Deanship of Graduate Studies

Al-Quds University

Nurses' Perception of Family Presence During Resuscitation in Pediatric Wards and Pediatric Intensive Care Unit at Southern s West Bank Hospitals

Katy Johnny Matia Abu Sada

M. Sc. Thesis

Jerusalem – Palestine

1443 / 2022

Nurses' Perception of Family Presence During Resuscitation in Pediatric Wards and PediatricIntensive Care Unit at SouthernWest Bank Hospitals

Prepared by:

Katy Johnny Matia Abu Sada

BSc. Nursing Science/ Bethlehem University/ Palestine

Supervisor: Dr. Kawther Shaban Alayasa

A Thesis Submitted in Partial Fulfillment of Requirements for the Degree of Master of Nursing Management /Faculty of Health Professions/Al-Quds University

1443 / 2022

Al – Quds University
Deanship of Graduate Studies
Faculty of Health Professions / Nursing Management

Thesis Approval

Nurses' Perception of Family Presence During Resuscitation in Pediatric Wards and Pediatric Intensive Care Unit at Southern West Bank Hospitals

Prepared By: **Katy Johnny Abu Sada**
Registration No.: 21911880

Supervisor**:** Dr. Kawther Shaban Alayasa

Master thesis submitted and accepted. Date: 03/01/2022
The names and signatures of the examining committee members are as follows:

1. Dr. Kawther Alayasa Head of committee Signature …
2. Dr. Maysa Al Usta Internal examiner Signature…… …
3. Dr. Mohammad Marie External examiner Signature……

Jerusalem – Palestine

1443 / 2022

Declaration

I certify that this thesis submitted for the degree of Master is the result of my own research, except where otherwise acknowledged, and that this thesis (or any part of the same) has not been submitted for a higher degree to any other university or institution.

Signed:

Katy Abu Sada

2022/01/03

Dedication

To the greatest man I have in my life, the light of my life... my lovely

Father.

To the biggest heart with the most loving care, who sacrificed a lot for me to become what I am now,

My Mother

To my **Husband** who supported me through each step of the way and for being for me the greatest source of inspiration...

To the light of my eyes... my **Sons**

To all those who encouraged, supported, and helped me all the way.

I dedicate this research for all of them …

Katy Abu Sada

Acknowledgments

I thank Allah for helping me all moment and during my study.

Thanking to all those who have helped me throughout the course of the study in general and this thesis in particular, would need a book of its! The list is endless.

I owe a great deal to my academic supervisor Dr. Kawther Alayasa for the patience, careful direction and never-ending support.

Special thank and respect to the academic and administrative staff in the Faculty of Health Professions at Al Quds University for their collaborations, supports and assistance.

Special thanks to my teachers in the Faculty of Health Professions who give me the science and art in nurse management and research, Dr. Farid Ghrayeb and Dr. Salam Al-Khatib.

Special thanks to health care providers within the Ministry of health hospital, the atmosphere reigning within you made my work enjoyable.

Special thanks to my parents very deep and heartfelt appreciation for what you have done to make me what I am, to all relative and friends.

Thanking to my dear husband, my son and daughters, with good hope for them forever.

Thanks to everyone who participated in this study and to everyone who me not mentioned by the name. Many thanks for the hidden hands that stand behind my work.

Katy Johnny Abu Sada

03/01/2022

Abstract

Background: The primary focus of nursing is to promote health, alleviate suffering, and advocate in the care of individuals, families, and communities. Caring interpersonal relationships that demonstrate respect for patient and family preferences is fundamental to nursing practice, Research has shown patient- and family-centered care is not universally upheld by nurses during times of acute health crises.

Objective: The aim of this study was to assess the perception of nurses towards family presence during resuscitation (FPDR). It will also assess the self-confidence of nurses in facilitating FPDRof patients in pediatric ward and PICU at Southern West Bank Hospitals in Palestine.

Methods: The study is based on a cross-sectional, descriptive, analytical quantitative designconducted in spring 2020, from 4 hospitals in West Bank (Caritas baby; Beit-Jala; Red Crescent; Al-Ahli Hospital). Data was collected by using a self-administrated questionnaire, which included a sociodemographic section and 2 scales previously validated by Twibell et al (2008). Family Presence Risk/Benefit and Family Presence Self-Confidence scales developed by Twibell et al.(2008) was used.A convenience sample of 136 nurses was selected and the response rate was 92.64% (n=127)

Results: Most of the study participants were females (71%), aged between 30 and 34 years (N=53, 42%) and more than 65% of them (N=82)were married. The highest percent of nurses had Bachelor degree (N=73, 57.9 %), followed by Diploma (N=23, 18.3%), while 30 (23.8%) of them had higher education. According nurses experience, 40 (32.3%) of the participants had an experience between one and five years, 38 (30.6%) had experience between 6 and 10 years. According to job title, 92 (74.8%) were staff nurse and 23 (18.7%) werepractical nurses. Results indicated that 70 (57.4%) of the participants were working in pediatric ward, while 52 (42.6%) of them were working in PICU. In this study, 106 (86.2%) of participants reported that they had been involved in resuscitation of a child and17 (13.8%) had not been involved in child resuscitation. In addition, of the 106 nurses who had been involved in resuscitation, 10 (9.4%) had invited family members to be present during resuscitations, and 96 (90.6%) had not. Also, of the 106 nurses who had been involved in

resuscitation, 99 (93.4%) confirmed that a family member outside the resuscitation room.The participants' level on the FPS-CS scale was 3.11(SD 0.92), which reflects a moderate level of self-confidence in FPDR. Meanwhile, their level on the FPS-BS scale was 2.68 (SD 0.45), indicating that nurses' perception of risk-benefit related to FPDR is moderate. Moreover, there was a positive statistically significant correlation at the level ($\propto \leq 0.05$) between nurses' perceptions of confident scale and risk/ benefit scale of *FPDR*.

Conclusions: FPDR remains a controversial subject amongst health professionals in the pediatric setting. Nursing staff have shown reluctance to allow families to be present for fear of interference from family members, and nurses have concerns over the psychological well-being of families who witness resuscitation attempts. Many of these concerns have not been supported by evidence.

***Keywords*:** FPDR, self-confidence, risk-benefit, Nursing, family members

تصور الممرضين/ات لوجود الأسرة أثناء الإنعاش في جناح الأطفال ووحدة العناية المركزة للأطفال في مستشفيات جنوب الضفةالغربية بفلسطين.

إعداد: كاتي جوني أبو سعدة

إشراف: د. كوثر العيسة

الملخص:

الخلفية: ينصب التركيز الأساسي للتمريض على تعزيز الصحة، وتخفيف المعاناة، والدعوة لرعاية الأفراد والأسر والمجتمعات. لذا، فرعاية العلاقات الشخصية التي تظهر الاحترام لتفضيلات المريض والأسرة أمر أساسي بالنسبة لممارسة التمريض، أظهرت الأبحاث أن الرعاية التي تتمحور حول المريض والأسرة لا يتم دعمها بشكل عام من قبل الممرضات خلال أوقات الأزمات الصحية الحادة.

الهدف: الهدف من هذه الدراسة هو تقييم تصور الممرضين/ات تجاه التواجد الأسري أثناء الإنعاش. كما سيقيم ثقة الممرضين/ات بالنفس في تسهيل التواجد الأسري أثناء إنعاش المرضى في جناح الأطفال ووحدة العناية المركزة للأطفال في مستشفيات جنوب الضفة الغربية في فلسطين.

الأساليب: الدراسة مبنية على تصميم كمي مقطعي ووصفي وتحليلي أجري في ربيع 2021 من 4 مستشفيات في الضفة الغربية (مستشفى كاريتاس للأطفال، ومستشفى بيت جالا، ومستشفى الهلال الأحمر، والمستشفى الأهلي/ الخليل) تم جمع البيانات باستخدام استبيان ذاتي الإدارة، حيث يشمل الاستبيان البيانات الاجتماعي الديموغرافي ومقاييستم التحقق من صحتها مسبقًا بواسطة دراسة Twibell et al. (2008).مقياس مخاطر الوجود العائلي ومقياس الثقة بالنفس لوجود الأسرة. حيث وزع الاستبيان على عينة قصدية قوامها 136 ممرضاً تم اختيارهم في المستشفيات المذكورة، تم استرجاع 127 استبانة صالحة للتحليل. كان معدل الاستجابة 92.64%.

النتائج: معظم العينة من الإناث 88 (71%) و36 (29%) من الذكور. غالبية الممرضات (ن=53، 42%) تتراوح أعمارهم بين 30 و34 سنة. وكان أكثر من نصف العينة (ن=82، 65.6%) متزوجين/ات. وكانت أعلى نسبة من الممرضين حاصلين على درجة البكالوريوس (ن=73، 57.9%)، يليهم الدبلوم (ن=23، 18.3%)، بينما 30 (23.8%) منهم حاصلون على تعليم عالي. وفقًا لخبرة الممرضين/ات، 40 (32.3%) من الممرضين/ات لديهم خبرة تتراوح بين سنة واحدة وخمس سنوات، و38 (30.6%) لديهم خبرة تتراوح بين 6 و10 سنوات. حسب المسمى الوظيفي، 92 (74.8%) ممرض قانوني، 23 (18.7%) ممرض عملي. كما أشارت النتائج إلى أن 70 (57.4%) من الممرضين/ات يعملون في مجال طب الأطفال، في حين أن 52 (42.6%) منهم كانوا يعملون في وحدة العناية المركزة للأطفال.

في هذه الدراسة، سُئل المشاركون عما إذا كانوا قد شاركوا في إنعاش طفل، أفاد 106 (86.2%) من الممرضين/ات أنهم قد شاركوا، بينما 17 (13.8%) لم يشاركوا. بالإضافة إلى ذلك، من بين 106 ممرضات شاركن في الإنعاش، قام 10

(9.4%) بدعوة أفراد الأسرة للحضور أثناء الإنعاش، و96 (90.6%) لم يفعلوا ذلك. أيضًا، من بين 106 ممرضًا شاركوا في الإنعاش، أكد 99 (93.4%) أن أحد أفراد الأسرة بقي خارج غرفة الإنعاش.

كان مستوى الإدراك العام لمقياس الثقة بالنفس لوجود الأسرة هو 3.11 مع انحراف معياري 0.92، وهذا يعني أن تصور الممرضين/ات للثقة بالنفس في التواجد الأسري أثناء الإنعاش معتدل. وكان الإدراك العام لمقياس مخاطر التواجد العائلي 2.68 مع انحراف معياري 0.450، هذا يعني أن تصور الممرضين/ات للمخاطر والفوائد المرتبطة بالتواجد العائلي أثناء الإنعاش معتدل. إضافة، هناك علاقة إيجابية ذات دلالة إحصائية على المستوى (0.05) بين تصورات الممرضين/ات للمقياس الثقة وتصوراتهم لمقياس المخاطر/الفائدة لوجود الأسرة أثناء الإنعاش.

الاستنتاجات: لا يزال التواجد العائلي أثناء الإنعاش موضوعًا مثيرًا للجدل بين المهنيين الصحيين في مجال طب الأطفال. أظهر طاقم التمريض ترددًا في السماح للعائلات بالحضور خوفًا من تدخل أفراد الأسرة، والقلق بشأن الصحة النفسية للعائلات التي تشهد محاولات إنعاش. لم يتم دعم العديد من هذه المخاوف بالأدلة ولا يزال الموضوع بحاجة لمزيد من البحث

الكلمات المفتاحية: وجود الأسرة أثناء الإنعاش، الثقة بالنفس، المخاطرة/ المنفعة، الممرضين/ات.

Table of Contents

Declaration ..... **I**
Dedication ..... **II**
Acknowledgments ..... **III**
Abstract ..... **IV**
Arabic Abstract ..... **V**
Table of Contents ..... **VIII**
List of Tables ..... **XI**
List of Figures ..... **XII**
List of Annexes ..... **XIII**
List of Abbreviations ..... **XIV**
Chapter One Introduction **1**
1.1 Background 1
1.2 Problem Statement 3
1.3 Justification of the Study 4
1.4 Aim of the Study: 6
1.5 Objectives of the Study 7
1.6 Research questions: 7
1.7 Study hypothesis: 8
1.8 The following were the assumptions of this study: 8
1.9 Summary: 9
Chapter Two Literature Review **10**
2.1 Introduction 10
2.2 Search Strategy 10
2.3 History of Family Presence During Resuscitation: 10
2.4 Perceived Risk & Barriers to Family Presence During Resuscitation: 12
2.5 Perception of family members about their presence during resuscitation: 15
2.6 Benefits of Family Presence During Resuscitation: 17
2.7 Nurses' perception of Family Presence During Resuscitation: 19
2.8 Patient's Perspective of Family Presence During Resuscitation: 22
2.9 Importance of Family-Centered Care 23
2.10 Summary: 25
Chapter Three Conceptual Framework **26**

3.1 Introduction 26
3.2 Dependent Variables 26
3.3 Study Independent Variables 27
3.4 Socio demographic data: 28
3.5 Definition of terms 29
3.5.1 Operational definition: 29
3.5.2 Conceptual definition 30
3.6 Framework of the study: 31
Chapter Four Methodology 32
4.1 Introduction 32
4.2 Study design 32
4.3 Study setting 32
4.4Study population: 33
4.5Sampling frame 34
4.5.1 Inclusion criteria: 34
4.5.2 Exclusion criteria: 34
4.6Study Sample 34
4.7Tools for data collection 35
4.8Pilot Study 36
4.9Reliability and Validity of the instrument 37
4.10Ethical and Administrative Considerations: 40
4.11Data collection 40
4.12Data Management 41
4.12.1Data Entry: 41
4.12.2Data analyses 42
4.13Summary 43
Chapter Five Results 44
5.1 Introduction 44
5.2 Sample Characteristics 44
5.2.1 Socio-demographic Characteristics 44
5.2.2 Working Characteristics 45
5.3 What is the level of nurses' self-confidence in facilitating FPDR in the pediatric ward and the PICU? 46

5.4 What is the level of nurses' perception of risks and benefits of FPDR in the pediatric ward and the PICU?.....49
5.5 What is the relationship between nurses' perception of and self-confidence in facilitating FPDR and sociodemographic characteristics 51
5.6 What is the relationship between nurses' perception of risk and benefit of FPDR and sociodemographic characteristics?.....54
5.7 What is the relationship between nurses' perceptions of confident scale and their perceptions for risk/ benefit scale of FPDR?.....56
Chapter Six Discussion 58
6.1 Introduction 58
6.2 Socio Demographic Characteristics 58
6.3 Working Characteristics 60
6.4. Level of nurses' self-confidence in facilitating FPDR in the pediatric ward and the PICU?.....61
6.5 The level of nurses' perception of risks and benefits of FPDR in the pediatric ward and the PICU. 62
6.6 The relationship between nurses' perception of and self-confidence in facilitating FPDR and sociodemographic characteristics 63
6.7 The relationship between nurses' perception of risk and benefit of FPDR and sociodemographic characteristics. 66
6.8 There a relationship between nurses' perceptions of confident scale and their perceptions for risk/ benefit scale of FPDR. 68
6.9 Conclusion 69
6.10 Recommendation 70
References: 72
Annexes 84

List of Tables

Table 4.1: Population distribution.....33

Table 4.2: Distribution of Population from Selected Hospitals.....35

Table 4.3: Distribution of Respondents from Selected Hospitals.....35

Table 4.4: Results of confirmatory factor analysis of the Family Presence Risk-Benefit Scale (FPR-BS).....38

Table 4.5: Results of confirmatory factor analysis of the Family Presence Self-Confidence Scale (FPS-CS).....39

Table 4.6: Shapiro-Wilk Test for normal distribution 42

Table 4.7: Distribution of mean value into one of the agreement classes.....43

Table 5.1: Socio-demographic Characteristics of Nurses (N=126).....45

Table 5.2: Working Characteristics of Nurses (N=126)in resuscitation according to the work place 46

Table 5.3: Descriptive statistic for items on Family-Presence Self-Confidence Scale.....47

Table 5.4: Descriptive statistic for items on Family-Presence Risk-Benefit Scale 49

Table 5.5: Result of main differences in confident scale mean score due to .....52 demographic characteristics 52

Table 5.6: Result of main differences in mean Risk-Benefit scoredue to demographic characteristics 55

List of Figures

Figure 3.1: Conceptual framework model of the study 31

Figure 5.1: The distribution of participants who had been involved 46

Figure 5.2: Participant's responses distribution of items on 48

Family-Presence Self-Confidence Scale 48

Figure 5.3: Participant's responses distribution of items on Family-Presence 50

Risk-Benefit Scale 50

Figure 5.4: Mean and standard deviation of confident scale due to significant factor;

Different letters within bars indicate a significant difference 53

Figure 5.5: Mean and standard deviation of Risk-Benefit score due to significant factor;

Different letters within bars indicate a significant difference 56

Figure 5.6: Relationship between confident scale and risk/ benefit scale 57

List of Annexes

Annex (1) Map of Palestine 84

Annex (2) MOH Approval Latter.....84

Annex (3) Research Ethics Committee.....86

Annex (4) The final form of questionnaire (Arabic Version).....87

Annex (5): The final form of questionnaire (English Version) 91

Annex (6): Participant's responses distribution of items on Family-Presence Self-Confidence Scale 95

Annex (7): Participant's responses distribution of items on Family-Presence Risk-Benefit Scale.....96

List of Abbreviations

AAP	American Academy of Pediatrics
AACN	American Association of Critical-Care Nurses
AHA	American Heart Association
ANA	American Nurses Association
CPR	cardiopulmonary resuscitation
CBH	Caritas Baby Hospital
CR	Composite Reliability
CA	Cronbach's α coefficient
ENA	Emergency Nurses Association
EFA	Exploratory Factor Analysis
FCC	Family Centered Care
FPDR	Family Presence During Resuscitation
FPR-BS	Family Presence Risk-Benefit Scale
FPS-CS	Family Presence Self-Confidence Scale
ICU	Intensive Care Unit
KMO	Kaiser-Meyer-Olkin
MSN	Master Science of Nursing
MOH	Ministry of Health
PFCC	Patient And Family-Centered Care
PICU	Pediatric Intensive Care Unit
SD	Standard Deviations
SPSS	Statistical Package for Social Science
PRCS	The Palestine Red Crescent Society
WHO	World Health Organization

Chapter One

Introduction

1.1 Background

Patient and family-centered care is central to professional nursing practice (Finkelman & Kenner, 2009). The primary focus of nursing is to promote health, alleviate suffering, and advocate in the care of individuals, families, and communities. Nurses must strive to provide holistic care to all persons and in all practice settings. Caring interpersonal relationships that demonstrate respect for patient and family preferences is fundamental to nursing practice (American Nurses Association [ANA], 2010), However, research has shown patient- and family-centered care is not universally upheld by nurses during times of acute health crises, including times when life-saving measures such as cardiopulmonary resuscitation (CPR) are implemented.

Resuscitation of a human being whose life is threatened by inadequate circulation of breathing often occurs as a result of a crisis situation. In the hospital, multiple health care team members are present, rendering their expertise to save the patient's life.

Historically, many health care providers do not allow the family members to be inside the room during resuscitation efforts. Previous research suggests that various healthcare professionals have different opinions about family presence in the emergency room (Cross, 2018; Johnson, 2017). This issue is always subject to continuous controversy among health care professionals, family and patients (Porter et al, 2016; Magowan and Melby, 2019). In many countries the debate is centered on the advantages and disadvantages of FPDR. For example Tudor et al. (2014) concluded that the rationale behind preventing

FPDR was the belief that the presence of family members can provoke stress among them and can also negatively affect the performance of the medical team.

Few studies have shown that the advantages of FPDR would improve the family grieving, since family members could see everything that was done for their loved ones and ultimately, they had the opportunity to say goodbye (De Stefano et al., 2016; Jabre et al. 2014). On the other hand, FPDR will also give an opportunity for the family members to know what is happening, and will also show that all medical efforts were exhausted to their family member, which will provide support and comfort both for the patient and the family member (Pratiwi, 2018). The vast majority of patients who have experienced resuscitation support the idea of having family members next to them because they feel that this could provide them with emotional support and comfort (Twibell et al., 2015).

FPDR is defined as the presence of relatives in the area of patient care where the family members can have a visual or physical contact with the patient during resuscitation and invasive procedures (Pratiwi, 2018). FPDR was first pioneered at Foote Hospital, Jackson, Michigan, in the 1980s, when the relatives of two patients asked to be present while their loved one underwent resuscitation (Hanson & Strawer, 1992). The Foote hospital study led a number of American, British and Australian hospitals to implement the idea of giving the family members the right to choose to be present during resuscitation.

Through the researcher work in a pediatric hospital, the researcher sees in pediatric hospitals medical care is not only centered on the child but it is also given to the parents or family members present with the child. This is because when a child is admitted to the hospital, he/she will never be treated as a single individual patient, but the whole family will be involved to reach for the wellbeing of the child .

