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Policy Development: Family Presence during Resuscitation (FPDR) Procedure

Laila AL-Daken[1], Ahmad Rayan[2], Hana Abu- Snieneh[3], Ghadeer Al-Dweik[4], Maysoun Atoum[5], Atif Katib[6], Fathieh Abu Mogli[7]

[1]Adult Health Nursing Department, Nursing Faculty, Zarqa University, Zarqa, Jordan

[2]Psychiatric and Mental Health Nursing Department, Nursing Faculty, Zarqa University, Zarqa, Jordan

[3]Nursing Faculty, University of Jordan, Amman, Jordan

[4]Nursing Faculty, Applied Science University, Amman, Jordan

[5]Nursing Faculty, Hashemite University, Zarqa, Jordan

[6]Augusta Victoria Hospital, Jerusalem

[7]Faculty of Nursing, University of Jordan, Amman, Jordan

Email address

lailadaken@ hotmail.com (L. AL-Daken), Ahmed_rayan87@yahoo.com (A. Rayan), Abusnieneh13@hotmail.com (H. Abu- Snieneh), ghadeerdweik@yahoo.com (G. Al-Dweik), Mays_atoum@hotmail.com (M. Atoum), Atif_rimawi@yahoo.com (A. katib)

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Abstract

Purpose. The purpose of this paper is to develop a policy regarding family presence during resuscitation in Jordan. Methods. Policy context, issue statement, stakeholders, identification and of evaluation of policy alternatives were described. Results. The recommended solution allows family members of all patients undergoing resuscitation to be given the option of presence at the bedside during CPR, and family members decide if they want to attend CPR situation or not. Conclusion. Policy makers should consider developing specific policies regarding family members presence during resuscitation of their beloved one in culturally and legally acceptable manner.

Keywords

Resuscitation, Family Presence, Policy, Problem, Critical, Procedure, Jordan

1. Introduction

Cardiopulmonary resuscitations are sudden and traumatic clinical events that frequently jeopardize patients to death or permanent damage in health status. Family presence during resuscitation (FPDR) is defined as "the presence of family in the patient care area, in a location that affords visual or physical contact with the patient during resuscitation events. It involves the selective, monitored admission of one or two family members into the care area while their loved one is undergoing resuscitation" (Bradley, Lensky, & Brasel, 2011). Historically, many practitioners thought that FPDR was inappropriate and injurious to families, as well as bothersome or dangerously distracting to clinicians. Recently, however, many institutions have developed formal policies and protocols to support the practice, and FPDR has been the subject of intense research. Based on literature review, multiple professional societies have endorsed FPDR, and FPDR has gradually become more accepted by clinicians. Not only the time period of the resuscitation can be the chance for family members to see a patient before death, but families are sometimes called upon to make end-of-life or other critical medical decisions during this highly emotional event. Allowing family presence during resuscitation (FPDR) has been proposed as a way to better support the emotional needs of family members and facilitate the understanding of healthcare professionals' decisions when they announce the

stoppage of resuscitation. In fact, the end of life issues are very crucial for a range of reasons, including family involvement in decision making, meeting family needs at death and in after death or bereavement care (Eshah & Rayan, 2015; Myatra, et al., 2014; Truog, Meyer & Burns, 2006). Recently, the issue of end of life and family presence during resuscitation have gained a debate and more interest in the international literature (Engelhardt, 2008; Strasen, Van Sell, & Sheriff, 2015; Truog, Meyer, & Burns, 2006).

