there can distract from care
	Family can cause distraction if they cannot handle it
	The team needs to focus on the patient
FPDR has helped with closure	FPDR helps family see we did everything we could
	Allowing family to be present, they expressed their gratitude
	FPDR gives some closure for the family
	A lot of good experiences with FPDR
	Family gets closure when present
Family distractions can make it hard to focus	Calming family is important
	Staff seeing family can make it hard
	Family begging and yelling can be hard

	Distractions from yelling are hard for the staff
	Sometimes family needs to be removed to avoid hindering care
	Hearing family grieve can be a distraction from your task
	Everyone has a role/task in a code-family can get in the way of that
	Seeing patient as a human when the family is there can distract from care
	Chaplains support the family so the team can do their job
	Family can cause distraction if they cannot handle it
	Chaplains help assess if the family needs to be there or not
	Assessing if the family should come back or not
	Family needs to be stable to avoid hindering care
	A support person helps family understand it better
	FPDR can be emotional for family
	If family are emotional, it can distract the team
	The team needs to focus on the patient
	Communication with the family helps avoid distraction
	Family making a scene and hard to concentrate
Seeing family's grief can be hard to see	Staff seeing family can make it hard
	Family begging and yelling can be hard
	Distractions from yelling are hard

	for the staff
	Staff seeing the family's grief can be hard for staff
	Hearing family grieve can be a distraction from your task
	Everyone has a role/task in a code- family can get in the way of that
	Seeing patient as a human when the family is there can distract from care
	Family can cause distraction if they cannot handle it
Family gets closure when they are present	FPDR helps family see we did everything we could
	FPDR helps families to see what was done to help
	Allowing family to be present, they expressed their gratitude
	FPDR gives some closure for the family
	A lot of good experiences with FPDR
	Family gets closure when present
Family hears code blue and freak out	Family think it is like what they see on TV and get confused
	Family hears code blue and freak out
	Sometimes family needs to be removed to avoid hindering care
	Chaplains help assess if the family needs to be there or not
	Assessing if the family should come back or not
	FPDR can be emotional for family
	Family often confused if the situation is not explained

	Someone needs to be present to help family
	If family are emotional, it can distract the team
	Communication with the family helps avoid distraction
	Some people can handle witnessing it better than others
	Family making a scene and hard to concentrate
Everyone has a role and task in a code and family can get in the way of that	Staff seeing family can make it hard
	Distractions from yelling are hard for the staff
	Support person there for the family so the staff can focus on the patient
	Sometimes family needs to be removed to avoid hindering care
	Hearing family grieve can be a distraction from your task
	Everyone has a role/task in a code-family can get in the way of that
	Seeing patient as a human when the family is there can distract from care
	Chaplains support the family so the team can do their job
	Family can cause distraction if they cannot handle it
	Chaplains help assess if the family needs to be there or not
	Assessing if the family should come back or not
	Family needs to be stable to avoid hindering care
	FPDR can be emotional for

	family
	If family are emotional, it can distract the team
	The team needs to focus on the patient
	Communication with the family helps avoid distraction
	Family making a scene and hard to concentrate
Seeing the patient as a human when the family is there can distract from care	Staff seeing family can make it hard
	Everyone has a role/task in a code-family can get in the way of that
	Seeing patient as a human when the family is there can distract from care
	The team needs to focus on the patient
Chaplains help assess the family	Sometimes family needs to be removed to avoid hindering care
	Chaplains support the family so the team can do their job
	Chaplains help assess if the family needs to be there or not
	Assessing if the family should come back or not
	A support person helps family understand it better
	Family often confused if the situation is not explained
	Someone needs to be present to help family
	Supporting and explaining helps the family
Some people can handle	Asking family members-May or

witnessing it better than others	may not want to come back
	Calming family is important
	Seeing a code can be scary for the family
	Family can cause distraction if they cannot handle it
	Chaplains help assess if the family needs to be there or not
	Assessing if the family should come back or not
	FPDR can be emotional for family
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	Case by case-not all are the same