Patients and their families gained increased knowledge on all subjects regarding healthcare, which has contributed to a shift in healthcare from a patient-centered approach to a family-centered approach (McLean, 2013).

The definition of Family Centered Care (FCC) which is an accepted care philosophy in pediatric nursing is based on the belief that child health affects family's health and vice versa. Thus family involvement in child's life should be present, and family members should have a say in the decision-making related to the child's care and health (Girgin et al., 2015).

A phenomenological study inquired about the lived experiences of pediatric ward and Pediatric Intensive Care Unit (PICU) nurses regarding FPDR events (Maxton,2008). The information will assist health care leaders in understanding the perceptions of pediatric ward and pediatric intensive care unit nurses regarding family presence and assist in developing policies and guidelines regarding FPDR. The data collected also may helped to identify factors which influence the nurse's feelings about the practice and help to overcome resistance. So, the practice of allowing family members to be present during the resuscitation of a family member has gained increased worldwide attention.

1.2 Problem Statement

Caring for hospitalized children and their families has developed over time with care not only centered on the child, but also incorporating the family to maintain family centered and holistic approach even in emergency resuscitative care.

When a child becomes critically unwell and needs CPR, traditionally, the child's family is asked to stay in the waiting room (outside the resuscitation room). This is because nurses are trying to protect the families from witnessing distressing scenes (Redley & Hood, 1996). On the other hand, this notion ignores the distress that the family may experience in

the waiting room. Thus, separating the family is not always to their best interest and is not always consistent to the philosophy of nursing (Madden &Condon, 2007).

Currently, there are many reasons why facilities do not allow family members at the bedside during resuscitation. Many of these reasons are based on healthcare professionals' perceptions of the process and of any perceived problems that may occur during resuscitation. Some healthcare professionals feel as though it is a very limited space in a highly traumatizing environment. They also feel that the family may not truly understand the events and the actions of the healthcare team. Other healthcare professionals feel as though the presence of highly upset and crying family members can disturb the procedures during the resuscitation and remove the focus from the potentially life-saving events (Miller,2009).

Therefore, FPDR must be a priority of nursing as there is evidence that supports important benefits for family members, such as; decreasing the patient's fear, providing comfort, helping with closure and grieving, and reducing incidences of post-traumatic stress (Jabre et al. 2014). However, FPDR is still a controversial issue among healthcare providers including nurses. For example, some nurses have a perception that FPDR might disrupt resuscitation process, increase the anxiety of both the nurses and family members. Despite the fact that many international professional bodies, such as the Emergency Nurses Association (ENA), American Association of Critical-Care Nurses (AACN), and American Heart Association (AHA), promote the option of FPDR, many health care professionals have continued to be resistant to the practice (Tudor et al., 2014).

1.3 Justification of the Study

Family members are generally prevented from being present during resuscitation efforts and only 5% of emergency departments have written guidelines for FPDR events in

USA (Farah et al., 2007). Few health care organizations have developed policies regarding family presence, despite research supporting the practice and guidelines established by professional organizations for developing policies (Twibell et al., 2008).

The first recorded incidents of FPDR were at Foote Hospital in Jackson, MI in 1982 (Hanson & Stawser, 1992). Two family's members requested to be present during the resuscitation. So, when the two situations were evaluated, both the families and healthcare professionals had positive feedback. A program was implemented at Foote Hospital with a follow up survey which showed that 76% of families felt that their adjustment to the death was made easier by their presence in the room, 64% felt that their presence was beneficial to the dying person, and 94% believed that they would choose to be present again during Cardiopulmonary Resuscitation (CPR) if given the opportunity (Hanson & Stawser, 1992). In 1993 the ENA adopted a resolution in support of FPDR as well as a position statement in 1994. In 1995 the ENA also released an educational program entitled “Presenting the Option for Family Presence” (Eckle, 2007).

Since most health care organizations do not have policies regarding FPDR, the decision to allow family members to be present at the bedside is often decided on an individual basis (Twibell et al., 2008). The specific problem is that the decision to allow family presence is often done by a member of the nursing staff and a nurse’s feelings and perceptions about family presence will influence their practice. Most emergency departments do not have a policy for permitting family members to be present during resuscitation and the gatekeeper to the bedside is often a nurse. The phenomenological study sought to identify how, if at all, previous experiences of emergency department nurses impact their feelings towards family presence and their willingness to

allow/permit/encourage FPDR in organizations where no written policy is present(Gluck, 2014).

Some facilities have implemented FPDR programs; however, this practice still remains highly controversial. MacLean reported in 2003 regarding the state of family presence in facilities by publishing the results of a survey that had been mailed to 1,500 members of the American Association of Critical Care Nurses (AACN) and 1,500 members of the ENA (Maclean et al., 2003). Nine hundred and eighty-four surveys were returned showing: 5% of the respondents worked in units that had a written policy allowing the option of FPDR, 45% of the nurses responded that their institution did not have policies related to family presence, but their unit allowed FPDR, 29% reported that FPDR was prohibited on their unit but there was no written policy, 36% of the respondents had taken a family member to the bedside during resuscitation a mean of three times during the past year, and 31% said that a patient's family had asked whether they could be present during CPR a mean of three times during the past year.

Therefore, revealing how nurses perceive family presence during their child's resuscitation will provide information that may influence the support implemented and will help both families and nurses to deal with such an event. In addition, the nurses involved in resuscitation may be able to identify what kind of support could be most helpful for both families and nurses.

1.4 Aim of the Study:

To assess the perception of nurses towards FPDR. It will also assess the self-confidence of nurses in facilitating FPDR of patients in pediatric ward and PICU at Southern West Bank Hospitals in Palestine.

1.5 Objectives of the Study

- To assess levels of self-confidence among nurses in facilitating FPDR in a pediatric hospital setting.
- To assess nurses' perceptions of risks and benefits of FPDR in the pediatric ward and the PICU.
- To examine the association between nurses' sociodemographic characteristics and their perceptions of FPDR.
- To examine the association between nurses' sociodemographic characteristics and their self-confidence in facilitating FPDR.
- To examine the relationship between nurses' perceptions of risks and benefits of FPDR and their levels of self- confidence

1.6 Research questions:

- What is the level of nurses' self-confidence in facilitating FPDR in the pediatric ward and the PICU?
- What is the level of nurses' perception of risks and benefits of FPDR in the pediatric ward and the PICU?
- What is the relationship between nurses' sociodemographic characteristics and their perceptions of FPDR?
- What is the relationship between nurses' sociodemographic characteristics and their perceptions of risks and benefits of FPDR?
- What is the relationship between nurses' perceptions of risks and benefits of FPDR and their levels of self- confidence?

1.7 Study hypothesis:

- There will be a positive relationship between nurse's perception of FPDR and sociodemographic characteristics
- There will be a positive relationship between nurses' self-confidence of FPDR and sociodemographic characteristics.
- There will be a positive relationship between nurses' perception of risks and benefits of FPDR and sociodemographic characteristics.
- There will be a positive relationship between nurses' perceptions of confident scale and their perceptions for risk/ benefit scale of FPDR.

1.8The following were the assumptions of this study:

- Nurse participants can best relate their lived experiences of allowing families to be present during invasive procedures and resuscitation within the hospital.
- Nurse participants will answer the questions based on their perceptions of their experiences.
- Resuscitations occur with regularity in the hospital.
- Every patient is a member of a family system.
- There is value in allowing family members the option to be present with their loved ones to support and comfort them during a time of stress and crisis.
- The results of this study add to the limited body of knowledge concerning family presence during pediatric resuscitation lead to positive change in dealing with resuscitations and providing care properly.
- The results will further aid educators, researchers and managers to understand factors which may influence health professionals' decision to invite families to witness

resuscitation. Further the study will have implications for education, resources, policy formation and further research.

1.9 Summary:

This introductory chapter presented FPDR as a significant topic to patients and families. FPDR is also significant to the profession of nursing as a component of patient and family-centered care. The need for interventions to improve critical care nurses' perception and self-confidence for FPDR is evident and education is one such intervention. However, there are significant gaps in the FPDR education research. Most notably, there exists very little research on FPDR education. This study's intent to address such gaps was presented.

So, in this chapter, an overview of the proposed study has been presented including the background of the study, the statement of the problem, the aim and objectives as well as the importance of the study. In addition, the research assumptions were defined.

Chapter Two

Literature Review

2.1 Introduction

The existence of family members of patients during the resuscitation process has become an important practical issue, which has caused much controversy worldwide. In this literature review, the researcher describes the advantages and disadvantages of FPDR beside their patient from the point of view of nurses and family members. It also provides a background for understanding the importance of FPDR debate. add to that, the researcher summarizes main studies related to nurses' perception of FPDR.

2.2 Search Strategy

A comprehensive and systematic search process was conducted to retrieve relevant literature on Family Presence During Resuscitation and nurses' perception about that. The search process targeted articles published in reviewed journals in English language between 2005 and 2021 related the Nurses' Perception of Family Presence During Resuscitation in Pediatric Wards and Pediatric Intensive Care Unit. The search was completed on 30th Dec. 2021 and will be updated if required.

2.3 History of Family Presence During Resuscitation:

In 1982, Foote Hospital in Jackson, Michigan became the first documented health care organization to allow family member presence during resuscitation. The program of planned family member participation involved controlled periods where family members were allowed to provide support to the patient in the resuscitation room. The program was started by the hospital chaplain and a small group of emergency department nurses and

physicians in response to two separate instances where family members demanded to be present during resuscitative efforts.

One situation included a family member who refused to leave her loved one's bedside after riding in the ambulance with them during resuscitation efforts. The other situation involved a woman who begged staff to allow her to be with her husband, a police officer who sustained a gunshot wound. Both of these individuals were allowed to be present during resuscitation and were accompanied by a chaplain. After these events, both the families and the staff had positive feedback. The organization then surveyed family members of patient who had recently died to determine their feelings about being present in the resuscitation room. Thirteen of the 18 family members surveyed reported they wished they were present during resuscitative events (Hanson & Strawser, 1992).

Doyle et al. (1987) provided that first research indicating that family members want to be present when their loved ones are being resuscitated. The staff members at Foote Hospital began to question the policy that family members are excluded from the room when a patient is being resuscitated. Families were permitted to enter the resuscitation room with chaplain support and were later included in a survey to determine if family members wish to be present during resuscitation. As a result of the survey, Foote Hospital began a structured program that allowed certain family members to be present during resuscitation.

FPDR is defined as the presence of relatives in the area of patient care where the family members can have a visual or physical contact with the patient during resuscitation and invasive procedures (Pratiwi, 2018).

The Emergency Nurses Association (ENA) was the first organization to support the presence of family members during resuscitation. They argued that it is beneficial for both patients and family members. At the ENA annual meeting in 1993, the organization

recognized support of FPDR and created guidelines based on their beliefs for the best interest of the patient and family (ENA, 2007).

Also, the presence of families with their child during resuscitation of cardiopulmonary arrest (CPR) was recognized as standard care procedure in many national organizations such as; American Heart Association (AHA), 2000, Emergency Nurses Association (ENA), 2012; American Association of Critical Care Nurses (AACN), 2016; and American Academy of Pediatrics (AAP), 2016.

In addition, American Association of Critical Care Nurses recommended that the adult patient should agree on the presence of his/her family members in the resuscitation area provided that the hospital policy allows their presence. The association argues that the presence of family members increases comfort of the patient, provide better ability to understand the present health condition of the patient, decrease anxiety of family members, and provide privacy for the family, etc. (Guzzetta, 2016). The association stated that this can also apply to pediatric critical care units because the presence of parents can increase their satisfaction and they can cope with the health situation of their child (McAlvin, 2014).

2.4Perceived Risk& Barriers to Family Presence During Resuscitation:

A pilot study by Robinson et al. (1998) sought to determine if any adverse effects occur to family members witnessing resuscitation. The study took place between 1995 and 1997 in the Accident and Emergency Department of Addenbrooke's Hospital in Cambridge, United Kingdom. Twenty-five patients underwent resuscitation and relatives of these patients were given the option of remaining with the patient or staying out of the room (control group). Due to relatives being lost prior to follow-up, eight people who witnessed resuscitation and ten who did not were provided with a survey to ask about their decision one month after the event. No adverse psychological effects were reported among the

relatives who witnessed the resuscitation and all were content with their decision to remain in the room. The researchers were so convinced of the benefit of family presence that they terminated the trial. The study provided evidence that there are no adverse psychological effects on relatives witnessing resuscitation (Robinson et al., 1998).

A common perceived impediment to allowing family presence is that family members will get in the way of staff trying to perform their duties (Fitzgerald, 2008). The aforementioned research by Mangurten et al. (2005) showed most respondents felt that their performance was unaffected by family presence (69% for invasive procedures and 76% for resuscitation events). In Basol's study (2009), 41.4% of the respondents 34 thought their job performance was impeded by family member presence. The three leading explanations for this where the focus was taken away from the patient, the family was emotional, and the families were in the way of the staff.

Basol et al. (2009) used a survey to determine the concerns, beliefs, and attitudes of healthcare providers regarding FPDR and invasive procedures. Responses from staff that did not support family presence include discomfort, potential for family interference, emotional trauma may be endured by observer, the focus would be taken away from the patient, it would not be helpful, it is not appropriate, and the staff might make poor decisions. However, 90.3% of the respondents said they would want the option to have their family members at the bedside if they were critically injured or ill. The three main reasons are comfort, love, and support (Basol et al., 2009).

When the respondents were asked about their feelings towards policy development for allowing family member presence, negative comments included some threatening to quit their jobs and "there should be more psychologists and social workers to treat the dysfunctional families" (Basol, et al., 2009, p. 242). Overall respondent support for policy

development giving the family the option to be present was reported at 61.3%. Over 64% of the respondents believed that there were system barriers to FPDR (Basol, 2009).

Demir (2008) used a descriptive questionnaire study to determine family presence opinions of physicians and nurses working in critical care areas in a Turkish hospital. More than 82% of respondents did not agree with FPDR, with the most common concerns being the potential of family interference with procedures and that the process is traumatic for family members to witness. Other concerns were the possibilities of repercussions, an uncomfortable feeling for staff, a negative effect on performance, a lack of physical space, increased stress on the staff involved, less confidence in the physician if resuscitation is unsuccessful, and the possibility that family themselves become patients due to fainting. The data collected showed a focus on staff performance and concerns about family members and does not address the personal feelings and preferences of the study population.

Koberich et al. (2011) used a descriptive survey to explore the experiences and attitudes of German intensive care nurses towards FPDR. One hundred sixty-six German intensive care nurses attending a conference completed the 36-item questionnaire about their attitudes and experiences with FPDR. Of the 70 respondents that had experienced a family presence event,46 (%65.7) reported this as a negative experience. More than half of the respondents (56%) felt that family presence would negatively impact staff performance during the resuscitation event. Most of the respondents (68%) do not feel that family members should be given the option to be present during resuscitation. Four broad themes were identified from the qualitative responses, including: supporting families, individualized decision-making, threats of violence, and family involvement. Some nurses were apprehensive about possible breaches of confidentiality if family members were to hear the

patient's health being discussed. Nurses also felt that family members may find the resuscitation too upsetting and they may suffer long-term emotional effects (Koberich,2011).

Kosowan and Jensen (2011) used a survey to explore the beliefs and attitudes of cardiac health care providers about family presence. The survey included cardiac health care providers in five Edmonton, Canada area hospitals. Of the respondents, 40.9% believe that family presence should be permitted for cardiopulmonary resuscitation and 44.3% believed that family members should have the option to be present. Respondents identified several barriers towards family presence although less than half had previous experience with this practice. Despite the lack of support from the respondents, the majority supported the development of policies and procedures to help overcome barriers to family presence.

Tomlinson et al. (2010) used a questionnaire-based survey to evaluate the attitudes of nurses and staff regarding FPDR in the emergency department. The convenience sample included emergency department staff at a level-II trauma center and teaching hospital in the Midwestern United States. The survey included 79 responses from staff and registered nurses. Of the respondents, 65% had been involved in a family presence event in the past year and 82% reported supporting the practice of FPDR. Barriers to family presence included increased stress on resuscitation team and the potential for family interference. The researchers concluded that despite the potential barriers, most emergency department staff supported family presence and recommend education to increase understanding of this practice.

2.5Perception of family members about their presence during resuscitation:

Family members and their patients believe that their presence together in the resuscitation area would give them a feeling of comfort and will decrease the distress either emotional or physical for both (O'Connell et al., 2017).

Many families claim that it is their right to be present during the resuscitation process and will take any measure to enter the patient's room. However, most people agree that if conditions prove that the presence of family members during resuscitation will hinder the patient's health rather than help them, family members are prepared to give up this right (O'Connell et al., 2017).

For example, in Jordan a qualitative study was conducted by Masa'Deh et al, (2014) concluded that family members need to be present during resuscitation in adult critical care units. The study was carried out on seven family members who had the experience of resuscitating relatives in six hospitals in two major Jordanian cities. Semi-structured interviews were used as the main data collection method. The results of the study revealed three main categories: families need peace of mind; families need closeness; and families need support. All family members interviewed hoped to stay with their relatives selectively in the final stages of their lives. Most family members wanted to use this option for religious and cultural reasons (such as praying and pleading for support of their loved ones).

Another reason of FPDR was their medical background. A qualitative study was conducted in Jordan by Bashayreh &Ibrahim (2015), to explore family members' attitudes, beliefs, and perceptions regarding FPDR in adult critical care settings. The sample was conducted in six intensive care units of hospitals in Jordan, only one adult family member was chosen. Whole family Members have accepted the efforts of CPR whether the procedure was a failure or success. A purposeful sample recruited 14 family members in six months. It showed that the majority of the professionals would allow FPDR if the family members have a medical background, or if they are well educated about CPR. On other hand, many family members wanted to be present during resuscitation for religious purposes, because they wanted to pray and read from the Holy Quran at these moments as they mentioned.

A qualitative descriptive study which was performed by Stewart (2019) showed that offering FPDR goes along with the wishes of the family because they are allowed to be present in the resuscitation area of their children and they can also give their experience about the health status of their child. The sample was done on (280) children in hospitals with parents who experienced resuscitation with their children whether in the same room or nearby room. Semi-structured interviews were used for data collection. The result showed that thematic analysis resulted in four overarching themes for parents' experience: "Overwhelming chaos", "Getting through it", "Cognitive presence" and "Joy mixed with heartache". The majority result show that parents wanted the option to be with their children during resuscitation in spite of the overwhelming chaos, also they need to understand the procedures made to their child. However, parents get information, as they mentioned, by watching and listening to the team who gives resuscitation to their child.

On the contrary to those who prefer to be present during resuscitation**,** some family members thought that their presence could affect them emotionally and assumed it would be traumatic, so they couldn't hold their emotions (DeStefano et al., 2016).

O'Connell et al., (2017) reported that family who don't experience FPDR, thought that it is better to let health care professionals do their job.

Another study by Niemczyk et al., (2020) stated that families who refuse to be present during resuscitation is usually due to lack of knowledge about resuscitative methods and they cannot see or cope with the pain and suffering of their family member.

2.6 Benefits of Family Presence During Resuscitation:

The benefits of FPDR to the patient, family, and healthcare team have been demonstrated and supported through research. Benefits of FPDR include: granting family the opportunity to see all possible efforts were taken to save their loved one (Davidson et al.,

2011; Lowry, 2012), promoting improved family understanding and a realistic view of the situation which can assist families to make decisions about patient care, including the cessation of futile resuscitation attempts (Axelsson et al., 2010; Lowry, 2012); enabling the family to spend the final moments of life with the patient to help promote closure and aid in the grieving process, provide the ability to say goodbye, and facilitate acceptance of the death (Badir & Sepit, 2007; Nykiel et al., 2011), promoting improved emotional support for both patients and their families (Axelsson et al., 2010; Miller & Stiles, 2009), gaining assistance from families through the provision of accurate and rapid patient information to the healthcare team (Holzhauser & Finucane, 2006; Lowry, 2012; Miller & Stiles, 2009), improving professional behaviors among resuscitation team members (Demir, 2008; Miller & Stiles, 2009), and granting the healthcare team the ability to see the patient as a valuable part of the family unit (Davidson et al., 2011; Miller & Stiles, 2009).

FPDR continues to be a controversial issue among healthcare providers. But few studies explored the benefits of FPDR.

For example, Jabre et al. (2014) reported several benefits in a randomized controlled trial. One of the benefits was that the family member who was present during resuscitation had significantly fewer symptoms of complicated grief, depression, anxiety, and post-traumatic stress disorder.

Another qualitative research done by De Stefano et al., (2016) reported that when the family member is present in the area of resuscitation area, their grief will improve significantly because they could see everything that was done for their loved ones and can be able to say goodbye.

Family presence can help reduce the pain of death, and at the same time support the patient during their transition from life to death. Davidson et al., (2017) also reported in the

study that FPDR can improve staff professionalism, increase understanding of the condition of the patient, and also improve the quality of care rendered to the patient. On the other hand, FPDR can facilitate decision-making regarding resuscitation, and can also give way for the family to witness the moment of death of their patient.