In Jordan a study conducted by (Masa'Deh, Saifan, Timmons & Nairn, 2014) to explore family members' needs during resuscitation in adult critical care settings; the findings in this study show that most of the family members wanted to stay beside their loved ones during CPR; many of them wanted this option for religious purposes. Another qualitative study conducted in Jordan by Bashayreh, Saifan, Batiha & Abu Ruz (2013) found that majority of the professionals in this study stated that they would allow FPDR if the family members have a medical background, or if they are well educated about CPR. Also, the participants in the study stated that they need a very clear and comprehensive policy about including the family in cardiopulmonary resuscitation process. This paper aims to use the step wise process (stage sequential model) to develop policy about the presence of family during the cardio pulmonary resuscitation procedure in Jordanian hospitals. Stage sequential model is an approach used to understand policy process which focuses on clarifying policy problem so that it gains the attention of stakeholders and policymakers; in this context, the policy problem may have many competing alternatives. Based on good data and evidences about what works better among these alternatives, the best policy option is adopted (Mason, Leavitt, & Chaffee, 2007). This model includes dynamic series of stages which include several essential activities.

2. Policy Context

Problem Identification

The first stage represents the identification of the policy problem (Mason, Leavitt, Chafee, 2007). In which a situation that produces need or dissatisfaction among people for which relief is sought through governmental action (Anderson, 1997). In this stage problem is refined to a policy issue, taking in consideration to value of the stakeholders which plays a large role in determining the amount of political interest that the issue will generate (Mason et al. 2007). This will help in identification of policy options and analysis of these options (Mason et al. 2007). The presence of family in the patient care area during resuscitation events is a matter of current debate among health care professionals in many communities; family presence is highly recommended by many health organizations worldwide for several reasons including patient and family rights. However, it is still a common practice to perform resuscitations in Jordan without giving the family members the option to attend. In fact, no clear policies or guidelines have been identified to supports family presence during resuscitations in Jordanian hospitals. Also, few published studies about family presence during resuscitation have been conducted in Jordan. Bashayreh, et al, (2013) revealed that health care providers need a very clear and comprehensive policy about including the family in cardiopulmonary resuscitation process; therefore, it is the time to formulate and develop a policy that is applicable to allow family presence during resuscitation in Jordanian Hospitals.

The most common oppositions to family presence during resuscitation are related to different issues. The fear is that family member's presence can increase the code team's anxiety and hindering their performance (Laskowski-Jones, 2007). In addition, family members may misinterpret some interventions, leading to the assumption that the code team is incompetent (Higazee, Rayan, & Khalil, 2016; Laskowski-Jones, 2007; Mian, Warchal, Whitney, Fitzmaurice, &Tancredi, 2007). Furthermore, lack of knowledge regarding resuscitation activities can add to the family member's distress (Cole, 2000). Another concern is for the safety of the family member. An emotional family member may faint, cause disruption, or be inadvertently exposed to blood or body fluids or contaminate equipment (Laskowski-Jones, 2007). Coping mechanisms of family members may lead to psychological trauma (Halm, 2005; Rayan & Ahmad, 2016; Rayan, & Dadoul, 2015). These reactions can interfere with resuscitation efforts.

Currently, all hospital departments in Jordan do not routinely offer relatives the chance to witness attempts at resuscitation of their loved ones, and hospitals have no written policy on the care of bereaved relatives that guide this ethical issue. The literature shows that there is a difference of opinion between the public and health professionals (Cornelius & McLauchlan, 1995; Rayan, Qurneh, Elayyan, & Baker, 2016). Some relatives have expressed strong feelings about wanting to be present during resuscitation one. However, the views of doctors and nurses are often opposite to the views held by the relatives (Doyle, 1987).

3. Background

3.1. Sociocultural Context

Strong bond between family members provides sources of support comfort for patients and the very closest relatives. Keeping families up to date about the prognosis of their loved one would increase trust in health professionals and would improve families' acceptance of the final outcomes of the treatment process (Masa'Deh, et al, 2014). However, some of health care providers indicated the difficulties of controlling the CPR situation with presence of visitors around the patient and refuse to keep family during resuscitation. So, the authors of this paper suggested developing policy and finding alternative solutions to deal with these issues rather than refusing them at all.

3.2. Moral and Ethical Context

To evaluate the ethical implications of FPDR, The authors of this paper adopt (Beauchamps and Childress framework,

2013) which uses four principles to describe the moral and ethical factors and its contributions to the problem: Nonmaleficence refers to the avoidance of harm; beneficence refers to provide benefit for others; respect for persons/autonomy refers to the right to make meaningful choices; and justice to the provision of fair treatment or interventions. Each ethical principle is presented from the point of view of the patient, family, and health care team. There are examples in specific situations where nonmaleficience indicates that the health care team should exercise caution and carefulness in allowing family presence, for instance if family members are aggressive, abuse is suspected, or there are other signs that their presence will be harmful to the patient (Ardley, 2003). However, such exceptions are not sufficient to justify exclusion of family members as the default option during resuscitation. Regarding Beneficence, unconscious patients undergoing resuscitation are unlikely to benefit from FPDR. However, FPDR has the potential to help family members by providing them with the reassurance that "everything is being done" by giving an opportunity for closure, and by allowing a final goodbye so as to plan the best death possible, when death cannot be reversed by CPR (Kritek, 2013; Lederman, Garasic & Piperberg, 2013).

Respect for persons (autonomy), birth and death are personal life events. Patients and families should, therefore, have as much autonomy as possible in matters concerning them. Refusing a family members request to see their loved one in the moments prior to death, or allowing a patient to die without a loved one nearby if that would be their wish, contravenes the right to autonomy.

The principle of justice encourages equal, reasonable access to health care and social resources including interventions such as FPDR. Multiple researches that have evaluated FPDR have demonstrated that more family members would accept the offer to be present than request it if not offered (Masa'Deh, et al, 2014; Jabre, Belpomme, Azoulay, et al, 2013, Dudley, Hansen, Furnival et al, 2009). This implies that without the systematic offering of FPDR to all families, only those family members who have the confidence and authority to specifically request to be present will have the opportunity to do so.

3.3. Health Context

As mentioned in The American Heart Association's (AHA) 2000, the Advanced Cardiac Life Support Provider Manual recommends to "considering the presence of the patient's family and loved ones during resuscitation attempts p.670." However, AHA found that only 5% of respondents work in units with written policies for family presence. If family presence during resuscitation becomes regular, code teams must generate a clear policy for their facility to enhance the process of resuscitation.

3.4. Legal and Political Context

To date, no nursing publications have described litigation associated with family presence; this may be due to the families gaining trust in staff members through observing their actions (Martin, 2010). In fact, many medico-legal conflicts are more the result of humble communication than issues of technique and practice (Kianmehr, Mofidi, Rahmani, & Shahin, 2010). Bashayreh, & Saifan (2015) showed in their study that the relatives were combined in their perceptions that close relatives should be allowed to presence during resuscitation. All relatives thought that only one to two patients' relatives should be allowed to be present at the same time with the possibility of exchange between relatives.

4. Issue Statement

Do family members have the option to be present during the resuscitation process of their patients and does the family presence have a positive or negative influence on the patient, family, and staff during resuscitation?

5. Policy Goals and Objectives

The desirable objectives from the legislation of the FPDR policy include the following: Advocating FPDR and fostering trust between the family members and the healthcare providers; increasing collaboration; helping families to understand the patient's condition; fostering more professional attitudes of healthcare providers; and helping meet family's/patient's spiritual and emotional needs (Doolin,Quinn, Bryant, Lyons, & Kleinpell, 2011).

6. Stakeholders

The primary stakeholders are: Ministry of Health, Jordan Nurses and Midwives Council, Jordan medical syndicate, Jordan nurses and midwives syndicate, accreditation organizations, nursing educators, researchers and the quality committee in the hospital which is responsible for developing the new policies. Other persons can be affected by (FPDR) policy are families of patients, health care professionals and providers (including nurses, physicians, anesthetist, social workers) and patients themselves.