O'Connell et al. (2017) conducted a study aimed at measuring the benefits of FPDR during pediatric trauma care and resuscitation, and also measuring family members' attitudes, behaviors, and experiences of their pediatric patients during resuscitation procedure. They used the observational mixed method which was a combination of interviews and focus groups. The sample was from family members (N=126). The results showed that the families preferred to be present during the resuscitation of their child, because they thought that their presence could provide emotional support for their patient (94%), will give information about their patient for the health care team (92%), and will give them better understanding about the condition of their child.

2.7 Nurses' perception of Family Presence During Resuscitation:

Nurses play an important role concerning the FPDR in cases of cardiac arrest, and recovery procedures. Nurses are supporters of themselves, their patients, their families, and their peers. They are responsible for fostering activities that foster healthy patient care and facilitate the process of healing or grief (Meghani, et al., 2019).

FPDR is still a subject of debate among health professionals. Several qualitative and quantitative studies have been conducted to explore and assess FPDR. For example, the first research regarding FPDR was published 30 years ago in the USA (Doyle et al. 1987). The author reported that 71% out of 21 nurses and physicians who took part in the trial FPDR study endorsed this option and thought that there was no reason why family members should be kept out of the CPR room.

Porter et al. (2015) conducted a study to investigate the following; extent to which FPDR was supported, the impact on professional practice and performance, and the differences in practice between adult and pediatric resuscitations. The sample size included emergency personnel (n = 347) from 18 participating emergency departments across the state of Victoria, Australia. The results showed that 83% of nurses supported FPDR and70% of them pointed out that it is a part of their current practice. The study also reported that (79%) of nurses and (77%) of doctors supported FPDR and considered it as a family matter. The findings also highlighted the importance of family support by nurses (92%) and doctors (89%) when allowing family to be present. The study was limited by the small sample size which restricted generalization of results, and this notion was one of the limitations of the study.

In a descriptive study done by Zali et al., (2017), data was collected from the random sample of (178) nurses and (136) family members in four Iranian hospitals. The result showed that 62.5% of the nurses disagreed with FPDR and thought that it has many disadvantages. Family members becoming distressed with prolonged resuscitation attempts and interaction with the patient. Nurses with previous FPDR education were more equipped to incorporate with the process. It is important to find a way to improve experiences and attitudes of healthcare professionals. Furthermore, developing local guidelines and multidisciplinary training plans is needed to respond to the needs of patients and their families.

Another descriptive-analytical study for Rafiei et al. (2018) was conducted to assess the relationship between the presence of family members during cardiopulmonary resuscitation and the confidence of nurses working in intensive care units in the presence of family members. The sample included (150) nurses in Iran working in acute care units

(intensive care units, coronary care units, and emergency departments). The study showed that during cardiopulmonary resuscitation, nurses with greater self-confidence have a more optimistic attitude toward the involvement of family members. So given the significance of the subject, nursing managers and planners should consider it in their plans.

Around the world, the idea of FPDR is gaining recognition. Over time, the rights of patients and families have gained respect and healthcare has advanced to become more patient-family oriented.

A Quasi-Experimental study performed by Meghani et al., (2019),to determine the effect of an educational program in Karachi, Pakistan, on the awareness, attitudes and practices (KAP) of health care professional towards FPDR in emergency department. The sample included (30) physicians and (55) nurses. The result showed that the educational intervention of FPDR effectively improved the knowledge of healthcare professionals and changed their attitudes towards FPDR.

Some factors significantly affect the decision of nurses to give the opportunity for family members to be present during resuscitation.

For example, Tudor et al. (2014) concluded that there was no significance between self-confidence and implementing of FPDR.

Another descriptive cross-sectional randomized by McLean et al. (2016) carried out a study to examine the attitudes and self-confidence of medical and nursing staff in promoting family involvement during resuscitation in a pediatric hospital environment. The sample included (300) surveys randomly selected from medical and nursing staff. The result showed that critical care employees had better risk/benefit ratings and higher self-confidence scores than people employed in fields of non-critical care. Getting expertise in pediatric resuscitation, having welcomed families to be present earlier and working in pediatrics for a

greater number of years greatly influenced the expectations and self-confidence of the participants.

2.8 Patient's Perspective of Family Presence During Resuscitation:

Typically, patients do not respond enough to give their consent when resuscitation is required. So, there are several researches showing the thoughts of the patient on FPDR. The research examined the opinions of patients on the benefits of FPDR after they were resuscitated. They thought that the FPDR helped the patient to feel like they cared, and it was calming for them to be able to see their family members even if they were unable to speak or contact them.

Twibell, Siela & Thomas (2015) performed a qualitative study to examine the expectations of family involvement of adult hospital patients during resuscitation, near-resuscitation, and unplanned intrusive cardiac operations immediately after the life-threatening case. Data was collected by interviews with (48) persons. The interviews were made least (13) hours after the crisis event and before hospital discharge. The outcome of the study was that the presence of the patients' family members provided them with emotional comfort and how important they are to their family members.

Other studies were carried out to investigate patients' attitude towards FPDR. They found out that patients had positive attitude towards FPDR. For example, Bradley et al., (2017) performed a cross-sectional study to investigate patients' views of general medical units and to recognize causes individually linked to the involvement of the family members during cardiopulmonary resuscitation. The sample size was (117) randomly adult patients who were on academic medical center. The result showed that approximately half of the participants accepted or strongly agreed on the presence and interaction of the family during

cardiopulmonary resuscitation (52.1%). (50.4) thought that the parents should be the decision makers about their presence with their patients.

Also, Niemczyk et al., (2020) conducted a cross sectional study to analyze the perspectives and views of patients and family members in hospitals in Poland on FPDR The study sample contained (1000) questionnaires (500 patient responses and 500 family responses).The result showed that both patients and their families preferred to be present during resuscitation. The overwhelming numbers of patients were not certain if they had the right to ask for their family members to be present next to them during resuscitation. The findings also highlighted that patient and their families had a low degree of understanding that they had the right to be together during resuscitation.

2.9Importance of Family-Centered Care

Doolin et al., (2011) performed a literature review of research-based articles to provide advanced practice nurses the best available evidence for implementation of FPDR in an acute care setting.

The results of the research indicated that there is more support in favor of allowing family presence. Furthermore, implementing policies and procedures permitting family presence allows health care facilities to develop into family-oriented and holistic environments.

Addressing this issue permits the advanced practice nurse with the ability to increase patient satisfaction and outcomes (Doolin, 2011). Four principles guide the practice of patient- and family-centered care: dignity and respect, participation, collaboration, and information sharing. By focusing on these principles, the health care professional listens to patient and family perspectives and honor their choices and wishes. Patients and their families are supported and encouraged to participate in care and become involved in

decision-making as they choose. Health care practitioners, patients, and families collaborate in developing plans of care.

Practitioners communicate with patients and families and provide complete, unbiased information to them in useful and affirming ways. The information provided is complete, accurate, and given in a timely manner to allow patients and families the opportunity to effectively participate in the delivery of care and the decision-making process (Institute for Family-Centered Care, n.d.).

According to Brown et al., (2008), "Patient and Family-Centered Care (PFCC) is an approach to health care that recognizes the integral role of the family and encourages mutually beneficial collaboration between the patient, family and health care professionals" (p. 38). This approach to health care acknowledges that family members are a constant in the patient's life. In cases involving children, the family brings strengths to the child's health care experiences.

The concept of patient- and family-centered care has historically been applied to individuals who have chronic diseases and are being cared for in hospital settings. However, this inclusive approach is applicable to patients of all ages and in all health care environments. In fact, PFCC has been reported to be a best practice in health care. The aforementioned principles of PFCC are consistent regardless of the situation in which they are applied (Brown et al., 2008).

One aspect of patient- and family-centered care is family member presence during resuscitation and invasive procedure. FPDR is supported by the American Heart Association and Emergency Nurses Association, as well as several other organizations. Health care organizations may lack the resources necessary for implementing a comprehensive PFCC program, but several simple steps can be taken to facilitate program implementation. This approach can be used in a health care setting of any size, and includes educating staff,

evaluating policies and procedures for PFCC, developing or modifying policies and procedures for PFCC, and assessing the current environment as it related to PFCC and making alterations (Brown et al., 2008).

Meyers et al. (2000) conducted a descriptive survey that polled 39 family members and 96 health care providers after family presence events about their feelings regarding FPDR and invasive procedures. Of the health care providers surveyed, 78% thought that allowing FPDR was important in meeting family members' emotional and spiritual needs. Seventy-three percent believed this practice met the emotional and spiritual needs of the patient.

Jones et al., (2011) sought to examine the perceptions of health care practitioners in regards to family presence during pediatric resuscitation. "The philosophy of patient-centered care, also called patient and FCC, has been universally recognized as a standard of care that results in better health care, safety, patient/family satisfaction, staff satisfaction, and high-quality outcomes for patients" (Jones et al., 2011).

2.10 Summary:

Given the mixed findings regarding FPDR in the literature and the almost nonexistent assessment of nursing staff attitudes outside of the emergency department regarding FPDR, more research regarding nursing staff attitudes is warranted. These findings can then be used to formulate educational programs about FPDR, foster support for FPDR, eliminate barriers to FPDR, and stimulate policy development concerning FPDR in hospitals

So, this chapter provided a literature review about the studies that were done about nurses, families and patients perception of FPDR. The studies also highlighted the effectiveness of nursing knowledge, attitudes concerning the importance of FPDR, and how to promote interventions in order to improve resuscitation during family presence.

Chapter Three

Conceptual Framework

3.1 Introduction

This chapter provides the framework of this study. It will explore the perception and self-confidence of nurses concerning the FPDR. The conceptual framework of the study is built based on the results of the literature reviews regarding nurses' perception about the of FPDR in pediatric ward and pediatric intensive care unit

The search strategy and main themes generated from the literature search are presented. The conceptual framework underpinning this study is the concept of family-centered care, which is addressed first. The main focus of this chapter addresses the concepts examined in the study questionnaire, that being perception of nurses perceived risks and benefits of family presence and nurses' self-confidence during the resuscitation of patients and the attendance of families.

3.2 Dependent Variables

Nurses' Perceptions and Self -Confidence of FPDR:

Nurses are supporters of patients and their families. They are responsible to facilitate activities that foster healthy conditions for the patient. They also care for the process of healing or grief for the families of patients. So, lack of nurses 'perception and self-confidence of FPDR will indicate a barrier to the proper implementation of FPDR. So, it is necessary for nurses to be aware of the benefit of FPDR for the patient and the team.

3.3 Study Independent Variables

This study will display the association between the independent variables represented by the socio demographic characteristic such as age, gender, marital status, educational level, work experience, job title, workplace (hospital), and work area. It will also show the previous experience in resuscitation, and the invitation of families to be present in the resuscitation area.

Regarding the relationship between nurses' characteristics and Nurses' Perception and Self -Confidence about allowing FPDR, Research has found self-confidence for FPDR positively correlates with an increased age of the nurse (Chapman et al., 2011); however, other studies did not find age to impact nurses' FPDR preferences or practices (Fallis et al., 2008; Twibell et al., 2008). No other demographic factors, such as gender or ethnicity, have demonstrated a statistically significant correlation.

Years of education and years of experience have unclear correlations to FPDR support. Higher level of education has been shown to positively impact perception and self-confidence for FPDR (Chapman et al., 2011), but research using the same scale refuted this finding (Twibell et al., 2008). Basol et al. (2009) found a significant correlation between a positive FPDR attitude and higher level of education.

Occupation and clinical practice setting appear to have a stronger correlation to FPDR support. The majority of research has found nurses to be more supportive of FPDR than physicians (Basol et al., 2009; Duran et al., 2007). Fulbrook et al. (2005) found no significant difference between nurses working in critical care or non-critical care, but did find differences between nurses working in clinical and non-clinical (management, education, and research) settings, with non-clinical nurses more supportive of FPDR.

Similarly, Twibell et al. (2008) found no significant difference between nurses working in critical care and non-critical care settings; however, emergency department nurses were found to be more supportive than all other clinical areas and nurses working in outpatient settings were found to be the least accepting of FPDR.

3.4 Socio demographic data:

Gender: This refers to male and female respondents.

Age: This refers to the age of the respondent: It was categorized into five groups: 20 – 24 years old, 25 -29 years old, 30 – 34 years old, 35 – 39 years old & 40 years old and above.

Marital status: This refers to the marital status of the respondent: it was categorized into three groups: single, married, and divorced.

Educational level: This refers to the level of nursing education obtained by respondents. It was categorized into five groups: Diploma, Bachelor Degree, High diploma, Master Science of Nursing (MSN), and PhD.

Years of work experiences: This refers to the years of work spent in pediatric units. It was categorized into the following: Less than 1 year, 1-5 years, 6-10 years, and more than 10 years.

Place of work: This refers to the employee's place of work in the pediatric unit. It was categorized into four groups: Caritas baby Hospital, Beit-Jala Governmental Hospital, Red Crescent Hospital, and Al-Ahli Hospital-Hebron,

Job title: This refers to the employee's job title. It was categorized into four groups:

Practical nurse, staff nurse, senior nurse, head nurse.

Have previous experience in resuscitation: This refers to the nurses' presence in resuscitation unit. It was categorized into two groups: yes or no.

Have invited families to be present: This refers to the nurses who invited families to be present during resuscitation. It was categorized into two groups: yes or no.

Place of residence of family: This refers to place of residence of family. It was categorized into two groups: inside the resuscitation room or outside the resuscitation room.

3.5 Definition of terms

3.5.1 Operational definition:

Family Member A person who's older than 18 years who had an established relationship with the patient, including the patient's family members, loved ones, and close friends(Fell, 2009).

Perception is defined the constellation of mental processes by which a person recognizes, organizes intellectual, sensory and emotional data in a logical or meaningful fashion (Farlex Partner Medical Dictionary 2012).

Self-confidence related to FPDR is defined as perception of ability to perform or manage in a given situation, specifically in FPDR (Twibell et al., 2008). And use scale to measure self-confidence for implementing and managing CPR in presence of family in the resuscitation room

Perceived Benefits and Risks Related to FPDR: Beliefs or opinions of nurses regarding the advantages and disadvantages of FPDR (Twibell et al., 2008). And use the Family Presence Risk-Benefit Scale (FPR-BS) was used to measure perception of the risks and benefits of FPDR. The FPR-BS measures risks and benefits to the patient, family, and healthcare providers (Twibell et al., 2008).

3.5.2 Conceptual definition

Family-centered care is partnering with patients and families in all healthcare settings and at all levels of care. It includes respect for choices, communication, encouraging participation, and collaboration (Conway et al., 2006). Family-centered care enhances patient and family comfort (Kolcaba et al., 2006) and FPDR is a form of family-centered care.

Family Presence During Resuscitation (FPDR) the presence of relatives in the area of patient care where the family members can have a visual or physical contact with the patient during resuscitation and invasive procedures(Pratiwi, 2018).FPDR enables family to promote patient comfort through touch and verbal reminders of their meaning (Kolcaba, 1994).

Family is defined by the patient and is the persons, related or not, who provide support and have a significant relationship with the patient (ANA, 2010; ENA, 2007).

Resuscitation is the care provided in order to sustain the life of the patient (ENA, 2007).

Perception is an individual's unique view of a phenomenon that is shaped by the processing of sensory and cognitive stimuli and experiences. It is influenced by imagined or observed benefits and risks (McDonald, 2012). Critical care nurses' perception of FPDR is influenced by the risks and benefits either imagined or observed.

Self-confidence is a personal belief in the ability to achieve a positive outcome for a specific goal, and can be fostered and influenced by attainment of knowledge through education, reinforcement of learning, and experience or practice (White, 2009). Self-

confidence in personal ability to implement FPDR is influenced by opportunities to practice FPDR implementation via educational or clinical experiences.

Critical care nurses are licensed nurses working in high acuity patient care areas that require intensive management of unstable patients with life-threatening problems. Critical care nurses are responsible for ensuring optimal nursing care is provided to acutely ill patients and their families (AACN, 2014b).

3.6 Framework of the study:

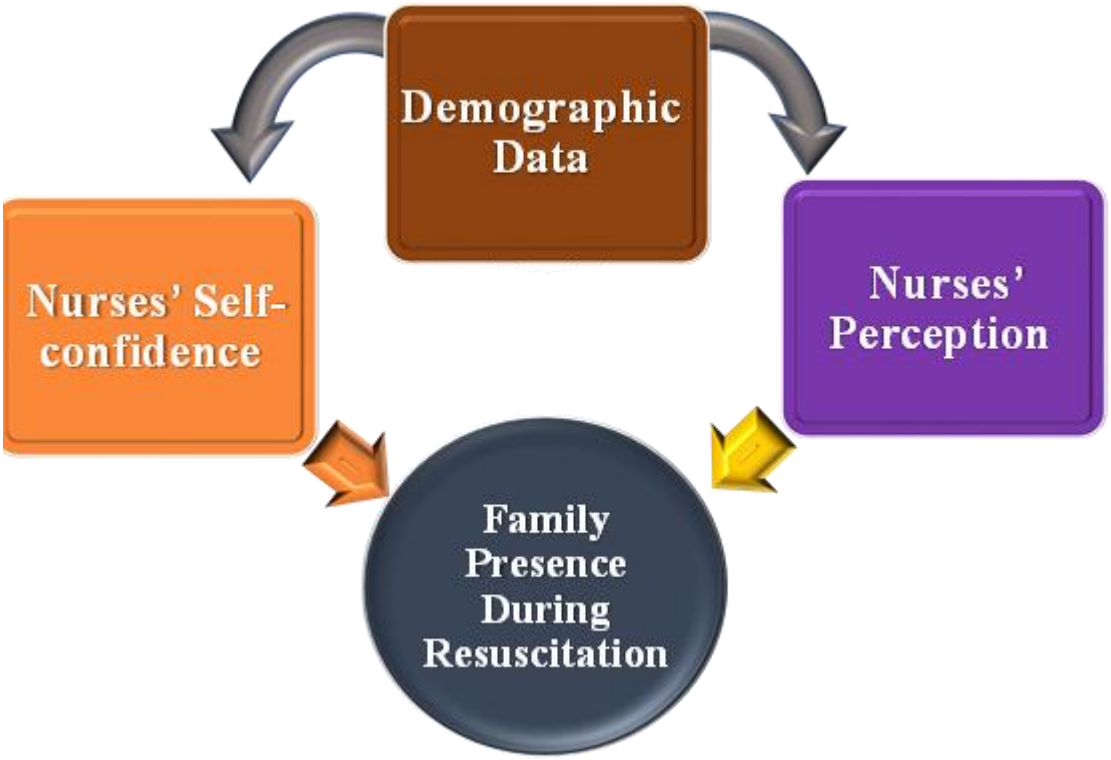

Figure 3.1: Conceptual framework model of the study

Chapter Four

Methodology

4.1 Introduction

This chapter describes the methodology to assess nurses' perception of FPDR. The study depended on the descriptive analysis methodology so as to answer the research aims and objectives. It describes the study design, study setting, study population, sampling frame, sample criteria, sampling process and data collection procedures. It also reviews the selection of the study tool and how it was built, the amendments made and procedures used to verify the validity and consistency of the questionnaire.

4.2 Study design

This study employed the cross-sectional, descriptive, analytical quantitative design. This design was used to assess nurses 'perceptions and self-confidence in facilitating FPDR. This design is appropriate for describing the status of phenomena or for describing relationships among phenomena and involves the collection of data once the phenomena under study are captured during a single period of data collection (Polit and Beck, 2012).

4.3 Study setting

The setting of this study is the pediatric ward and PICU in the following four hospitals in Bethlehem and Hebron cities, Palestine. These hospitals include: Beit-Jala Governmental Hospital, Caritas Hospital in Bethlehem city, Red Crescent Hospital and Al-Ahli Hospital both in Hebron city.

- **Beit -Jala Governmental Hospital** is a government hospital in the Beit Jala city, West Bank, Palestine. It is affiliated with the Palestinian Ministry of Health. It contains 131 beds.It has a pediatric ward with 14 beds and an oncology pediatric ward with 18 beds.

- **Caritas Baby Hospital (CBH)** is a private hospital, in Bethlehem. It provides treatment for pediatric illnesses, and neonatal. It also treats patients with hereditary, neurologic and metabolic diseases. It has two pediatric wards with 41 beds for pediatric inpatients up to (14) years old. Also, the ICU contains four pediatric beds.
- **The Palestine Red Crescent Society (PRCS)**is a national humanitarian organization. The hospital provides health, social and academic services to Palestinians. It contains a pediatric ward with 20 beds, and Pediatric ICU ward with five beds.
- **Ahli Hospital-Hebron** is a private hospital, in Hebron. It provides health services to Palestinians. It has pediatric ward with 26 beds for pediatric inpatients up to 14 years old. They also have an intensive care unit which contains 20 pediatric beds.