Knowing that families are central to any debate about FPDR (McGahey-Oakland, Lieder, Young, & Jefferson, 2007). Not all family members may wish to witness resuscitation if offered, with a rate of 80% acceptance in the most recent study (Jabre et al., 2013), General surveys of the public are similarly supportive for the idea of FPDR (Mazer, Cox, & Capon, 2006). Many health organizations took the responsibility for support in several policy development issues. Health care professionals always disagree regarding their preferences of FPDR, physicians tend to be more reluctant to support FPDR than nurses, citing concerns about interference of family members with the resuscitation, fear of psychological trauma to family members, and medico legal consequences (Demir, 2008). A recent international poll found less than 40% of physicians favored the practice (Colbert & Adler, 2013). However, nurses more than doctors

want patients to provide advanced directives for family presence (Chapman et al., 2011). A number of surveys and qualitative studies have asked survivors of resuscitation what their preferences regarding FPDR would be, all of which were supportive of the practice (Leung & Chow, 2012). One study found elderly inpatients who had not undergone resuscitation to also be supportive (Albarran, Moule, Benger, McMahon-Parkes, & Lockyer, 2009). Patients were also aware that health care teams may need to exercise discretion in which, if any, family members may be present (Mcmahon-Parkes, Moule, Benger, & Albarran, 2009).

6.1. Ethical Issues

Ethical approval for conducting the study was obtained from the responsible persons in the faculty of nursing at the University of Jordan. As it is a new research study, opinions of stakeholders were sought after obtaining their consent and explaining to them that their names will not be included in the study and only the findings of the study will be published. The opinions of stakeholders were identified using thematic analysis after transcription of their opinions regarding the narrative data was completed.

6.2. Interviews with Stakeholders

Interviews were performed with different stakeholders including managerial representatives, representatives from patients and families were also interviewed. In addition, external stakeholders were interviewed such as representative from nursing educators and researchers. These interviews aimed at obtaining data regarding their perception and attitude toward family presence during resuscitation in Jordanian hospitals, explaining the potential reasons for the problem in Jordan, describing the consequences of this problem on both the quality of care and organizational development, discussing the need for developing a new policy knowing that there is no policy regarding FPDR in Jordanian hospitals, describing the obstacles for implementation and adoption of the new policy and finally, providing suggestions for appropriate development and implementation for the new policy in order to provide the best end of life care for patients and families.

Analysis of the interviews with all representatives revealed that actually there is no policy applied in Jordan regarding FPDR and this make patients and families unsatisfied about the provided end of life care. Interviews with conscious patients in the ICU and their families reflected their preference to be present during resuscitation for many reasons: they feels with safety and protection, their presence will encourage, support and give strength and ability to fight for life, they add this will make families more comfortable in end of life care and that everything possible have done for their loved one. Both patients and families prefer to have a written policy regarding their option for FPDR in Jordanian hospitals.

An interview was conducted with the vice director of nursing in a large hospital in Jordan regarding the FPDR, she agreed with idea but she preferred that limited number of family members to be present and those members should be aware of the condition of their patient from the physician and she also prefer that social workers to be available with family during the resuscitation process to support them psychologically, she stated that *"enough space should be available for the family so they will not interfere with the procedure."* She also urges the need for a written policy which includes details about the procedure for FPDR for two reasons: "*to assure consistency in applying the policy in all hospital units and to protect all health care providers who will be involved in any resuscitation process'* furthermore, she suggested that this policy should be developed by representatives from health care professionals in the multidisciplinary teams".

Another interview with an educator who is also a researcher in this field was conducted, she stated that: *"if the presence of family is going to interfere with the health care professionals function and the success of the resuscitation process, I would prefer the family to stay away from the scene because they set as barriers by their crying, shouting, etc. Unless the family member is one of the health care providers who know exactly what is going on and a one who is presence will contribute to the success of the resuscitation in this case I agree with the family presence. She also added that she prefer if there will be a written policy it will be helpful to provide guidance for the family presence protocol, the policy should state that family must remain away and be silent during their presence, they should take isolation precaution if there is a contagious disease, they should be prepared by the social workers for unexpected events and they should also sign a contract not to harm any of the health care professionals or interrupt the resuscitation process in any way".*

From previous interviews we can understand that several supporting stakeholders emphasized the importance of FPDR; they also urge the need for developing a written policy that should clarify all issues related to this decision. Then a plan should be specified to train health care professionals to implement effectively the policy in order to satisfy patients and family needs.

7. Policy Options and Alternatives

In this stage the information on the issue is collected, analyzed, and disseminated, and the final decision is made (Mason et al. 2007). To identify our alternatives, brainstorming and obtaining solutions by interviewing experts, researchers, policy makers, and key persons from nursing organizations were done. Also, considering the status quo or no-action alternative was also taken into consideration.

The first alternative is doing nothing or staying on the status quo option, this option will not make any modification on the current situation, and this means that patient families will not present during the resuscitation procedures. *The second alternative* is: Family members of all patients

undergoing resuscitation should be given the option of presence at the bedside, FPDR should always be optional and never mandated and the family members decide if they want to attend CPR situation or not. *The third alternative* is: Allowing the family presence during resuscitation decision varies from family to family. Health care worker decision and CPR team decision are considered to allow or refuse the presence of family during resuscitation.

8. Evaluation of Policy Alternatives

8.1. Evaluation Criteria

Comparison of policy alternatives will be based on five criteria including effectiveness, political feasibility, fairness, cost, and social acceptability, the selection of criteria was based on their relevance to family presence during resuscitation. The most important criterion is the effectiveness of policy by achieving the desired goals. Other important criteria include political feasibility, and cost of implementing solutions. In addition, fairness in distribution of benefits is also important. Finally, social acceptability which refers to being the proposed solution popular and acceptable among families and CPR team is considered.

8.2. Analysis and Comparison of Policy Alternatives

Alternative 1. The first alternative is the staying on the status quo or no-action or modification is suggested for the current situation, and this means that patient families will not present during the resuscitation procedures.

Pros

Refusing family presence during resuscitation may achieve its benefit from the view of some medical and health care providers; one of the reasons for medical staff opposing the family presence during resuscitation concept is a fear that the presence of family members might adversely affect resuscitation procedures. There is concern that family presence might hinder, impede, interfere with or obstruct resuscitation efforts; that the resuscitation process might be rendered less effective, and/or might disrupt the flow of the resuscitation attempt.

Sights and sounds in and around the resuscitation were identified as contributing to the negative experience; increased noise was the main disadvantage of family presence during resuscitation. Additionally, family members contribute on the need for concentration and the need for control in the situation, the presence of several persons in resuscitation room was expected to affect the health professionals' concentration and performance as mentioned in the previous interview section (the interview with researcher).

In summary, the advantages of keeping the situation as it is by not allowing the family to be present during resuscitation is not clearly documented in the literatures, however, some health care providers prefer not to involve family for many reasons as presented above but this is not enough evidence to prevent the family from their rights to be present with their loved patient during such difficult situation. According to the evaluation criteria the pros for this option that it is politically feasible.

Cons

During CPR situation the assigned nurse shouted "Patient has cardiac arrest", "call CPR team", this action increases family members' feelings of helplessness, anxiety, panic, and guilt. Keeping the situation as it is by not allowing the family to be present during resuscitation may prevent the family from being able to care for a loved one during his or her final moments, even in small ways, and to say good-bye can reduce those feelings and help family members through the grieving process. According to the previously mentioned evaluation criteria this option is not effective, unfair, and not socially accepted.

Alternative 2. Family members of all patients undergoing resuscitation should be given the option of presence at the bedside. FPDR should always be optional and never mandated and the family members decide if they want to attend CPR situation or not.

Pros

Family members are those individuals who are relatives or significant others with whom the patient shares an established relationship. Family presence during resuscitation and invasive procedures is beneficial to patients, families and staff. Meeting psychosocial needs in a time of crisis exemplifies care driven by the needs of patients and families.