4.4 Study population:

The population of this study will include all nurses who are working in pediatric wards and PICU in Beit -Jala Governmental Hospital, Caritas Baby Hospital (CBH), The Palestine Red Crescent Society (PRCS) and Ahli Hospital-Hebron, which include 186 nurses, table 4.1 illustrate the population distribution according to the work area and the hospitals.

Table 4.1: Population distribution

Name of hospital	Work Area		Total
	pediatric ward	pediatric ICU	
Caritas baby Hospital	41	15	56
Beit-Jala Hospital	37	0	37
Red Crescent Hospital	23	12	35
Al-Ahli Hospital-Hebron	33	25	58
Total of all population	**134**	**52**	**186**

4.5 Sampling frame

4.5.1 Inclusion criteria:

- Nurses who are working in the pediatric units and PICU at Caritas Baby Hospital, Beit-Jala Governmental Hospital, Red Crescent Hospital, and Al-Ahli Hospital during the period of the study and who are willing to participate in the study.
- Nurses who will agree to participate in this study during the period of data collection.

4.5.2 Exclusion criteria:

- Nurses who work in other medical departments in the selected hospitals.
- Nurses who are not willing to participate in the study.
- Student nurses and nurses who work as volunteers in the pediatric ward and pediatric intensive units in the selected hospitals.

4.6 Study Sample

Based on the communication with representatives of the hospitals' Human Resources department, the population consisted of 186 nurses distributed among four hospitals. The participants were selected through a convenience sampling method. In order to calculate and gain a more accurate result on the sample size, Slovin's Formula was used, equation (1) illustrate the basis to determine the sample size through Slovin's Formula.

$$n = \frac{N}{1 + Ne^2} \qquad eq.(1)$$

Where n is the sample size, N represent the population size, e represents the desired margin of error. The Slovin's formula shows that the efficiently sample size represents the population in this study is 136 by using 0.05 desired margin of error (e) and the population of nurses in selected hospitals is 186. The Slovin's formula shows that the number of 136 observations can efficiently represent the population in this study. In order to illustrate the accessible population located in four hospitals in selected general hospitals, a sampling

frame was constructed. The 136 respondents were selected in proportion to the accessible population in the four hospitals. Table (4.2) represent the sample distributed according the selected hospitals.

Table 4.2: Distribution of Population from Selected Hospitals

Name of hospital	Population		Sample	
	N	Percent (%)	N	Percent (%)
Caritas baby Hospital	56	30.1	41	30.2
Beit-Jala Governmental Hospital	37	19.9	27	19.8
Red Crescent Hospital	35	18.8	25	18.4
Al-Ahli Hospital-Hebron	58	31.2	43	31.6
Total of all population	**186**	**100**	**136**	**100**

From136 distributed questionnaires,127 questionnaires were returned, one respondent did not complete the questionnaire. and the response rate was 92.64%, table (4.3) represent the final distribution of respondents from selected hospitals.

Table 4.3: Distribution of Respondents from Selected Hospitals

Name of hospital	Sample		Final Sample	
	N	Percent (%)	N	Percent (%)
Caritas baby Hospital	41	30.2	38	30.2
Beit-Jala Governmental Hospital	27	19.8	25	19.8
Red Crescent Hospital	25	18.4	24	19.0
Al-Ahli Hospital-Hebron	43	31.6	39	31.0
Total of all population	136	100	126	100

4.7 Tools for data collection

Data collected by using a self-administrated questionnaire includingsociodemographic and 2 scales previously validated by Twibell et al (2008). The Family Presence Risk-Benefit Scale (FPR-BS) and The Family Presence Self-Confidence Scale (FPS-CS). These scales adapted to fit Palestinian cultural and the objectives of the study. Reliability and validity were estimated in the pilot study.

1. **Part One:** includes questions related to personal and demographic characteristics, such as age, gender, marital status, educational level, years of work experience, job title, workplace (hospital), have previous experience in resuscitation, have invited families to be present, and place of residence.
2. **Part two:** Contains the Family Presence Risk-Benefit Scale (FPR-BS) will be used to assess nurses' perceptions of the risks and benefits of family presence to the patient's family, the patient, and members of the resuscitation team. The instrument has 22 items, 16 items positively worded, while 6 negatively worded items were reverse coded (questions 2, 3, 8, 6, 9, 10) as done in the original study by Twibell et al. (2008), all items have an answer on a five-point Likert scale ranging between 1-5, where 1 represents 'strongly disagree' and 5 represents 'strongly agree'.
3. **Part three:** Contains the Family Presence Self-Confidence Scale (FPS-CS) developed by Twibell et al. (2008) was used to assess nurses' self-confidence with having patients' family members present during resuscitation. The instrument has 17 items on a five –point Likert scale ranging from not at all confident (1) to very confident (5).

4.8 Pilot Study

A pilot study was taken on a purposive sample of 15 nurse from pediatric word and Pediatric Intensive care units at CBH will be conducted before starting the actual data collection as a pretest to determine the real time need to fill the questionnaire (Arabic questionnaire) and identify areas of vagueness, to point out weaknesses in wording, to test reliability of its items and to test validity and suitability of the questionnaire. Modifications was made accordingly to these results. Data in pilot study excluded in the main study.

4.9 Reliability and Validity of the instrument

The reliability of an instrument is considered as consistency measure to indicate that, when the measurements are repeated among respondents, stable and consistent results are produced. While the instrument validity is often defined as the extent to which an instrument measures what it purports to measure, and validity requires that an instrument is reliable (Akib et al. 2015).

To check the reliability of the instrument, two tools were used which are Cronbach's α coefficient (CA) and Composite Reliability (CR). Content and face validity of the adopted and adapted questionnaire were assessed by a panel of 3 experts. The experts were chosen for their knowledge of family presence during resuscitation. The panel was asked to indicate if each item adequately represented the topic. Comments of the experts were considered and modified accordingly. To check the instrument validity, construct validity through convergent validity was used. To check it out, Exploratory Factor Analysis (EFA) was used with the application of varimax rotation. Exploratory factor analysis is a "statistical technique applied to a single set of variables when the researcher is interested in discovering which variables in the set form coherent subsets that are relatively independent of one another" (Tabachnick, 2014). Hair Jr et al. (2013) indicated that factor analysis shows whether all of the items of a construct are highly correlated and represent the same construct.

Kaiser-Meyer-Olkin (KMO) and Bartlett tests were applied to determine the suitability of the data sample for factor analysis. The KMO measure is 0.924 which is more than 0.60, that indicates the suitability of the items to measure the construct (factors). This is again confirmed by the Bartlett's test with a p-value of 0.000, which is less than 0.05 and is considered significant, so the assumption of the factor analysis was applicable.

Table (4.4): Results of confirmatory factor analysis of the Family Presence Risk-Benefit Scale (FPR-BS)

No.	Items	Factor Loading
1.	Family members should be given the option to be present when a loved one is being resuscitated.	0.653
2.	Family members will panic if they witness a resuscitation effort.	-0.079
3.	Family members will have difficulty adjusting to the long-term emotional impact of watching a resuscitation effort.	-0.777
4.	The resuscitation team may develop a close relationship with family members who witness the efforts, as compared to family members who do not witness the efforts.	0.616
5.	If my loved one were being resuscitated, I would want to be present in the room.	0.620
6.	Patients do not want family members present during a resuscitation attempt.	-0.735
7.	Family members who witness unsuccessful resuscitation efforts will have a better grieving process.	0.702
8.	Family members will become disruptive if they witness resuscitation efforts.	-0.736
9.	Family members who witness a resuscitation effort are more likely to sue.	-0.722
10.	The resuscitation team will not function as well if family members are present in the room.	-0.754
11.	Family members on the unit where I work prefer to be present in the room during resuscitation efforts.	0.746
12.	The presence of family members during resuscitation efforts is beneficial to patients.	0.757
13.	The presence of FPDR effort is beneficial to families.	0.768
14.	The presence of FPDR effort is beneficial to nurses.	0.596
15.	The presence of FPDR effort is beneficial to physicians.	0.689
16.	The presence of FPDR effort should be a component of family-centred care.	0.744
17.	will have a positive effect on patient ratings of satisfaction with hospital care.	0.840
18.	will have a positive effect on family ratings of satisfaction with hospital care.	0.850
19.	will have a positive effect on nurse ratings of satisfaction in providing optimal patient and family care.	0.782
20.	will have a positive effect on physician ratings of satisfaction in providing optimal patient and family care.	0.859
21.	The presence of FPDR effort is a right that all patients should have.	0.832
22.	The presence of FPDR effort is a right that all family members should have.	0.842

(CR=0.878, AVE=0.559, Cronbach's α=0.783)

According the result in table 4.4, the Cronbach's α coefficients are 0.783 and 0.960 for FPR-BS and FPS-CS respectively, and the CA value for them were found 0.878 and 0.961 respectively, which indicates an excellent internal consistency among factor, that's mean the instrument is reliable (Hair et al., 2017).

Table (4.5): Results of confirmatory factor analysis of the Family Presence Self-Confidence Scale (FPS-CS)

No.	Items	Factor loading
1.	I could communicate about the resuscitation effort to family members who are present.	0.748
2.	I could administer drug therapies during resuscitation efforts with family members present.	0.837
3.	I could assist medical staff in performing electrical therapies during resuscitation efforts with family members present.	0.827
4.	I could deliver chest compressions during resuscitation efforts with family members present.	0.804
5.	I could communicate effectively with other health team members during resuscitation efforts with family members present.	0.793
6.	I could maintain dignity of the patient during resuscitation efforts with family members present.	0.790
7.	I could identify family members who display appropriate coping behaviours to be present during resuscitation efforts.	0.708
8.	I could prepare family members to enter the area of resuscitation of their family member.	0.757
9.	I could enlist support from attending physicians for FPDR efforts.	0.760
10.	I could escort family members into the room during resuscitation of their family member.	0.731
11.	I could announce family member's presence to resuscitation team during resuscitation efforts of their family member.	0.706
12.	I could provide comfort measures to family members witnessing resuscitation efforts of their family member.	0.718
13.	I could identify spiritual and emotional needs of family members witnessing resuscitation efforts of their family member.	0.800
14.	I could encourage family members to talk to their family member during resuscitation efforts.	0.745
15.	I could delegate tasks to other nurses in order to support family members during resuscitation efforts of their family member.	0.772
16.	I could debrief family after resuscitation of their family member.	0.756
17.	I could coordinate bereavement follow-up with family members after resuscitation efforts of their family member, if required.	0.781

(CR=0.961, AVE=0.589, Cronbach's α=0.960)

In addition, to check the instrument validity, Hair et al. (2010) is suggested that the item with factor loading more than 0.50 can be accepted in the study, furthermore, Fornell

et al. (1981) suggested that the AVE should be greater than 0.50. According that, result in table 4.4 indicates the factor loading of all items were between 0.596 and 0.859, which indicates all items are acceptable, except item two in FPR-BS was deleted because the factor loading of this item less than 0.50. On other hand the result of AVE values of FPR-BS and FPS-CS are 0.559 and 0.589 respectively were suggesting convergent validity is ensured.

4.10 Ethical and Administrative Considerations:

The researcher maintained all ethical and administrative requirements to conduct this study. An academic approval was obtained from General Administration of Health Education and Scientific Research in the MOH (Annex2). Additionally, ethical approval letter was obtained from the ethical committee at al-Quds university in Palestine (Annex 3).

Every participant was provided with full explanatory form attached to the questionnaire. This form includes the purpose of the study, assurance about the confidentiality of their information, and instruction to respond the questionnaire. In addition, it included statement indicating to their participation is voluntary.

4.11 Data collection

Data were collected by using two self-administered questionnaires; Family Presence Risk-Benefit Scale (FPR-BS) and Family Presence Self-Confidence Scale (FPS-CS) to explore nurses' perceptions toward of FPDR in pediatric ward and PICU. The researcher distributed the questionnaires to the participants at the working hours in the morning, evening and night work shifts and then receiving them after completion of the questionnaires. The average time for filling the questionnaire about 15 minutes. The covering letter of the two questionnaires outline the title and the purpose of the study and the identity of the researcher.

Initially, permissions from selected hospitals administration (directors of nursing) obtained to introduce their total approval to conduct this study. The researcher herself collected data using a self-administered questionnaire. Consent form obtained from the participants in the study after clarifying the purpose of the study and confirmed the anonymity and confidentiality of information. The questionnaire filled individually and completed by the study participants while they will be on duty.

4.12 Data Management

4.12.1 Data Entry:

The questionnaire was entered onto the Statistical Package for Social Science (SPSS) version (24) for data cleaning and analysis.

Recoding performed for continuous variables by cross tabulation as needed. To quantify the responses into scores, the researcher gives coding to the responses for the second part of the questionnaire which is The Family Presence Risk-Benefit Scale (FPR-BS) as 1= strongly disagree, 2= disagree, 3= neutral, 4= agree, 5= strongly agree. The researcher gives coding to the response for the part three which is The Family Presence Self-Confidence Scale (FPS-CS) as 1= not all confident, 2= not very confident, 3= somewhat confident, 4= quite confident, 5= very confident. The dependent variables the Nurses' perception and self - confidence of FPDR. The independent variables will be socio demographic characteristic such as age, gender, marital status, educational level, years of work experience, job title, workplace (hospital), place of residence, previous experience in resuscitation, and invitation of families to be present in the resuscitation area.

One sample used to investigate the variation of perception of subjects to dependent variable among independent variable that consist of two categories and used one-way ANOVA test for continuous variable composed of three and more categories.

4.12.2 Data analyses

Data analyses were performed by using version 24of the Statistical Package for Social Sciences (SPSS). The assumption of normality needs to be checked for many statistical procedures, namely parametric tests, because their validity depends on it, so before determine the statistical tools that the research must be used,Shapiro-Wilk Test were used to checking the factor distribution, table (4.6) clarifies that Family Presence Risk-Benefit Scale (FPR-BS) and Family Presence Self-Confidence Scale (FPS-CS) had non normal distribution with p-values less than the significance level (α=.05).

Table (4.6): Shapiro-Wilk Test for normal distribution

Factor	Statistic	Df	Sig.
FPR-BS	0.948	126	0.000
FPR-CS	0.973	126	0.013

In this study, to examine the hypotheses and questions, the researcher must use some parametric and nonparametric statistical tools as follows:

- Frequencies and percentage to describe the sample's characteristics and responses.
- Normality test to examine if the variable has the normal distribution or not, by Shapiro-Wilk Test of Normality.
- Independent sample t-test to test the differences between mean score of factors (FPR-BS, FPR-CS) with non-normal distributions & equal variance in 2 groups (e.g gender).
- Mann-Whitney U Test to examine the differences between mean score of factors (FPR-BS, FPR-CS) with non-normal distributions or non-equal variance in two groups.

- One-way analysis of variance tests to examine the differences of mean score factors (FPR-BS, FPR-CS), if variable distributions in all groups were not significantly different from normal and have a homogenous variance
- Kruskal Wallis test is the non-parametric alternative of variance test (One Way-ANOVA), which is appropriate when there is a need compare between data that have more than two groups to determine if there is a significant difference between the tested groups or not.
- Simple linear regression was used to study the relation between Family Presence Risk-Benefit Scale (FPR-BS) and Family Presence Self-Confidence Scale (FPS-CS).
- To describe the participant's response, the researcher uses five main classes for easier response interpretation by divided the range of response scale to main classes which is five, table 4.7 illustrate the distribution of mean value into one of the agreement classes.

Table (4.7): Distribution of mean value into one of the agreement classes

Class	Mean Range	Agreement class
1	Less than 1.80	Very Low
2	1.80 -2.59	Low
3	2.60 - 3.39	Moderate
4	3.40 - 4.19	High
5	4.20 or more	Very high

4.13 Summary

This chapter provides an overview of the methodology whichused in this assessment, describing study design, population and sampling method, the instrument that used and its reliability, data collection, and ethical consideration.

Chapter Five

Results

5.1 Introduction

This chapter includes the presentation of data analysis and testing the research hypotheses by answering the research questions and reviewing the main results of the questionnaire reached through analyzing the various paragraphs. The researcher presents the study results to answer the questions that appeared and were included in the questionnaire, and which represent the problem of the study after collecting the data required by the study tool. Several of the results were reached, and advice for future research is offered to researchers in the same field, both at universities and in any other organization.

5.2 Sample Characteristics

5.2.1 Socio-demographic Characteristics

Through the questionnaire, the researcher observed certain demographic characteristics of respondents that included six variables as shown in Table 5.1, which contains the frequency and percentage for each variable listed according to the survey categories. According the Table 5.1, result found 126 nurses completed the questionnaire, 36 (29%) were males, and 88 (71%) were females. About age categories, the majority of nurses (N=53, 42%) aged between 30 and 34 years. However, more than half of the nurses (N=82, 65.6%) were married. The highest percent of nurses had Bachelor degree (N=73, 57.9%), followed by Diploma (N=23, 18.3%), while 30 (23.8) % of them had high education (High Diploma, Master Degree).

Table 5.1: Socio-demographic Characteristics of Nurses (N=126)

Variable	Categories	Frequency	Valid Present %	Missing
Gender	Female	88	71.0	2
	Male	36	29.0	
Age	20- 24 years	20	15.9	0
	25 – 29 years	16	12.7	
	30 – 34 years	53	42.0	
	35 – 39 years	16	12.7	
	40 year or above	21	16.7	
Marital Status	Single	37	29.6	1
	Married	82	65.6	
	Divorced	5	4.0	
	Widowed	1	0.8	
Education Level	Diploma	23	18.3	0
	Bachelor	73	57.9	
	High diploma	21	16.7	
	Master Degree	9	7.1	

5.2.2 Working Characteristics

Table 5.2 illustrates that 40 (32.3%) of nurses had an experience between one and five years, 38(30.6%) their experience between 6 and 10 years, 37 (29.8%) of them had more than 10 years of experience. A total of 92 (74.8%) staff nurses and 23 (18.7%) practical nurses, while 8 (6.5%) of respondents were senior and head nurses. In addition, the result indicates that 70 (57.4%) of nurses were working in pediatric word, while52 (42.6%) of them were working PICU.

Table 5.2: Working Characteristics of Nurses (N=126)

Variable	Options	Frequency	Valid Present %	Missing
Job title	Practical nurse	23	18.7	3
	Staff nurse	92	74.8	
	Senior nurse	4	3.25	
	Head nurse	4	3.25	
Years of work experience	Less than 1 year	9	7.3	2
	1-5 years	40	32.3	
	6-10 years	38	30.6	
	More than 10 years	37	29.8	
Working Area	Pediatric word	70	57.4	4
	PICU	52	42.6	

The participants were asked if they have been involved in resuscitation of a child, 106 (86.2%) of nurses reported that they had been involved, 17 (13.8%) had not. Figure 5.1 clarifies that the majority of nurses who are working in pediatric had been involved in child resuscitation (n=55, 82.1%), and 47 (90.4%) of ICU nurses had been involved.

In addition, of the 106 nurses who had been involved in resuscitation, 10 (9.4%) had invited family members to be present during resuscitations, and 96 (90.6%) had not. Also, of the 106 nurses who had been involved in resuscitation, 99 (93.4%) confirmed that a family member outside the resuscitation room.

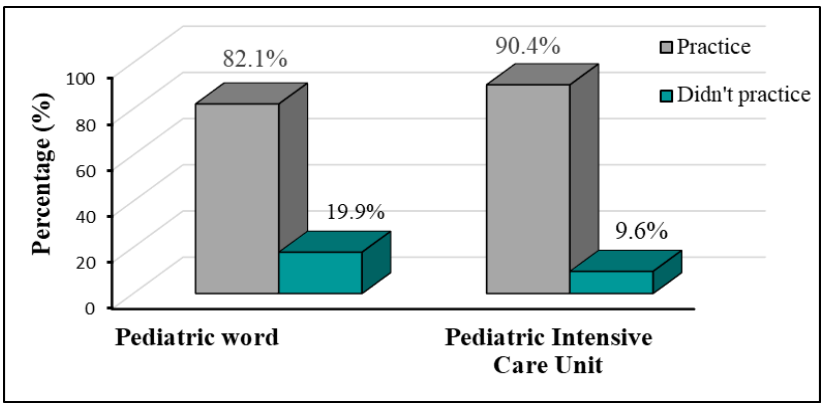

Figure (5.1): The distribution of participants who had been involved in resuscitation according to the work place

5.3 What is the level of nurses' self-confidence in facilitating FPDR in the pediatric ward and the PICU?

Nurses' perception of FPDR questionnaire has 17 items, table 5.3 showed that the mean score of the overall perception of FPS-CS was 3.11 with stander deviation 0.92, that means the nurses perception of self-confidence in FPDR is moderate. In addition, participants indicate that they had high confidence for two items of FPS-CS which are item 6 and item 4, while 15 items were moderate confidence. Participants confirmed that they were high confident to maintain dignity of the patient during resuscitation efforts with family members present (mean=3.45, SD=1.20), followed by they can deliver chest compressions during resuscitation efforts with family members present (mean =3.44, SD=1.25), while they

had a lowest confident for announce family member's presence to resuscitation team during resuscitation efforts of their family member (mean =2.90, SD=1.17).

Table (5.3): Descriptive statistic for items on Family-Presence Self-Confidence Scale

No.	Items	Mean	SD	Rang	Confident Degree
6	I could maintain dignity of the patient during resuscitation efforts with family members present.	3.45	1.20	1-5	High
4	I could deliver chest compressions during resuscitation efforts with family members present.	3.44	1.25	1-5	High
5	I could communicate effectively with other health team members during resuscitation efforts with family members present.	3.38	1.14	1-5	Moderate
2	I could administer drug therapies during resuscitation efforts with family members present.	3.37	1.24	1-5	Moderate
3	I could assist medical staff in performing electrical therapies during resuscitation efforts with family members present.	3.22	1.21	1-5	Moderate
15	I could delegate tasks to other nurses in order to support family members during resuscitation efforts of their family member.	3.13	1.16	1-5	Moderate
17	I could coordinate bereavement follow-up with family members after resuscitation efforts of their family member, if required.	3.10	1.19	1-5	Moderate
16	I could debrief family after resuscitation of their family member.	3.07	1.19	1-5	Moderate
13	I could identify spiritual and emotional needs of family members witnessing resuscitation efforts of their family member.	3.03	1.30	1-5	Moderate
9	I could enlist support from attending physicians for FPDR efforts.	3.02	1.22	1-5	Moderate
8	I could prepare family members to enter the area of resuscitation of their family member.	2.99	1.13	1-5	Moderate
10	I could escort family members into the room during resuscitation of their family member.	2.98	1.19	1-5	Moderate
12	I could provide comfort measures to family members witnessing resuscitation efforts of their family member.	2.97	1.12	1-5	Moderate
7	I could identify family members who display appropriate coping behaviors to be present during resuscitation efforts.	2.96	1.10	1-5	Moderate
1	I could communicate about the resuscitation effort to family members who are present.	2.95	1.10	1-5	Moderate
14	I could encourage family members to talk to their family member during resuscitation efforts.	2.94	1.12	1-5	Moderate
11	I could announce family member's presence to resuscitation team during resuscitation efforts of their family member.	2.90	1.18	1-5	Moderate
	Total score of FPS-CS	3.11	**0.92**	**1.47-4.88**	**Moderate**

Figure 5.2 illustrate the distribution of participant's responses to items on Family-Presence Self-Confidence Scale, participants indicated that they were quite or very confident for 7 of the 17 items (2, 3, 4, 6, 9, 15 and 16), where the highest positively perceptions for "deliver chest compressions during resuscitation efforts with family members present" (n=64, 50.8%), followed by "maintain dignity of the patient during resuscitation efforts with family members present" (n=59, 46.8%), while the lowest positively perception for "debrief family after resuscitation of their family member" (n=46, 36.5%).

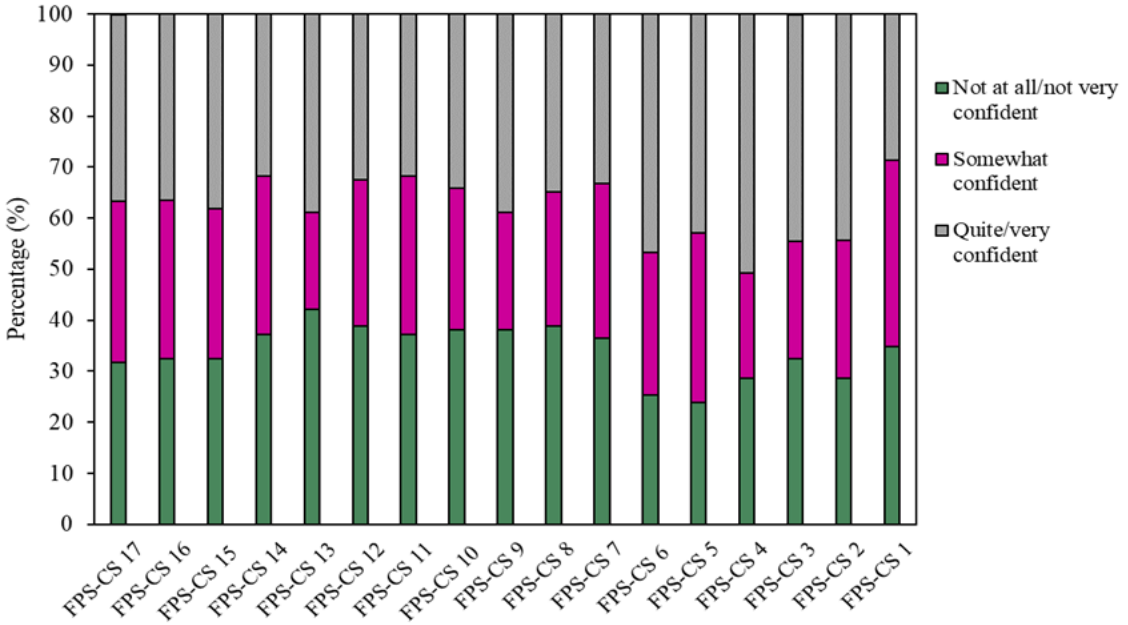

Figure 5.2: Participant's responses distribution of items on Family-PresenceSelf-Confidence Scale

On other hand, participants indicated that they were not very confident or not of all for 7 of the 17 items (7, 8, 10, 11, 12, 13 and 14), where the highest negatively perceptions for "identify spiritual and emotional needs of family members witnessing resuscitation efforts of their family member" (n=53, 42.1%), followed by "prepare family members to enter the area of resuscitation of their family member and identify spiritual" and "emotional needs of family members witnessing resuscitation efforts of their family member" (n=49, 38.9%, for each of them), while the lowest negatively perception for "debrief family after resuscitation of their family member" (n=46, 36.5%) (Annex 6).

5.4 What is the level of nurses' perception of risks and benefits of FPDR in the pediatric ward and the PICU?

Nurses' perception of family presence risk and benefit questionnaire has 22 items,one of them was deleted, so the number of items in this factor is 21, table 5.4 showed that the mean score of the overall perception of FPS-BS was 2.68 with stander deviation 0.450, that's mean the nurses perception of risk-benefit related to FPDR is moderate.

Table (5.4): Descriptive statistic for items on Family-Presence Risk-Benefit Scale

No.	Items	Mean	SD	Rang	Agreement Degree
8	Family members will become disruptive if they witness resuscitation efforts.	3.65	1.01	1-5	High
3	Family members will have difficulty adjusting to the long-term emotional impact of watching a resuscitation effort.	3.65	1.25	1-5	High
10	The resuscitation team will not function as well, if family members are present in the room.	3.59	1.11	1-5	High
9	Family members who witness a resuscitation effort are more likely to sue.	3.44	1.05	1-5	High
6	Patients do not want family members present during a resuscitation attempt.	3.26	1.02	1-5	Moderate
4	The resuscitation team may develop close relationship with family members who witness the efforts, as compared to family members who do not witness the efforts.	2.69	0.87	1-5	Moderate
21	is a right that all patients should have.	2.56	1.06	1-5	Low
5	I could identify spiritual & emotional needs of family members witnessing resuscitation efforts of their family member.	2.56	1.16	1-5	Low
16	should be a component of family-centred care.	2.54	1.09	1-5	Low
18	will have a positive effect on family ratings of satisfaction with hospital care.	2.50	1.04	1-5	Low
7	Family members who witness unsuccessful resuscitation efforts will have a better grieving process.	2.49	0.93	1-5	Low
19	will have a positive effect on nurse ratings of satisfaction in providing optimal patient and family care.	2.48	1.00	1-5	Low
20	will have a positive effect on physician ratings of satisfaction in providing optimal patient and family care.	2.46	1.02	1-5	Low
22	is a right that all family members should have.	2.44	1.03	1-5	Low
17	will have a positive effect on patient ratings of satisfaction with hospital care.	2.42	1.05	1-5	Low
1	Family members should be given the option to be present when a loved one is being resuscitated.	2.39	1.10	1-5	Low
11	Family members on the unit where I work prefer to be present in the room during resuscitation efforts.	2.26	0.96	1-5	Low
14	is beneficial to nurses.	2.25	0.96	1-5	Low
15	is beneficial to physicians.	2.21	1.10	1-5	Low
12	The presence of family members during resuscitation efforts is beneficial to patients.	2.21	0.93	1-5	Low
13	is beneficial to families.	2.17	1.03	1-5	Low
Total score of FPS-BS		**2.68**	**0.045**	**1.81-4.24**	**Moderate**

In addition, participants indicate that family presence risk and benefit is high for four items of FPS-BS which are 3, 8, 9 and item 10, while 15 items were low degree of 21 items. The highest mean score was for two items which are "family members will become disruptive if they witness resuscitation efforts" (mean =3.65, SD=1.10) with high agreement, and "family members will have difficulty adjusting to the long term emotional impact of watching a resuscitation effort" (mean =3.65, SD=1.25) with high agreement, followed by "the resuscitation team will not function as well if family members are present in the room" (mean = 3.59, SD= 1.11) with high agreement, while the lowest mean score was for "family members present in resuscitation room is beneficial to families" (mean =2.17, SD=1.03).

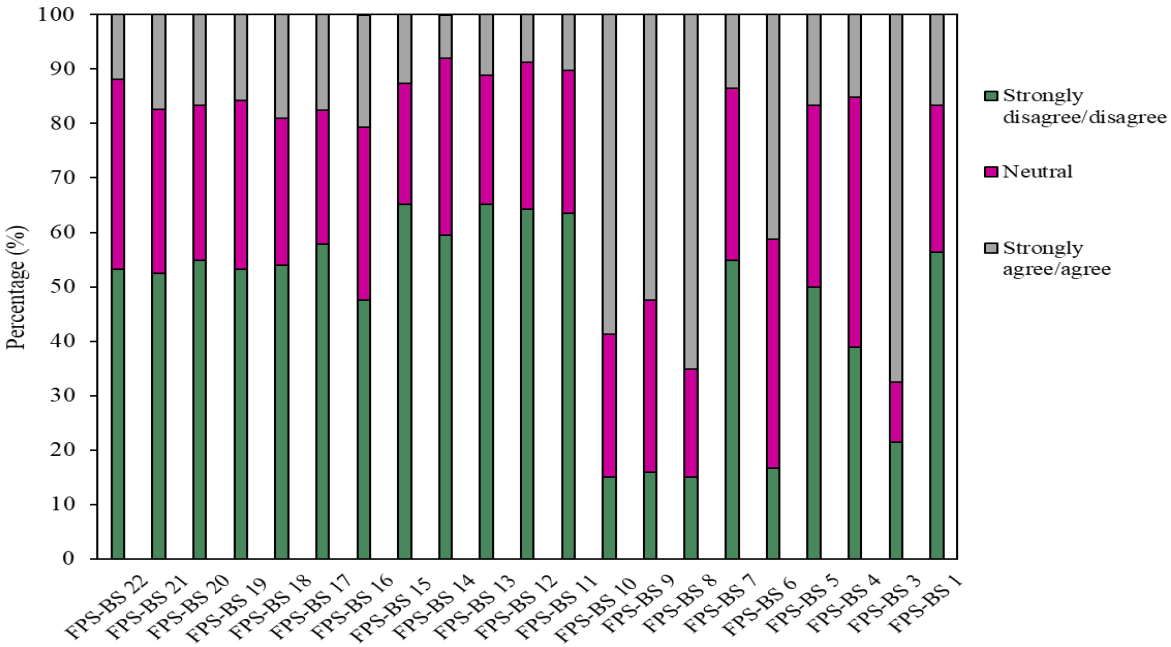

Figure 5.3: Participant's responses distribution of items on Family-Presence Risk-Benefit Scale

Figure 5.3 illustrate the distribution of participant's responses to items on Family-Presence Risk-Benefit Scale, participants indicated that they were strongly agree and agree for 4 items of the 21 items (3, 8, 9 and 10), where the highest positively perceptions for "family members will have difficulty adjusting to the long term emotional impact of watching a resuscitation effort" (n=85, 67.5%), followed by "family members will become

disruptive if they witness resuscitation efforts" (n=82, 65.1%), while the lowest positively perception for "Family members who witness a resuscitation effort are more likely to sue" (n=66, 52.4%). On the other hand, participants indicated that they were strongly disagree and disagree for 15 of the 21 items (1, 5, 7, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22), where the highest negatively perceptions for "The presence of FPDR efforts is beneficial to physicians" and "The presence of FPDR efforts is beneficial to families" (n=82, 65.1%, for each of them), while the lowest negatively perception for "should be a component of family-centered care" (n=60, 47.6%) (Annex 7).

5.5 What is the relationship between nurses' perception of and self-confidence in facilitating FPDR and sociodemographic characteristics

This section displays the result of first-main hypothesis which stating: "**There is no significant difference between nurses' perception of FPDR and sociodemographic characteristics**(Gender, Age, Marital status, Education level, Job tittle, work area, experience in resuscitation, and invited families to resuscitation room)"

The result of Mann-Whitney U-test in table 5.4 indicates that there is no statistically significant difference of confident scale mean score between female nurses and male nurses (p=0.268), also there is no statistically significant difference of confident scale mean score between participants who had invited families to be present during resuscitation and who do not (p=0.175), and there was no statistically significant difference of confident mean score due to work area (p=0.205). In addition, Kruskal–Wallis test showed there is no statistically significant differences of confident mean score due to participant's material status (p=0.180), education level (p=0.123), and job title (p=0.309).

Furthermore, Kruskal-Wallis test revealed a statistically significant differences of confident scale mean score due to participant's age (p=0.025), participant's work experience (p=0.009) and previous experience of resuscitation (p=0.009).

Table (5.5): Result of main differences in confident scale mean score due to demographic characteristics

Variables	Categories	Mean	SD	Mean rank	Test statistic	Sig.
Gender	Male	2.93	0.97	56.92	-1.107‡	0.268
	Female	3.17	0.90	64.78		
Age	20- 24 years	2.72	0.81	49.70	11.069†	0.026*
	25 – 29 years	3.06	0.94	60.00		
	30 – 34 years	2.99	0.86	58.73		
	35 – 39 years	3.58	1.05	82.47		
	40 year or above	3.50	0.86	76.90		
Material status	Single	2.84	0.91	52.80	4.893†	0.180
	Married	3.23	0.90	67.79		
	Divorced	2.92	1.09	55.80		
	Widowed	3.71	0.00	83.50		
Education Level	Diploma	3.40	0.95	74.70	5.784†	0.123
	Bachelor	2.95	0.82	57.22		
	High diploma	3.22	1.14	67.29		
	Master Degree	3.42	0.91	77.00		
Job title	Practical nurse	3.40	0.95	52.80	3.44†	0.309
	Staff nurse	3.07	0.90	67.79		
	Senior nurse	2.87	1.19	55.80		
	Head nurse	3.49	0.79	83.50		
Years of work experience	Less than 1 year	2.90	0.96	52.94	11.469†	0.009*
	1-5 years	2.99	0.84	56.90		
	6-10 years	2.91	0.93	54.45		
	More than 10 years	3.57	0.85	79.15		
Working Area	Pediatric word	3.02	0.91	58.01	-1.266‡	0.205
	Pediatric ICU	3.24	0.94	66.20		
Have you been involved in resuscitation of a child?	Yes	3.23	0.90	65.34	-2.60‡	0.009*
	No	2.63	0.84	41.15		
Have you invited family into the resuscitation room?	Yes	3.54	1.01	77.90	-1.357‡	0.175
	No	3.09	0.90	61.70		

†: Result obtained by Kruskal–Wallis test at p-value ≤0.05
‡: Result obtained by Mann–Whitney U-test at p-value ≤0.05
*: Result significant at 5%.

Figure 5.5 clarifies the sources of differences in the confident scale mean score due to the age categories, work experience and pervious experience in resuscitation (Have you been involved in resuscitation of a child?), the result indicates the confident mean score of

participants who had a previous experience in resuscitation is higher than the confident mean score of who do not have (p=0.009), on other word the participants who had a previous experience in resuscitation is more self-confident compared with who do not have. In addition, the result showed there is a statistically significant difference of confident scale mean score between participant their age between 20 and 24 years and others who their age between 35 and 39 years (p=0.074<0.10), participants who their age between (35-39) years are more self-confident compared with others who their age between 20 and 24 years (mean=3.58), also there was a significant difference of confident mean score between participants who had an experience between 1 and 5 years and others who had more than 10 years (p=0.040<0.05) in favor of the participants who had more than 10 years. Furthermore, there was a statistically significant difference of confident mean score between participants who had an experience between 6 and 10 years and others who had more than 10 years (p=0.017<0.05). So, the favor of the participants who had more than 10 years.

Figure 5.4: Mean and standard deviation of confident scale due to significant factor; Different letters within bars indicate a significant difference

5.6What is the relationship between nurses' perception of risk and benefit of FPDR and sociodemographic characteristics?

This section displays the result of second-main hypothesis which stating: **"There is no significant difference at a level of ($\propto \leq 0.05$) between nurses' perception of risks and benefits of FPDR and sociodemographic characteristics. (Gender, Age, Marital status, Education level, Job tittle, work area, experience in resuscitation, invited families to resuscitation room)"**

The result of Independent sample t-test in table 5.5 indicates that there is no statistically significant difference of risk/benefit scale mean scores between female nurses and male nurses (p=0.101), also there is no statistically significant difference of risk/benefit scale mean score between participants who working in pediatric word and PICU groups (p=0.926), while there was a statistically significant difference of risk/benefit scale mean scores between participants who had invited families to be present during resuscitation and who do not (p=0.030), also there was a statistically significant difference of risk/benefit scale mean scores between participants who had previous experience of resuscitation and who do not had (p=0.095<0.10).

Furthermore, ANOVA test showed there is no statistically differences of risk/benefit scale mean scores due to participant's experience of work (p=0.226), material status (p=0.587), education level (p=0.102) and work area (p=0.926).

Furthermore, Kruskal-Wallis test revealed a statistically significant differences risk/benefit scale mean score due to participant's job title (p=0.083<0.10), In addition, Kruskal-Wallis test showed there is no statistically significant differences of risk/benefit mean score due to age categories (p=0.587).

Table (5.6): Result of main differences in mean Risk-Benefit score due to demographic characteristics

Variables	Options	Mean	SD	Test statistic	Sig.
Gender	Male	2.57	0.39	-1.654‡	0.101
	Female	2.72	0.47		
Age	20- 24 years	2.72	0.81	2.829†	0.587
	25 – 29 years	3.06	0.94		
	30 – 34 years	2.99	0.86		
	35 – 39 years	3.58	1.05		
	40 year or above	3.50	0.86		
Material status	Single	2.61	0.42	0.587ᴛ	2.829
	Married	2.72	0.46		
	Divorced	2.37	0.27		
	Widowed	3.29	0.00		
Education level.	Diploma	2.65	0.65	0.959ᴛ	0.102
	Bachelor	2.70	0.36		
	High diploma	2.65	0.44		
	Master Degree	2.66	0.56		
Job title	Practical nurse	3.40	0.95	6.667†	0.083*
	Staff nurse	3.07	0.90		
	Senior nurse	2.87	1.19		
	Head nurse	3.49	0.79		
Working Area	Pediatric word	2.64	0.38	-0.094‡	0.926
	Pediatric ICU	2.65	0.46		
Years of work experience	Less than 1 year	2.52	0.29	1.471ᴛ	0.226
	1-5 years	2.68	0.42		
	6-10 years	2.62	0.46		
	More than 10 years	2.80	0.49		
Have you been involved in resuscitation of a child?	Yes	3.23	0.90	1.681‡	0.095*
	No	2.63	0.84		
Have you invited family into the resuscitation room?	Yes	3.54	1.01	2.210‡	0.030**
	No	3.09	0.90		

ᴛ: Result obtained by One Way Analysis of Variance (ANOVA)
‡: Result obtained by independent sample t-test
*, **: Result significant at 10% and 5% respectively.

Figure 5.6 clarifies the sources of differences in the risk/benefit scale mean score due to the job title, families' invitation to resuscitation room and pervious experience in resuscitation, the result indicates the risk/benefit mean score of participants who had a previous experience in resuscitation is higher than the confident mean score of who do not have (p=0.095), that means nurses who had a previous experience in resuscitation perceived

more benefits and fewer risks than other who did not have. In addition, the result showed there is a statistically significant difference of risk/benefit scale mean score between participant who had invited families to be present during resuscitation and who do not (p=0.030), participant who had invited families to be present during resuscitation perceived more benefits and fewer risks than other who did not invited (mean=2.98), also there was a significant difference of risk/benefit mean score between staff nurse and senior nurse (p=0.088), staff nurse perceived more benefits and fewer risks than other senior nurses (mean=2.70).