This alternative is more comprehensive and considers the variation among patients families for example if family members request is not to attend the CPR situation; their request must be respected because some time family presence will be harmful psychologically and they can't tolerate such difficult emotions (Ardley, 2003).

Its suitable and ethical alternative; patients families have a right to decide and identify their desire to stay with their lovely one at such difficult moments, It is feasible alternative; the resources needed to implement this alternative are available in the hospitals; it requires educational program to nurses and health care providers about how to communicate and support family in the CPR situation. Implementing the policy in this way increases the family satisfaction, comfort and support. So it is effective by meeting the policy objectives, fair for both patients and families; it is more socially acceptable than the previous option. It could be cost effective if the resuscitation process will be maintained and not interrupted by family.

Cons:

No disadvantage, this alternative seems to be highly effective and meets the policy objectives. It is Suitable, Flexible and Feasible one. But it might not be cost effective if interruption or family members cause harm for health care providers or damage in hospital resources.

Alternative 3. Allowing the family presence during resuscitation decision varies from family to family, health care worker decision and CPR team decision are considered to allow or refuse the presence of family during resuscitation.

Pros:

This alternative is politically feasible and cost effective; in some conditions health care team should exercise caution and carefulness in allowing family presence, for instance if family members are aggressive, abuse is suspected and their presence will be harmful (Ardley, 2003), in this situation health care providers estimate a bad response from family if the patient die during resuscitation; so they decide to refuse family presence.

Cons

This alternative is not effective because does not meet the policy objective, it is not practical and not ethical because its limitation of autonomy and justice, in practice its difficult from health care providers to discriminate between patients families by allowing some to present and preventing others; this decision may lead to clash between families and staff and between families themselves, it is also not fair and not socially accepted by the public view.

After identifying three policy alternatives, it is necessary to narrow the alternatives to choose the policy that is most consistent with the evaluation criteria. Table (1) describes and compares the alternatives by using scorecard based on strengths and weaknesses of each alternative according to the evaluation criteria.

Table 1. *Policy Analysis Scorecard.*

	Alternatives		
Criteria	**Alternative: 1 No modifications**	**Alternative: 2 Based on family choice**	**Alternative: 3 Based on health care providers choice**
Effectiveness	-	++	-
political Feasibility	+	-\+	+
Cost	-	-\+	++
Fairness	-	++	-
Social acceptability	-	++	-
Total	-3	6	0

9. Recommended and Selected Solution

As showed in Table 1, after weighing alternatives the authors of this paper suggested selecting the alternative number 2: Family members of all patients undergoing resuscitation should be given the option of presence at the bedside. FPDR should always be optional and never mandated and the family members decide if they want to attend CPR situation or not (Appendix A).

Because it's effective, politically feasible, fair and socially accepted, also it is practical, and flexible alternative, takes in the consideration the patients family rights to be present or absent during resuscitation time.

10. Implementation

Regarding the implementation stage, Mason et al. 2007 described this stage to involve developing regulations and guidelines important for the functioning program, and to meet policy goals and objectives.

11. Strategy for Policy Advocacy

Health care professionals are important stakeholders in any health care system so they should have part in changing or developing the health policies which might be reflected on the provided care (World Health Organization, 2005). FPDR in Jordan and elsewhere is very sensitive issue that necessitate the health care organizations to formulate a group of health care professionals from multidisciplinary team and make efforts for developing a new policy that make long term efforts to achieve the intended goals of the policy which meet both patients and family needs and at the same time protect health care professionals from any legal accountability. Health care professionals should be supportive for patients and families in their end of life care; they should have a voice and join official organizations to have a source of power to develop new policies in beneficial ways for better provided care.