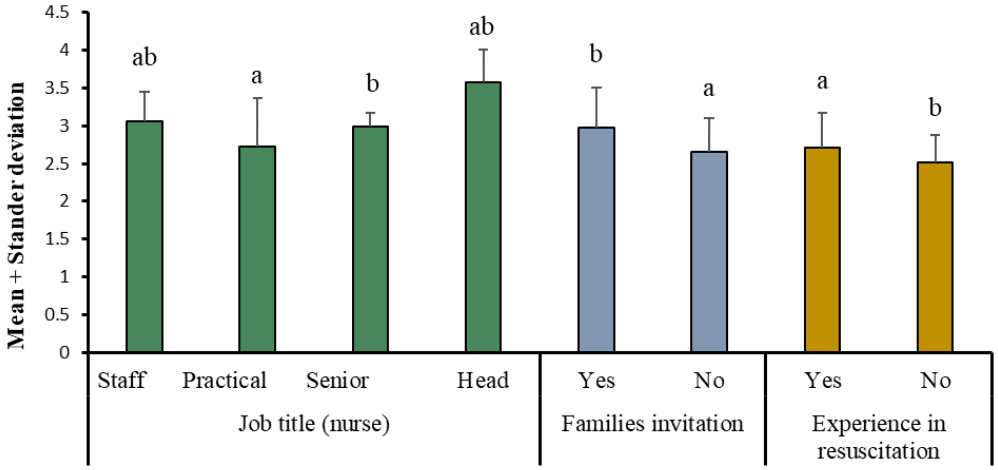

Figure 5.5: Mean and standard deviation of Risk-Benefit score due to significant factor; Different letters within bars indicate a significant difference

5.7What is the relationship between nurses' perceptions of confident scale and their perceptions for risk/ benefit scale of FPDR?

This section displays the result of third-main hypothesis which stating: **"There is a positive statistically significant correlation at the level ($\propto \leq 0.05$) between nurses' perceptions of confident scale and their perceptions for risk/ benefit scale of FPDR."**

In order to test the hypothesis, simple linear regression was applied, The Pearson r correlation between FPS-CS and FPR-BS was significant (r = 0.396, p =0.00), that means

the nurses who were more self-confident in their ability to include patients' family members during resuscitation also perceived more benefits to FPDR.

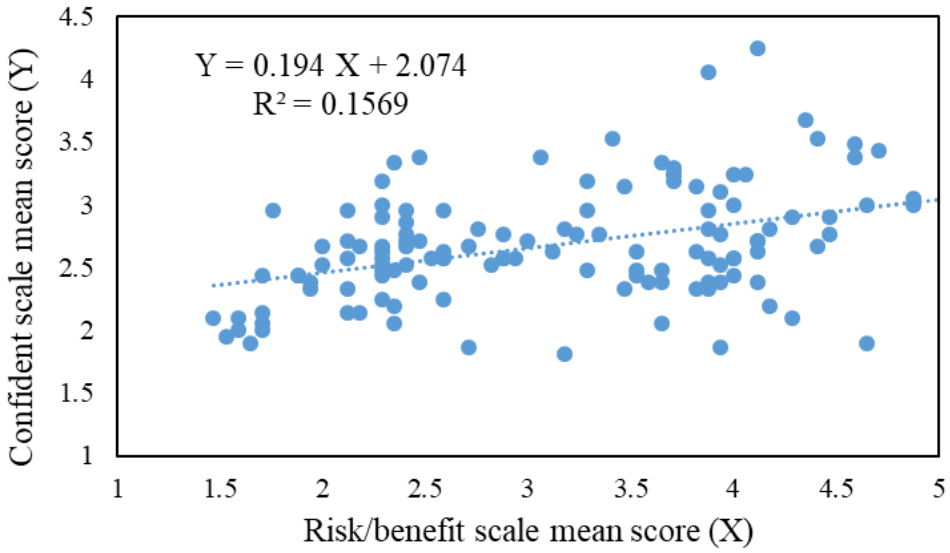

Figure 5.6: Relationship between confident scale and risk/ benefit scale

According the result of simple linear regression in figure 5.6, R squared equals to 0.157, which means that 15.7% of the variation in the participant's perceptions for self-confident in their ability to include patients' family members during resuscitation is explained by variation in their perceptions for risk/ benefit to FPDR. Also, If the participant's perceptions for risk/ benefit to FPDR will increase by one unit, the participant's perceptions for self-confident in their ability to include patients' family members during resuscitation action increases by 0.194 unit.

Chapter Six

Discussion

6.1 Introduction

This chapter summarizes the study and conclusions drawn from the data analysis in chapter five. It also provides a discussion of the implications for actions and recommendations for further research. The focus of this research is to assess the perception of nurses towards FPDR. It will also assess the self-confidence of nurses in facilitating family presence during the resuscitation of patients in pediatric ward and PICUat Southern West Bank Hospitals .

First discussed are the sample characteristics and the influence of demographic characteristics. The theoretical framework of family-centered care is examined in terms of the influence on the results of this study. Study strengths and limitations are presented. Recommendations are made for education and further research.

The nursing experience is important as the routine incorporation of families during CPR is becoming more common due to recent recommendations by professional nursing and medical associations. However, few hospitals have written policies allowing for or guiding nursing practice with families during these situations (Miller & Stiles, 2009). Perception and knowledge gained from this study can provide a foundation for planning nursing interventions and informing nurses who support and assist FPDR.

6.2 Socio Demographic Characteristics

As mentioned in Table 5.1, 126 nurses participated in the questionnaire, 36 (29%) were males, and 88 (71%) were females. The majority of nurses (N=53, 42%) aged between 30 and 34 years. However, more than the half of the nurses (N=82, 65.6%) were married. The highest percent of nurses had Bachelor degree (N=73, 57.9%), followed by Diploma

(N=23, 18.3%), while 30 (23.8%) of them had high education (High Diploma, Master Degree).

Previous studies varied in describing social demographic variables according to the purpose and location of each study. According to gender, the current study had a higher percentage of females than males. The reason is that the place of study is children's hospitals, and these institutions prefer to employ females more than males according to the service provided, and this was confirmed by many studies, including a study by Adams 2007 which found greater percent of female than male, the reason for this is that the nursing profession in European countries was for females only. Recently, men began entering this profession. same result in study by Gluck (2014) study population was comprised of 15% males and 85% females.

According education level, most of the participant held a bachelor's degree in nursing, because the direction of the Palestinian Ministry of Health seeks to hire those who have a bachelor's degree in nursing in the intensive care departments and neonatal intensive care departments (MOH, 2020). In study by Powers (2014) The majority of subjects (45%) reported their highest earned nursing degree was a baccalaureate degree. In addition, 23.5% of the indicated they held a graduate level degree. Degree attained differed in the number of subjects who held an associate's or diploma degree, with 32.5% indicating this was their highest earned nursing degree.

Other study by McLean (2013) found Nurses who had completed a post-graduate qualification equaled 46 (56.8%) and the remaining 35 (43.2%) without a post-graduate qualification held a hospital certificate, a hospital diploma or bachelor degree.in study by Miller & Stiles (2009) found six of the nurse participants held a Master's degree, eight a

Bachelor's degree, one an associate's degree and two with diplomas in nursing. Ten of the nurses held certifications in a nursing specialty and seven did not.

6.3 Working Characteristics

Table 5.2 illustrated that 40 (32.3%) of nurses had an experience between one and five years, 38(30.6%) had experience between 6 and 10 years, 37 (29.8%) of them had more than 10 years of experience. A total of 92 (74.8%) staff nurse and 23 (18.7%) practical nurses, while 8 (6.5%) of the respondents were seniors and head nurses. In addition, the result indicated that 70 (57.4%) of nurses were working in pediatric word, while52 (42.6%) of them were working in PICU.

In this study, the participants were asked if they have been involved in resuscitation of a child, 106 (86.2%) of nurses reported that they had been involved, 17 (13.8%) had not. Figure 5.1 clarifies that the majority of nurses who are working in pediatric had been involved in child resuscitation (n=55, 82.1%), and 47 (90.4%) of ICU nurses had been involved. In addition, of the 106 nurses who had been involved in resuscitation, 10 (9.4%) had invited family members to be present during resuscitations, and 96 (90.6%) had not. Also, of the 106 nurses who had been involved in resuscitation, 99 (93.4%) confirmed that a family member outside the resuscitation room.

In study by Imperatrice (2019) found more than half (76.7%) have invited a family member to be present during a resuscitation attempt. A total of (68%) of participants indicated that they would want a member of their family to be present during their own resuscitation. More than half of the participants (79.6%) have never been present in the room when one of their own family members was being resuscitated. When asked who should make the overall decision about FPDR, (42%) indicated the patient, (25.2%) indicated the family, (23.3%) indicated the physician and (8.7%) indicated the nurse. Three-fourths of the

participants indicated that FPDR should be a part of the advanced directive authorized by the patient.

In study by Herron (2014) The final analyses found44.1% of the healthcare professionals have never invited a family member to be present during resuscitation while 37.3% had invited families greater than five times and 18.6% have invited families less than five times. The units that this happened most frequently in are the ED at 47.5%, Critical Care at 15.3%, Inpatient at 5.1%, other at 3.4% while 28.8% were not applicable.

Other study by Axelsson et al. (2010) the researcher distributed the survey to nurses (N = 411) attending a cardiovascular nursing conference in Europe and found implementation of FPDR more common in the United Kingdom (52.9%) and Ireland (58.9%) than in Norway (34.8%), and rates of implementation correlated with scores on the attitude survey.

6.4. Level of nurses' self-confidence in facilitating FPDR in the pediatric ward and the PICU?

Nurses' perception of FPDR questionnaire has 17 items; table 5.3 showed that the mean score of the overall perception of FPS-CS was 3.11 with stander deviation 0.92, that means the nurses perception of self-confidence in FPDR is moderate.

In study conducted by Tudor et al. (2014), the same survey tools were used to explore nurses' experiences with resuscitation, perceptions of benefits and risks of having a patient's family member present, and self-confidence in having family presence at their workplace. The study results revealed that nurses' self-confidence levels and perceived benefits of family presence were significantly ($r = 0.54$; related $p < .001$).

Twibell et al. (2008) explored nurses' perceptions of self- confidence and Families' and Healthcare examined whether self-confidence influenced whether they brought family

to the patient's bedside. Data findings identified a positive correlation between nurse's self-confidence in caring for families during resuscitation and their support of FPDR.

Chapman et al. (2011) found nurse and physician perception and self-confidence for FPDR were more positive with a history of higher frequency of FPDR invitation to families. Using the same scale, Twibell et al. (2008) found the more nurses had invited FPDR, the higher the mean scores for perception (from 2.99 to 3.38 to 4.00) and for self-confidence (from 3.47 to 3.93 to 4.43), further linking FPDR experience to increased support. Others have also found improved attitude and perception positively correlated with prior FPDR experience (Fallis et al., 2008; Feagan & Fisher, 2011; Leung & Chow, 2012). Lastly, Feagan and Fisher (2011) found a positive correlation between prior FPDR education and increased support for FPDR.

6.5 The level of nurses' perception of risks and benefits of FPDR in the pediatric ward and the PICU.

Nurses' perception of family presence risk and benefit questionnaire has 22 items, one of them was deleted, so the number of items in this factor is 21, table 5.4 showed that the mean score of the overall perception of FPS-BS was 2.68 with stander deviation 0.450, that's mean the nurses perception of risk-benefit related to FPDR is moderate.

Nurse and healthcare provider support for FPDR is influenced by the risks and benefits perceived (McClement et al., 2009). The higher the perceived risks and lower the perceived benefits, the less support for FPDR and vice versa (Twibell et al., 2008).

Oman and Duran (2010) used a descriptive study design to evaluate the impact of family presence at resuscitation events. During the study period, 106 resuscitations took place at an academic medical center in Western United States. In 31 cases, there was documentation of family presence during the event. The 134 staff members whose names were legible on the resuscitation record were invited to complete the electronic survey. Of

the 65 respondents, 59% felt that family member was able to emotionally handle the situation and 88% felt family members did not interfere with the care given or resuscitation team communication. In 70% of cases, a family facilitator was present and this role was held by a registered nurse in 41% of cases. The three themes identified from the narrative comments were that family presence is beneficial, emotional, and the use of a facilitator is required.

According from Jabre et al (2014), the pros and cons of FPDR have been argued and disagreed upon by health professionals since the practice was first proposed in 1987. This has resulted in a lack of family member presence policies in many health care settings. However, their research indicated that family presence was associated with positive results on several psychological variables, did not interfere with treatments or result in medico-legal conflicts, or cause increased stress in the health care providers.

6.6 The relationship between nurses' perception of and self-confidence in facilitating FPDR and sociodemographic characteristics

The result of Mann–Whitney U-test in table 5.4 indicates that there is no statistically significant difference of confident scale mean score between female nurses and male nurses ($p=0.268$), also there is no statistically significant difference of confident scale mean score between participants who had invited families to be present during resuscitation and who do not ($p=0.175$), and there was no statistically significant difference of confident mean score due to work area ($p=0.205$). In addition, Kruskal–Wallis test showed there is no statistically significant differences of confident mean score due to participant's material status ($p=0.180$), education level ($p=0.123$), and job title ($p=0.309$).

Figure 5.4 clarifies the sources of differences in the confident scale mean score due to the age categories, work experience and pervious experience in resuscitation (Have you been involved in resuscitation of a child?), the result indicates the confident mean score of

participants who had a previous experience in resuscitation is higher than the confident mean score of who do not have (p=0.009), on other word the participants who had a previous experience in resuscitation is more self-confident compared with who do not have. In addition, the result showed there is a statistically significant difference of confident scale mean score between participant their age between 20 and 24 years and others who their age between 35 and 39 years (p=0.074<0.10), participants who their age between (35-39) years are more self-confident compared with others who their age between 20 and 24 years (mean=3.58), also there was a significant difference of confident mean score between participants who had an experience between 1 and 5 years and others who had more than 10 years (p=0.040<0.05) in favor of the participants who had more than 10 years. Furthermore, there was a statistically significant difference of confident mean score between participants who had an experience between 6 and 10 years and others who had more than 10 years (p=0.017<0.05) in favor of the participants who had more than 10 years.

Research has found self-confidence for FPDR positively correlates with an increased age of the nurse (Chapman et al., 2011); however, other studies did not find age to impact nurses' FPDR preferences or practices (Fallis et al., 2008; Twibell et al., 2008). No other demographic factors, such as gender or ethnicity, have demonstrated a statistically significant correlation.

Research has found self-confidence for FPDR positively correlates with an increased age of the nurse (Chapman et al., 2011); however, other studies did not find age to impact nurses' FPDR preferences or practices (Bassler, 1999; Fallis et al., 2008; Twibell et al., 2008). No other demographic factors, such as gender or ethnicity, have demonstrated a statistically significant correlation.

Inconclusive relationships between certain professional attribute factors and FPDR support have been noted and more research is needed. Years of education and years of experience have unclear correlations to FPDR support. Higher level of education has been shown to positively impact perception and self-confidence for FPDR (Chapman et al., 2011), but research using the same scale refuted this finding (Twibell et al., 2008). Basol et al. (2009) and Ellison (2003) found a significant correlation between a positive FPDR attitude and higher level of education; however, others did not (Fallis et al., 2008; Meyers et al., 2004). Similarly, increased years of experience has been noted to correlate with improved self-confidence for FPDR (Chapman et al., 2011), while others found no relationship to perception of FPDR (Fallis et al., 2008; Feagan & Fisher, 2011; Fulbrook et al., 2005; Twibell et al., 2008).

Occupation and clinical practice setting appear to have a stronger correlation to FPDR support. The majority of research has found nurses to be more supportive of FPDR than physicians (Basol et al., 2009; Duran et al., 2007; Meyers et al., 2004; Mian et al., 2007). Only one study by(Chapman et al., 2011) found no significant difference amongst nurses and physicians. Clinical practice setting has been found to correlate to FPDR support, with more supportive attitudes among emergency department nurses than those nurses working in critical care or other acute care settings (Basol et al., 2009; Bassler, 1999; Ellison, 2003; Twibell et al., 2008). Fulbrook et al. (2005) found no significant difference between nurses working in critical care or non-critical care, but did find differences between nurses working in clinical and non-clinical (management, education, and research) settings, with non-clinical nurses more supportive of FPDR. Similarly, Twibell et al. (2008) found no significant difference between nurses working in critical care and non-critical care settings; however, emergency department nurses were found to be more supportive than all other

clinical areas and nurses working in outpatient settings were found to be the least accepting of FPDR.

6.7 The relationship between nurses' perception of risk and benefit of FPDR and sociodemographic characteristics.

The result of Independent sample t-test in table 5.5 indicates that there is no statistically significant difference of risk/benefit scale mean scores between female nurses and male nurses (p=0.101), also there is no statistically significant difference of risk/benefit scale mean score between participants who working in pediatric word and PICU groups (p=0.926), while there was a statistically significant difference of risk/benefit scale mean scores between participants who had invited families to be present during resuscitation and who do not (p=0.030), also there was a statistically significant difference of risk/benefit scale mean scores between participants who had previous experience of resuscitation and who do not had (p=0.095<0.10).

Furthermore, ANOVA test showed there is no statistically differences of risk/benefit scale mean scores due to participant's experience of work (p=0.226), material status (p=0.587), education level (p=0.102) and work area (p=0.926).

Furthermore, Kruskal–Wallis test revealed a statistically significant differences risk/benefit scale mean score due to participant's job title (p=0.083<0.10), In addition, Kruskal–Wallis test showed there is no statistically significant differences of risk/benefit mean score due to age categories (p=0.587).

Figure 5.5 clarifies the sources of differences in the risk/benefit scale mean score due to the job title, families' invitation to resuscitation room and pervious experience in resuscitation, the result indicates the risk/benefit mean score of participants who had a previous experience in resuscitation is higher than the confident mean score of who do not

have (p=0.095), that means nurses who had a previous experience in resuscitation perceived more benefits and fewer risks than other who did not have. In addition, the result showed there is a statistically significant difference of risk/benefit scale mean score between participant who had invited families to be present during resuscitation and who do not (p=0.030), participant who had invited families to be present during resuscitation perceived more benefits and fewer risks than other who did not invited (mean=2.98), also there was a significant difference of risk/benefit mean score between staff nurse and senior nurse (p=0.088), staff nurse perceived more benefits and fewer risks than other senior nurses (mean=2.70).

According study by Carroll (2014) there were significant differences in risks/benefits with medical and pediatric intensive care unit nurses rating lower risk and higher benefit for resuscitation. Perceptions of family presence were significantly higher for pediatric and medical intensive care unit nurses. Further education and support may be needed in the surgical and mixed intensive care units as compared to the critical care and emergency units. Evidence-based practice guidelines that are family centered can define the procedures and resources for family presence, to ultimately promote professional practice.

Chapman et al. (2013) also found that higher educational levels, post graduate specialty and experience in inviting families to be present were associated with perceptions of greater benefits and greater confidence. These differences may be explained by a number of variables. Participants were recruited from the emergency department and did not include inpatient ward areas. In addition to this, the setting in which the study by Chapman et al. (2013) was undertaken, did not have formal guidelines to inform staff on the process of FPDR. However similarly to this current study, Chapman et al. (2013) found that there were no significant differences in perceptions and confidence between medical and nursing staff.

The majority of medical staff in Chapman et al. (2013) worked at a senior level, as did medical participants here. This may account for the support of family presence by medical staff in both studies.

6.8 There a relationship between nurses' perceptions of confident scale and their perceptions for risk/ benefit scale of FPDR.

According the result of simple linear regression in figure 5.6, R squared equals to 0.157, which means that 15.7% of the variation in the participant's perceptions for self-confident in their ability to include patients' family members during resuscitation is explained by variation in their perceptions for risk/ benefit to FPDR. Also, If the participant's perceptions for risk/ benefit to FPDR will increase by one unit, the participant's perceptions for self-confident in their ability to include patients' family members during resuscitation action increases by 0.194 unit.

Twibell et al. (2008) developed a survey tool to examine the relationship between nurses' self confidence in providing care and support of families during resuscitation and support of FPDR in relation to the risk or benefit of such actions. Results showed a positive correlation between nurses' self confidence in caring for the families during resuscitation and their support of FPDR. It was unclear as to whether self-confidence resulted in or was the result of adoption of FPDR.

Twibell et al. (2008) assessed four clinical area categories (critical care [ICU], non-critical care inpatient areas, the emergency department and outpatient setting) compared to McLean study which included only two clinical area categories - critical care (E.D, PICU, and NICU) and non-critical care areas (all other inpatient areas). Results of study by McLean (2013) found that critical care participants perceived more benefits and had greater self-confidence than participants in non-critical care areas, whereas Twibell et al. (2008) found

no differences between critical care and non-critical care participants. The variation in categorizing clinical areas may account for the difference in results. The similarities were that critical care participants in McLean study and staff working in the emergency department in Twibell et al. (2008) perceived more benefits and greater self-confidence than those in other areas. In both studies, nurses who had invited families to be present during resuscitation perceived more benefits and were more confident in facilitating family presence.

6.9 Conclusion

Understanding the necessities of families in a horrible mishap, like resuscitation, is a significant part of really focusing on families in the pediatric climate. Plainly families need to be available while their youngster is being revived, and their essence has had positive results for the individuals who have had the chance to do as such. In spite of this, family presence during revival stays a questionable subject among wellbeing experts in the pediatric setting. Medical and nursing staff have demonstrated hesitance to permit families to be available because of afear of impedance from relatives, and worry over the mental prosperity of families who witness revival endeavors. A significant number of these worries have not been upheld by proof. The critical discoveries from this study are that staff working at pediatric wards endorsed the presence of relatives during the revival of their kid. Both medical and nursing staff comprehended the necessities of families during revival and the way of thinking of family-centered care is a model of care rehearsed across disciplines.

The key findings resulting from this study have highlighted that staff understand the needs of family members who witness the resuscitation of their child. In particular nursing staff who have experienced family presence, perceived fewer risks, more benefits and were more confident in facilitating family presence .

Understanding the needs of families in a traumatic event, such as resuscitation, is an important aspect of caring for families in the pediatric environment. Evidence indicates that families want to be present while their child is being resuscitated, and their presence has had positive outcomes for those who have had the opportunity to do so (Gluck, 2014). Despite this, FPDR remains a controversial subject amongst health professionals in the pediatric setting. Nursing staff have shown reluctance to allow families to be present for fear of interference from family members, and concern over the psychological well-being of families who witness resuscitation attempts. Many of these concerns have not been supported by evidence.

6.10 Recommendation

Based on the study finding, the researcher would provide recommendations as outlined below. Decision makers, health managers, nursing supervisors, nursing leaders, professionals and researchers need to consider these recommendations and intensively work to address them.

- This research recommends that explicit training on FPDR, and should be implemented and adopted within the hospital setting.
- A multidisciplinary group procedure would be needed for the most common way of organizing and executing organized FPDR guidelines, recognizing staff training requirements, and creating separate teaching lessons in regards to FPDR.
- There ought to be a conventional FPDR strategy to guarantee a predictable methodology for family presence as an alternative, so the medical services suppliers can survey and screen every family at its solitary circumstance.
- A single time educational program does not change the disposition and practice of health care providers. Constant educational intercessions and techniques ought to be organized

to build up the significance of tolerating and starting the endeavors for fostering the FPDR practice guidelines that can be supported over the long run.

- Extra studies should be directed to pursue the information, including families' perspectives and sentiments in regards to FPDR from a Palestinian setting.
- Recommendations for the future include the need for further research to explore other patient populations, different clinical environments, and sociodemographic variables that may impact perceptions of FPDR.

References

Adams, Watson. (2007). Attitudes of Hospital Nurses regarding Family Presence during Resuscitation, **Master of Nursing Thesis**, The University of Wyoming, USA.

Akib, E., & Ghafar, M. N. A. (2015). The validity and reliability of assessment for learning (AfL). **Education Journal**, 4(2), 64-68.

American Academy of Pediatrics (2016). Pediatric advanced life support provider manual.Dallas, Texas: **American Heart Association**.

American Association of Critical Care Nurses (AACN) (2016). Practice alert: Family presence during resuscitation and invasive procedures. **Critical Care Nurse**, 36(1),

American Heart Association (2000). Ethical Aspects of CPR and ECC. **Circulation**.

American Heart Association in collaboration with the International Liaison Committee on Resuscitation (AHA/ILCR). (2000). Guidelines 2000 for cardiopulmonary resuscitation and emergency cardiovascular care. **Circulation**, 102, 11–374 (Suppl).

American Nurses Association (2010). Nursing: Scope and standards of practice (2nd ed.). Silver Spring, MD: **Nursebooks**.org.

Arnold, Sarah S. (2014) Family presence during resuscitaiton: Changing the american paradigm, **doctoral dissertation**, Drew University, USA.

Axelsson, A. B., Fridlund, B., Moons, P., Martensson, J., Reimer, W. S., Smith,Norekval, T., M. (2010). European cardiovascular nurses' experiences of and attitudes towards having family members present in the resuscitation room. **European Journal of Cardiovascular Nursing**, 9(1), 9.

Badir, A., & Speit, D. (2007). Family presence during CPR: A study of the experiences and opinions of Turkish critical care nurses. **International Journal of Nursing Studies**, 44(1), 9.

Bashayreh, I., & Saifan, A. (2015). Family Witnessed Resuscitation: Through the Eyes of family Members. **Journal of American Science,** 11(3).

Basol, Roberta, Kathleen Ohman, Joyce Simones, and Kirsten Skillings (2009). Using Research to Determine Support for a Policy on Family Presence During Resuscitation. **Dimensions of Critical Care Nursing** 28, no. 5, 237- 47.

Bassler, P.C. (1999). The impact of education on nurses' beliefs regarding family presence in a resuscitation room. **Journal for Nurses in Staff Development**, 15(3), 126-131.

Bradley C, Keithline M, Petrocelli M, Scanlon M, Parkosewich J. (2017) Perceptions of Adult Hospitalized Patients on Family Presence During Cardiopulmonary Resuscitation. **Am J Crit Care. Mar**;26(2):103-110.

Brown, K., Mace, S.E., Dietrich, A.M., Knazik, S., & Schamban, N.E. (2008). Patient and family-centered care for pediatric patients in the emergency department. **CJEM: Journal of the Canadian Association of Emergency Physicians**, 10(1), 38-43.

Carroll, D.L. (2014). The effect of intensive care unit environments on nurse perceptions of family presence during resuscitation and invasive procedures. **Dimensions of Critical Care Nursing**, 33(1), 34-39.

Chapman, R., Watkins, R., Bushby, A., & Combs, s. (2013). Assessing health professionals' perceptions of family presence: A replication study. **International Emergency Nursing**,21, 8.

Chew, K., S. & Ghani, A., Z. (2014) Attitudes and perceptions of the general Malaysian public regarding family presence during resuscitation. **Singapore Medical Journal,** 55(8): 439-442

Conway, J., Johnson, B., Edgman-Levitan, S., Schlucter, J., Ford, D., Sodomka, P.,

&Simmons, L. (2006). Partnering with patients and families to design a patient- and family-centered health care system: A roadmap for the future: **A work in progress. Institute for Family-Centered Care**.

Cross, D. (2018). Evaluating Nurses perceptions of family presence during resuscitation efforts and invasive procedures before and after an educational intervention.**Master's in Advanced Practice Nursing thesis,** Wegman's School of Nursing, John Fisher College, USA.

Davidson, J. E., Buenavista, R., Hobbs, K., & Kracht, K. (2011). Identifying factors inhibiting or enhancing family presence during resuscitation in the emergency department. **Advanced Emergency Nursing Journal,** 33, 336–343.

Davidson, J.E., Aslakson, R.A., Long, A.C., Puntillo, K., Kross, E., Hart, J., et al., (2017). Guidelines for family-centered care in the neonatal, pediatric, and adult ICU. ***Crit. Care Med***. 45, 103–128.

De Stefano, C., Normand, D., Jabre, P., Azoulay, E., Kentish-Barnes, N., Lapostolle, F.,et al. (2016). Family presence during resuscitation: a qualitative analysis from a national multicenter randomized clinical trial. **PLoS One**.11 (6).

Demir, F. (2008). Presence of patients' families during cardiopulmonary resuscitation: Physicians' and nurses' opinions**. Journal of Advanced Nursing,** 63(4), 409-416.

Doolin, C.T., Quinn, L.D., Bryant, L.G., Lyons, A.A., & Kleinpell, R.M. (2011). Family presence during cardiopulmonary resuscitation: Using evidence-based knowledge to guide the advances practice nurse in developing formal policy and practice guidelines. **Journal of the American Academy of Nurse Practitioners**, 23(1), 8-14.

Doyle, C. J., Post, H., Burney, R. E., Maino, J., Keefe, M., & Rhee, K. J. (1987) Family participation during resuscitation: An option. **Annals of Emergency Medicine**, 16(6), 673-675

Duran CR, Oman KS, Abel JJ, Koziel VM, Szymanksi D. (2007). Attitudes toward and beliefs about FP: a survey of healthcare providers, patients' families, and patients.**Am J Crit Care**.16:270-282.

Dwyer, T. A. (2015) Predictors of public support for family presence during cardiopulmonary resuscitation: A population-based study**. International Journal of Nursing Studies**, 52(6): 1070-1077

Eckle, N. (Ed.) (2007). Presenting the Option for Family Presence. Dallas, TX. **Emergency Nurses Association**.

Ellison, S. (2003). Nurses' attitudes towards family presence during resuscitative efforts and invasive procedures. **Journal of Emergency Nursing**, 29(6), 515-521.

Emergency Nurses Association (2007). **Emergency Nurses Association: Presenting the option for family presence** (3rd ed.). Des Plaines, IL:

Emergency Nurses Association (2012). Clinical practice guideline: Family presence during invasive procedures and resuscitation. Des Plaines, IL: **The Emergency Nurses Association.**

Emergency Nurses Association. (2007). Presenting the option for family presence (3rd ed.). Des Plaines, IL**: Emergency Nurses Association**.

Fallis, W.M., McClement, S., & Pereira, A. (2008). Family presence during resuscitation: A survey of Canadian critical care nurses' practices and perceptions. **The Canadian Association of Critical Care Nurses**, 19(3), 22-28.

Farah, M.; O'Connell K.; Spandorfer P. and Zorc J. (2007). Family Presence During Pediatric Trauma TeamActivation: An Assessment of a Structured Program, **PEDIATRICS** Volume 120, Number 3. **http://pediatrics.aappublications.org/content/120/3/e565.**

Farlex **Partner Medical Dictionary**. (2012). Retrieved January 13 2021 from https://medical-dictionary.thefreedictionary.com/perception

Feagan, Lori M., and Nancy J. Fisher. "The Impact of Education on Provider Attitudes Toward Family-Witnessed Resuscitation." **Journal of Emergency Nursing** 37, no.3: 231-3.

Fell, O. (2009). Family presence during resuscitation efforts. **Nursing Forum**, 44(2), 144-150.

Finkelman, A., & Kenner, C.K. (2009). **Teaching IOM: Implications of the Institute of Medicine reports for nursing education**(2nd ed.). Silver Spring, MD: Nursebooks.org.

Fornell, C., & Larcker, D. F. (1981). Evaluating structural equation models with unobservable variables and measurement error. **Journal of marketing research**, 18(1), 39-50.

Fulbrook, P., J. W. Albarran, and J. M. Latour. "A European Survey of Critical Care Nurses'Attitudes and Experiences of Having Family Members Present During Cardiopulmonary Resuscitation." **International Journal of Nursing Studies** 42, (2005): 557–68.

Giles, T., de Lacey, S. & Muir-Cochrane, E. (2016). Factors influencing decision-making around family presence during resuscitation: a grounded theory study. **Journal of Advanced Nursing**, 2(11): 2706-2717

Girgin, B. A., Sivri, B. B., Girgin, A., & Sivri, B. (2015). Global Journal on Advances in Pure & Applied Sciences**The Importance of Family Centered Care and Assessment**. 7(7), 29–33.

Gluck, Denise M. (2014). How past experiences impact a nurse's decision about family Presence during resuscitation: a phenomenological study, **Doctor of Health Administration thesis**, University of Phoenix, USA.

Guzzetta, C. E. (2016). Family presence during resuscitation and invasive procedures. **Critical Care Nurse**, 36(1), e11-e14.

Hair Jr, J. F., Hult, G. T. M., Ringle, C., & Sarstedt, M. (2017). **A primer on partial least squares structural equation modeling (PLS-SEM).** Sage publications.

Hair, J. F., Anderson, R. E., Babin, B. J., & Black, W. C. (2010). **Multivariate data analysis: A global perspective** (Vol. 7).

Hair, J. F., Money, A. H., Page, M., & Samouel, P.(2007).*Research methods for business*. New York: John Wiley and Sons.

Hair, J.F., Hult, G.T.M., Ringle, C.M. and Sarstedt, M. (2013), **A Primer on Partial Least Squares (PLS) Structural Equation Modeling**, Sage, Los Angeles, CA.

Hanson C, Strawser D. (1992) Family presence during cardiopulmonary resuscitation: Foote Hospital emergency department's nine-year perspective. **J Emerg Nurs**.;18(2):104–106.

Herron, Stephanie L. (2014). Staff Perception Related to Family Presence during Resuscitation, **thesis submitted to the faculty**of Gardner-Webb University School of Nursing, North Carolina, USA.

Holzhauser, K., Finucane, J., & De Vries, S. (2006). Family presence during resuscitation: A randomized study**. Journal of Emergency Nursing**, 34(4), 290-300.

Imperatrice, Josephine (2019). What are the Differences Between Nurses' and Physician Perception of Family Presence During Resuscitation in the Emergency

Department?**Doctor of Nursing Practice**, DeSaies University, USA.

Institute for Family-Centered Care (2021). **Advancing the Practices of Patient and Family- Centered Care**," http://www.health.gov.sk.ca/advancing-pfcc . html.

Jabre, P., Tazarourte, K., Azoulay, E., Borron, S.W., Belpomme, V., Jacob, L., et al., 2014. Offering the opportunity for family to be present during cardiopulmonary resuscitation: 1-year assessment. **Intensive Care Med**. 40, 981–987.

Johnson C. (2017). A literature review examining the barriers to the implementation of family witnessed resuscitation in the Emergency Department. **Int Emerg Nurs**. 30(30):31–35.

Jones, B. L., Parker-Raley, J., Maxson, T., & Brown, C. (2011). Understanding Health Care Professionals' Views of Family Presence During Pediatric Resuscitation.**American Journal of Critical Care**, 20(3), 8.

Koberich, S., Arnold, K., Oliver, R., & Albarran, J. W. (2010). Family witnessed resusciation - experience and attitudes of German intensive care nurses.**Nursing in Critical Care,** 15(5), 9.

Kolcaba, K. (1994). A theory of holistic comfort for nursing**.** ***Journal of Advanced Nursing***, 19, 1178-1184.

Kolcaba, K., Tilton, C., & Drouin, C. (2006). Comfort theory: A unifying framework to enhance the practice environment.**Journal of Nursing Administration**, 36(11), 538-544.

Kosowan, S., & Jensen, L. (2011). Family presence during resuscitation: Cardiac health care professionals' perspectives.**Canadian Journal of Cardiovascular Nursing**, 21(3), 23-29.

Leske, J. S., McAndrew, N. S., Brasel, K. J., & Feetham, S. (2017) Family presence during resuscitation after trauma**. Journal of Trauma**, 24(2): 85-96.

Leung, N.Y., & Chow, S.K.Y. (2012). Attitudes of healthcare staff and patients' family members towards family presence during resuscitation in adult critical care units. **Journal of Clinical Nursing**, 21, 2083-2093.

Lowry, E. (2012). "It's just what we do": A qualitative study of emergency nurses working with well-established family presence protocol. **Journal of Emergency Nursing,** 38, 1 (6).

MacLean SL, Guzzetta CE, White C, Fontaine D, Eichhorn DJ, Myers TA & Desy P (2003) Family presence during cardiopulmonary resuscitation and invasive procedures: practices of critical care and emergency nurses**. American Journal of Critical Care**,12, 246–258.

Madden E, Condon C. (2007). Emergency nurses' current practices and understanding of family presence during CPR**. J Emerg Nurs**;33(5):433-40.

Madden, E., & Condon, C. (2007). Emergency nurses' current practices and understanding of family presence during CPR**. Journal of Emergency Nursing**, 33(5), 433-440.

Magowan E, Melby V. (2019). A survey of emergency department staff 's opinions and experiences of family presence during invasive procedures and resuscitation**. Emerg Nurse**. 27(3):13–19.

Mangurten J, Scott SH, Guzzetta CE, Clark AP, Vinson L, Sperry J, et al. (2005) Effects of family presence during resuscitation and invasive procedures in a pediatric emergency department.**Journal of Emergency Nursing**;32:225-33.

Masa'Deh, R, Saifan, A, Timmons, S, Nairn, S. (2014). Families' Stressors and Needs at

Time of Cardio-Pulmonary Resuscitation: A Jordanian Perspective. **Global Journal of Health Science;** Vol. 6, No. 2

McAlvin SS, Carew-Lyons A. (2014). Family presence during resuscitation and invasive procedures in pediatric critical care: a systematic review. **Am J Crit Care**;23(6):477-84; quiz 485.

McDonald, S.M. (2012). Perception: A concept analysis. **International Journal of Nursing Knowledge,** 23(1), 2-9

McLean J, Gill FJ, Shields L. (2016). Family presence during resuscitation in a paediatric hospital: health professionals' confidence and perceptions**. J Clin Nurs**.;25(7-8):1045-52.

McLean, Julie A (2013). Family Presence during Resuscitation in a Paediatric Hospital: Health Professionals' Confidence and Perceptions, **Master of Philosophy thesis**, Curtin University, Australia.

Meghani, S., Karmaliani, R., Ajani, K., Shehzad-Bhamani, S., Khan, N.U., Lalani, N. (2019).Knowledge, attitude, and practice of healthcare professionals regarding family presence during resuscitation: An interventional study in a tertiary care setting, Karachi, Pakistan. Connect:**The World of Critical Care Nursing**, 13(1), 46-55.

Meyers, T.A., Eichhorn, D.J., Guzzetta, C.E., Clark, A.P., Klein, J.O., Taliaferro, E., & Calvin, A. (2004). Family presence during invasive procedures and resuscitation: The experience of family members, nurses, and physicians.**Topics in Emergency Medicine**, 26(1), 61-73.

Meyers, Theresa, Dezra Eichhorn, Cathie Guzzetta, Angela Clark, Jorie D. Klein, Ellen Taliaferro, and Amy Calvin. (2000). Family Presence During Invasive Procedures and

Resuscitation: The Experience of Family Members, Nurses, and Physicians. **American Journal of Nursing**100, no. 2: 32-43.

Mian, P., Warchal, S, Whitney, S., Fitzmaurice, J., & Tancredi, D. (2007). Impact of a multifaceted intervention on nurses' and physicians' attitudes and behaviors toward family presence during resuscitation. **Critical Care Nurse,** 27(1), 52-61.

Miller, J. H., & Stiles, A. (2009). Family Presence During Resuscitation and Invasive procedures: The Nurse Experience. **Qualitative Health Research**, 19(10), 11.

Ministry of Health (2020) **Workforce Report, Palestinian Health Information Center**, Ramallah.

Niemczyk, E., Ozga, D., Przybylski, A. (2020). Experiences and opinions of patients and their relatives to family presence during adult resuscitation in Poland: Quantitative research. **Patient Preference and Adherence**, 14(1), 227-234.

Nykiel, L., Denicke, R., Schneider, R., Jett, K., Denicke, S., Kunish, K., Sampson, A. & Williams, J. (2011). Evidence-based practice and family presence: Paving the path for bedside nurse scientist. **Journal of Emergency Nursing**, 37(1), 9-16.

O'Connell, K., Fritzeen, J., Guzzetta, C. E., Clark, A. P., Lloyd, C., Scott, S. H. Kreling, B. (2017). Family presence during resuscitation: family members' attitudes, behaviors, and experiences. **American Journal of Critical Care**, 26(3), 229-239

Porter JE, Miller N, Giannis A, Coombs N. (2016). Family presence during resuscitation (FPDR): observational case studies of emergency personnel in Victoria, Australia**. Int Emerg Nurs.**;33:37–42.

Porter, J. E., Cooper, S. J. & Taylor B. (2015) Family presence during resuscitation (FPDR): A survey of emergency personnel in Victoria, Australia. **Australasian Emergency**

Nursing Journal. 2015, 18(2): 98-105

Powers, Kelly (2014). Family presence during resuscitation of adults: the impact of an online learning module on critical care nurses' Perception and self-confidence, **doctor of Philosophy thesis**– Nursing, University of Nevada, Las Vegas, USA.

Pratiwi, I. D. (2018). Family presence during resuscitation: patient and family members' preferences and attitudes. **International Journal of Research in Medical Sciences**, 6(2), 394.

Rafiei, H., Senmar, M., Mostafaie, M. R., Goli, Z., Avanaki, S. N., Abbasi, L., Mafi, M. H.(2018). Self-confidence and attitude of acute care nurses to the presence of family members during resuscitation. **British Journal of Nursing**, 27(21), 1246-1249.

Redley B, Hood K. (1996). Staff attitudes towards family presence during resuscitation. **Accid Emerg Nurs**;4(3):145-51.

Robinson SM, Mackenzie-Ross S, Hewson GL, Egleston CV, Prevost AT. (1998). Psychological effects of witnessed resuscitation on bereaved relatives. **Lancet**;352:614-22.