Involvement of all health care professionals in policy development could be considered a strong power for change. Moreover, linking with people who have legitimate power is a very important way to develop a new policy. The media also can be utilized to support health care professionals in their view of point. Understanding and using the various sources of power available to health care professionals is critical to ultimate success in the legislative arena and to support their ideas in new policy development *(Abood, 2007*).

11.1 Implications for Practice

Health care institutions should decide how to proceed based on the assessment provided by Family Support Person (FSP) regarding their presence at the patient's bedside during cardiac resuscitation when there are serious disagreements among family members. When deciding family presence, it is important to remove non-essential equipment and personnel from the resuscitation room in order to make space for family members. In addition, infection control is an important issue to be considered, the family members should be asked to done gloves, gown and eye protection in order to prevent exposure to blood and body fluids? Furthermore, it is important to plan for the use of interpreters to partner with the (FSP) when language will be a problem when supporting family members. After the resuscitation is concluded, health care providers need to facilitate the family's viewing of the

body, help them with funeral arrangements and make sure to give them patient valuables. It is important also to plan for a bereavement follow-up process for families that involves periodic contact with them. Give the family the opportunity to ask questions of the medical staff at a later time.

11.2. Politics

Is the strongest way to accomplish the change, by politics we will influence policy makers in health care organizations to achieve our desirable change. We as a health care professionals need to be engaged in the development of this policy as well as our suggestions should be taken into account this can happen by making connection with policy makers and coalitions with other stakeholders. Stakeholders consist of several groups: health care professionals, health organizations, patients and their families. Once all stakeholders are with our side, the political process will be supported and we can support our work by the help of media.

11.3. Rule Makers and Timeframe

In order to organize the work in policy development process we need to identify the key players in the political process for policy making and their positions toward the issue to utilize the capabilities of supporters. In addition, it is useful to create a timetable of the planned events for further organization of the work (World Health Organization, 2005). Our issue will be passed through a quality assurance office by nominating representatives from health care professionals including (physicians, nurses, and social works) and representative from the security office to discuss the issue with top managers and general director office.

11.4. Decision Making Process

Many considerations should be taken into account before any decision-making processes for instance, ethical, legal, economical, political, social and environmental factors that have impact on policy making process. We are in a position to decide how and where to influence policy through the policy making process (World Health Organization, 2005). As mentioned in the interviews with stakeholders, we contacted directors, researchers and educators and they all assured that if the issue will be adopted it should be utilized according the formal decision making process in any health organization and have a written policy that protects all persons who involved in this issue. Implementing family presence requires educational programs to teach nurses how to provide constant support for family members, helping them understand what procedures they're witnessing and how the patient is responding. Facilities may need to commit to have a trained nurse available to take this role during resuscitation.

11.5. Policy Evaluation

Stage four is the policy evaluation in which the program implementation, performance and impact are evaluated to identify weather a program has satisfactorily met the policy goals original, and weather new issues have surfaced, thereby restarting the cycle (Mason et al. 2007).. Policy evaluation is suggested to be completed three months after implementation of the policy. A "Family Presence during CPR Policy Evaluation Form" will be used for the purpose of evaluation. This form will include perceived benefits of family presence during CPR from the perspectives of the family members and health care professionals. Examples of these benefits are

Reminding health care workers that the patient has a dignity and a member of a family; it allows family members of the patient to recognize the efforts of health care professionals to save the patient. Additional open-ended question will be added to inquire about the strengths and limitations of the policy.

12. Conclusion

This paper used a systematic method utilizing stage sequential approach to develop a policy regarding family presence during resuscitation in Jordan. The recommended solution was allowing family members of all patients undergoing resuscitation to be given the option of presence at the bedside during CPR, and family members decide if they want to attend CPR situation or not. Based on evaluation of policy alternatives, allowing family members to decide and giving them an option to decide if they want to attend CPR situation or not was associated with positive consequences. It is suggested that policy makers who are going to develop policies regarding family members presence during resuscitation carefully consider cultural and legal aspects.

Competing Interests

The authors declare no competing interests

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