Stewart, Stephanie Anne (2019). The experience of parents during their child's resuscitation and exploration of parental stress and family functioning after the event, **thesis for the Doctor of Philosophy** degree in Nursing in the Graduate College of The University of Iowa, USA.

Tabachnick, B. G. (2014) Using multivariate statistics, 6th ed. edition. Harlow, UK: Pearson.

Tomlinson, K.R., Golden, I.J., Mallory, J.L., & Comer, L. (2010). Family presence during adult resuscitation: A survey of emergency department registered nurses and staff attitudes.**Advanced Emergency Nursing Journal,** 32(1), 46-58.

Tudor, K., Berger, J., Polivka, B. J., Chlebowy, R., & Thomas, B. (2014). Nurses' perceptions of family presence during resuscitation. **American Journal of Critical Care**, 23(6), e88–e96.

Twibell, R.S., Craig, S., Siela, D., Simmonds, S., Thomas, C., (2015). Being there: inpatients' perceptions of family presence during resuscitation and invasive cardiac procedures. **Am. J. Crit. Care**24, e108–e115.

Twibell, R.S., Siela, D., Riwitis, C., Wheatley, J., Riegle, T., Bousman, D., . . . Neal, A. (2008). Nurses' perceptions of their self-confidence and the benefits and risks of family presence during resuscitation. **American Journal of Critical Care**, 17(2), 101-111.

White, K.A. (2009). Self-confidence: A concept analysis**. Nursing Forum,** 44(2), 103- 114.

Zali, M., Hassankhani, H., Powers, K. A., Dadashzadeh, A. & Ghafouri, E. R. (2017). Family presence during resuscitation: A descriptive study with Iranian nurses and patients' family members. **International Emergency Nursing, first published.**

Annexes

Annex (1) Map of Palestine

Annex (2) MOH Approval Latter

State of Palestine
Ministry of Health
General Directorate of Education in
Health and Scientific Research

دولة فلسطين
وزارة الصحة
الإدارة العامة للتعليم الصحي
والبحث العلمي

Ref.: .....
Date:.....

الرقم: ٢٠٢١/١٢٠/١٦٦
التاريخ: ٢٠٢١/٠٦/٠٧

الأخ مدير عام الادارة العامة للمستشفيات المحترم ،،،

تحية واحترام،،،

الموضـــوع: تسهيل مهمة بحث

مرفق طلب تسهيل مهمة **الطالبة: كيتي ابو سعدة– ماجستير ادارة التمريض/ جامعة القدس**، وباشراف د. كوثر العيسة، في عمل بحث بعنوان:

" مدى قبول الممرضين/ات لوجود الاسرة أثناء الانعاش في جناح الاطفال ووحدة العناية المركزة للاطفال في مستشفيات جنوب الضفة الغربية "

من خلال السماح للطالبة بجمع معلومات من خلال تعبئة استبانه من قبل الممرضين/ات، وذلك في:

- **مستشفى بيت جالا الحكومي**

على ان تكون المعلومات والبيانات لأغراض البحث العلمي فقط وتحت طائلة المسؤولية.
على ان يتم الالتزام بجميع تعليمات واجراءات الوقاية والسلامة الصادرة عن وزارة الصحة بخصوص جائحة كورونا، وتحت طائلة المسؤولية.
على ان يتم تزويد الوزارة بنسخة PDF من نتائج البحث، التعهد بعدم النشر.

مع الاحترام،،،

د. عبد الله القواسمي
مدير التعليم الصحي والبحث العلمي

دولة فلسطين وزارة الصحة
الإدارة العامة للتعليم الصحي

نسخة: منسق برامج الدراسات العليا المحترم/ جامعة القدس

P.O .Box: 14
Telfax.:09-2333901
scientificresearch.dep@gmail.com
ص.ب. 14
تلفاكس: 09-2333901

Annex (3) Research Ethics Committee

Al-Quds University
Jerusalem
Deanship of Scientific Research

بسم الله الرحمن الرحيم

جامعة القدس
القدس
عمادة البحث العلمي

Research Ethics Committee
Committee's Decision Letter

Date: June 26, 2021

Ref No: 194/REC/2021

Dears Dr. Kawther Alayasa, Ms. Katy Abusada,

Thank you for submitting your application for research ethics approval. After reviewing your application entitled "Nurses' perception of family presence during resuscitation in pediatric wards and pediatric intensive care units at Southern West Bank Hospitals", the Research Ethics Committee confirms that your application is in accordance with the research ethics guidelines at Al-Quds University.
We would appreciate receiving a copy of your final research report/ publication.

Thank you again and wish you a productive research that serves the best interests of your subjects.

PS: This letter will be valid for two years.

Sincerely,

Suheir Ereqat, PhD
Associate Professor of Molecular Biology

Research Ethics Committee Chair

Cc. Prof. Imad Abu Kishek - President
Cc. Members of the committee
Cc. file

Abu-Dies, Jerusalem P.O.Box 20002
Tel-Fax: #970-02-2791293
research@admin.alquds.edu
أبوديس، القدس ص.ب. 20002
تلفاكس: #970-02-2791293

Annex (4) The final form of questionnaire (Arabic Version)

عمادة الدراسات العليا
جـــامـعـة الـقـدس
كليـة المهن الصحية

الموافقة على إجراء بحث

تصور الممرضين/ت لوجود الأسرة أثناء الإنعاش في أقسام طب الأطفال ووحدة العناية المركزة للأطفال في مستشفيات جنوب الضفة الغربية

الإخوة والأخوات الحكماء الأفاضل..

تحية تقدير واحترام وبعد.....

السلام عليكم ورحمة الله وبركاته .....

أنت مدعو للمشاركة في دراسة بحثية حول مدى قبول "الممرضات–الممرضين" لوجود الأسرة أثناء الإنعاش في جناح الأطفال ووحدة العناية المركزة للأطفال في مستشفيات جنوب الضفة الغربية " الغرض من هذه الدراسة هو تقييم مدى قبول الممرضات –الممرضين ومدى ثقتهم بأنفسهم في تسهيل تواجد الأسرة أثناء الإنعاش في جناح الأطفال ووحدات العناية المركزة للأطفال في مستشفيات جنوب الضفة الغربية في فلسطين.

سيتم الحفاظ على خصوصية المشاركين في الدراسة لأي معلومات تعريفية لأي مستجيب في الاستطلاع وسيتم تسجيل جميع الردود في الاستطلاع بشكل مجهول.

من خلال استكمال وتقديم هذا الاستبيان، فإنك تشير إلى موافقتك على المشاركة في الدراسة.

إذا كان لديك أي أسئلة بخصوص الاستبيان أو هذا المشروع البحث هذا بشكل عام، يرجى الاتصال بالباحثة كيتي ابو سعدى أو المنسقة المسؤولة د. كوثر العيسة.

مشاركتكم هي موضع تقدير بالنسبة للباحث

لأي سؤال:
الهاتف: 0599212785
البريد الإلكتروني: bann.katy@hotmail.co
Kawtheralayasa@gmail.com

الجزء الأول: المعلومات شخصية:

الجنس :ذكر ☐ انثى ☐

العمر: ☐20 – 24 ☐25- 29 ☐3-34 35 39☐ 40 فوق☐

الحالة الاجتماعية: ☐ متزوج/ة ☐ مطلق /ة ☐ ارمل/ة ☐

المستوى التعليمي: د☐ بكالوريس ☐ دبلوم عالي ☐ ماجستير ☐ دكتوراه ☐

سنوات الخبرة:اقل☐ سنة ☐1-5 سنوات ☐6-10 سنوات ☐ اكثر من 10 سنوات ☐

المسمى الوظيفي: ☐ض مؤهل ☐ممرض قانون ☐ممرض مشرف ☐ رئيس قسم

مكان العمل: مستشفى بيت جالا الحكومي ☐ مستشفى الكاريتاس ☐

مستشفى الاهلي ☐الخليل مستشفى الهلال الاحمر ☐

القسم الذي تعمل فيه: ☐قسم الاطفال قسم العناية المكثفة للأطفال ☐

هل شاركت في عملية إنعاش طفل: نعم ☐ لا ☐

هل قمت بدعوة العائلة إلى غرفة الإنعاش؟نعم☐ لا ☐

مكان تواجد الأسرة أثناء إنعاش طفلهم: ☐داخل غرفة الانعاش ☐خارج غرفة الانعاش

الجزء الثاني: حول مقياس مخاطر أو منافع تواجد العائلة أثناء إنعاش المريض.

الرقم	الفقرات	معارض بشدة	معارض	محايد	موافق	موافق بشدة
.1	يجب أن يُمنح أفراد الأسرة خيار التواجد أثناء عملية إنعاش أحد أفراد أسرتهم					
.2	سيصاب أفراد الأسرة بالذعر إذا شاهدوا عملية الإنعاش.					
.3	سيجد أفراد الأسرة صعوبة في التكيف مع تأثير عاطفي طويل المدى بعد مشاهدة عملية الإنعاش.					
.4	قد يطور فريق الإنعاش علاقة وثيقة مع أفراد الأسرة الذين يشهدون عملية الإنعاش، مقارنة بأفراد الأسرة الذين لم يشهدوا العملية.					
.5	إذا تم إنعاش أحدأعزائي، فأنا أريد أن أكون حاضرا في غرفة الإنعاش.					
.6	المرضى لا يريدون أفراد الأسرة أن تكون حاضر أثناء محاولة الإنعاش.					
.7	أفراد الأسرة الذين يشهدون جهود الإنعاش غير الناجحة سيتأقلمون أسرع في حزنهم.					
.8	أفراد الأسرة سوف يصبحون مزعجين إذا شاهدوا محاولة الإنعاش.					
.9	من المرجح أن يقاضي أفراد الأسرة الذين يشهدون محاولة لإنعاش.					
.10	فريق الإنعاش لن يعمل بشكل جيد إذا كان أفراد الأسرة حاضرا في الغرفة.					
.11	يفضل تواجد أفراد الأسرة في الوحدة التي أعمل بها في الغرفة أثناء عملية الإنعاش.					
.12	حضور أفراد العائلة أثناء عملية الإنعاش مفيدة للمرضى					
	يرجى اختيار مدى موافقتك أو عدم موافقتك على العبارات التالية: حضور أفراد العائلة أثناء جهود الإنعاش.					
.13	مفيد للعائلات.					
.14	مفيد للممرضات.					
.15	مفيد للأطباء.					
.16	يجب أن يكون أحد مكونات الرعاية التي تتمحور حول الأسرة.					
.17	سيكون له تأثير إيجابي على تقييمات المرضى من الرضا عن الرعاية في المستشفى.					
.18	سيكون له تأثير إيجابي على تصنيفات الأسرة للرضا عن الرعاية في المستشفى.					
.19	سيكون له تأثير إيجابي على معدلات رضا الممرضات في توفير المريض الأمثل ورعاية الأسرة.					
.20	سيكون له تأثير إيجابي على معدلات رضا الطبيب في توفير أفضل النتائج في رعاية المريض والأسرة.					
.21	هو حق يجب أن يتمتع به جميع المرضى.					
.22	هو حق يجب أن يتمتع به جميع أفراد الأسرة.					

الجزء (الثالث): مقياس مدى الثقة بالنفس أثناء حضور الأسرة.

يرجى قراءة كل عنصر من العناصر أدناه ووضع الإشارة– حول مدى ثقتك في قدرتك على أداء السلوك المدرج أثناء جهود الإنعاش مع وجود أفراد العائلة.

الرقم	الفقرات	لست واثقًا على الإطلاق	غير واثق	واثق نوعا ما	واثق الى حد ما	واثق جدا
.1	يمكنني التواصل حول جهود الإنعاش لأفراد الأسرة من الحاضرين.					
.2	يمكنني إعطاء العلاجات بالعقاقير أثناء عملية الإنعاش مع وجود أفراد الأسرة.					
.3	يمكنني مساعدة الطاقم الطبي في إجراء العلاجات الكهربائية أثناء عملية الإنعاش مع تواجد أفراد الأسرة					
.4	يمكنني إجراء ضغطات على الصدر أثناء عملية الإنعاش مع وجود أفراد الأسرة.					
.5	يمكنني التواصل بشكل فعال مع أعضاء الفريق الصحي الآخرين أثناء جهود الإنعاش مع تواجد العائلة					
.6	يمكنني الحفاظ على كرامة المريض أثناء عملية الإنعاش مع تواجد العائلة					
.7	يمكنني تحديد أفراد الأسرة الذين يظهرون سلوكيات التأقلم المناسبة ليكونوا حاضرين أثناء الإنعاش					
.8	يمكنني مساعدة أفراد الأسرة للدخول إلى منطقة إنعاش أفراد أسرهم.					
.9	يمكنني الحصول على دعم من الأطباء المعالجين لحضور الأسرة أثناء عملية الإنعاش.					
.10	يمكنني مرافقة أفراد الأسرة إلى الغرفة أثناء إنعاش أفراد أسرهم.					
	يرجى قراءة كل عنصر مرقم أدناه واختيار المربع المناسب حول مدى ثقتك في أنه يمكنك تنفيذ السلوك أثناء عملية الإنعاش مع وجود أفراد الأسرة					
.11	يمكنني الإعلان عن حضور أحد أفراد العائلة لفريق الإنعاش أثناء عملية الإنعاش لعائلاتهم					
.12	يمكنني توفير تدابير الراحة لأفراد الأسرة الذين يشهدون عملية الإنعاش لأفراد أسرهم.					
.13	يمكنني تحديد الاحتياجات الروحية والعاطفية لأفراد الأسرة الذين يشهدون جهود إنعاش أسرهم					
.14	يمكنني تشجيع أفراد الأسرة على التحدث إلى أفراد أسرهم أثناء عملية الإنعاش.					
.15	يمكنني تفويض المهام إلى ممرضات أخريات من أجل دعم أفراد الأسرة خلال عملية الإنعاش لأفراد أسرهم.					
.16	يمكنني استخلاص المعلومات من الأسرة بعد إنعاش أفراد أسرتهم.					
.17	يمكنني المتابعة والتنسيق في حالات الوفاة مع أفراد الأسرة بعد محاولة عملية إنعاش أحد أعضاء الأسرة، إذا لزم الأمر.					

Annex (5): The final form of questionnaire (English Version)

Al – Quds University

Deanship of Graduate Studies

Faculty of Health Professions / Nursing Management

Nurses' perception of family presence during Resuscitation in pediatric ward and pediatric intensive care unit at Southern West Bank Hospitals

Dear participant:

The purpose of this study to assess the nurses' perceptions of FPDR and self-confidence in facilitating familyPresence during the resuscitation of a pediatric patient in pediatric ward and pediatric intensive care units Southern West Bank Hospitals in Palestine.

Definition of FPDR means one or more family members are Presenting the room while a patient is being resuscitated in an effort to sustain life.

Any identifying information for any respondent in the survey will be polled and all responses will be recorded inPoll anonymously.

By completing and submitting this questionnaire, you are indicating your consent to participate in the study.

Your participation is appreciated by the researcher.

If you have any questions regarding the survey or this research project in general, Please Contact Researcher

Katy Abu Sada

Dr. KawtherAlayasa (Responsible Coordinator).

For any question:

Phone:0599212785

Email:bann.katy@hotmail.com

Part A: Demographic Information

- **Gender:** ☐ Male ☐ Female
- **Age:** ☐ 20-24 ☐ 25-29 ☐ 35 35☐ Above 40
- **Marital status:** ☐ Single ☐ Married ☐ Divorced ☐ Widow
- **Educational level:** ☐ Diploma ☐ Bachelor ☐ High diploma

  MasterDegree ☐ PhD ☐
- **Years of work experience:** ☐ Less than 1 year 1-5 years ☐

  6-10 years More Than 10 years ☐
- **Job title:** ☐ Practical nurse Staff nurse ☐

  Senior nurse ☐ Head nurse ☐
- **Work place**: ☐ Beit-Jala Governmental Hospital ☐ Caritas Baby Hospital

  ☐ Red Crescent Hospital ☐ Al-Ahli Hospital-Hebron.
- **The area in which you work:** ☐ Pediatric word ☐ Pediatric ICU
- **Have you been involved in resuscitation of a child?** ☐ Yes ☐
- **Have you invited family into the resuscitation room?** ☐ Yes ☐ No
- **Place of residence of family during their child resuscitation:**

Inside ☐ resuscitation room Outside ☐ resuscitation room.

Part B: Family Presence Risk-Benefit Scale

Please circle the number that best represents your opinion.

No.	Item	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
1.	Family members should be given the option to be present when a loved one is beingresuscitated.					
2.	Family members will panic if they witnessa resuscitation effort.					
3.	Family members will have difficulty adjusting to the long-term emotional impactof watching a resuscitation effort.					
4.	The resuscitation team may develop a closerelationship with family members who witness the efforts, as compared to family members who do not witness the efforts.					
5.	If my loved one were being resuscitated, Iwould want to be present in the room.					
6.	Patients do not want family memberspresent during a resuscitation attempt.					
7.	Family members who witness unsuccessful resuscitation efforts will have a better grieving process.					
8.	Family members will become disruptive ifthey witness resuscitation efforts.					
9.	Family members who witness a resuscitation effort are more likely to sue.					
10.	The resuscitation team will not function aswell if family members are present in the room.					
11.	Family members on the unit where I work prefer to be present in the room during resuscitation efforts.					
12.	The presence of family members duringresuscitation efforts is beneficial to patients.					
Please circle the number that best represents the extent to which you agree or disagree with the following statements:The presence of family members during resuscitation efforts……..						
13.	is beneficial to families.					
14.	is beneficial to nurses.					
15.	is beneficial to physicians.					
16.	should be a component of family-centred care.					
17.	will have a positive effect on patient ratings of satisfaction with hospital care.					
18.	will have a positive effect on family ratings of satisfaction with hospital care.					
19.	will have a positive effect on nurse ratings of satisfaction in providing optimal patientand family care.					
20.	will have a positive effect on physician ratings of satisfaction in providing optimalpatient and family care.					
21.	is a right that all patients should have.					
22.	is a right that all family members should have.					

Part C: Family Presence Self-confidence Scale:

Please read each numbered item below and circle the number to indicate how confident you are that you could perform the listed behavior during a resuscitation effort with family members present.

No.	Item	Not at all Confident	Not Very Confident	Somewhat Confident	Quite Confident	Very Confident
1.	I could communicate about the resuscitation effort to family memberswho are present.					
2.	I could administer drug therapies during resuscitation efforts with family members present.					
3.	I could assist medical staff in performing electrical therapies during resuscitation efforts with familymembers present.					
4.	I could deliver chest compressions during resuscitation efforts with family members present.					
5.	I could communicate effectively with other health team members during resuscitation efforts with familymembers present.					
6.	I could maintain dignity of the patient during resuscitation efforts with familymembers present.					
7.	I could identify family members who display appropriate coping behaviors to be present during resuscitationefforts.					
8.	I could prepare family members to enter the area of resuscitation of their family member.					
9.	I could enlist support from attending physicians for FPDR efforts.					
10.	I could escort family members into the room during resuscitation of their family member.					
Please read each numbered item below and circle the number that indicates how confident you are that you could perform the listedbehavior during a resuscitation effort with family members present.						
11.	I could announce family member's presence to resuscitation team during resuscitation efforts of their familymember.					
12.	I could provide comfort measures to family members witnessing resuscitation efforts of their family member.					
13.	I could identify spiritual and emotional needs of family members witnessing resuscitation efforts of their familymember.					
14.	I could encourage family members to talk to their family member during resuscitation efforts.					
15.	I could delegate tasks to other nurses in order to support family membersduring resuscitation efforts of their family member.					
16.	I could debrief family afterresuscitation of their family member.					
17.	I could coordinate bereavement follow-up with family members after resuscitation efforts of their familymember, if required.					

Annex(6): Participant's responses distribution of items on Family-Presence Self-Confidence Scale

No	Items	Not at all/ Not very confident	Somewhat confident	Quite/ very confident
1	I could communicate about the resuscitation effort to family members who are present.	44 (34.9)	46 (36.5)	36 (28.6)
2	I could administer drug therapies during resuscitation efforts with family members present.	36 (28.6)	34 (27.0)	56 (44.4)
3	I could assist medical staff in performing electrical therapies during resuscitation efforts with family members present.	41 (32.54)	29 (23.02)	56 (44.44)
4	I could deliver chest compressions during resuscitation efforts with family members present.	36 (28.6)	26 (20.6)	64 (50.8)
5	I could communicate effectively with other health team members during resuscitation efforts with family members present.	30 (23.8)	42 (33.3)	54 (42.9)
6	I could maintain dignity of the patient during resuscitation efforts with family members present.	32 (25.4)	35 (27.8)	59 (46.8)
7	I could identify family members who display appropriate coping behaviours to be present during resuscitation efforts.	46 (36.5)	38 (30.2)	42 (33.3)
8	I could prepare family members to enter the area of resuscitation of their family member.	49 (38.9)	33 (26.2)	44 (34.9)
9	I could enlist support from attending physicians for FPDR efforts.	48 (38.1)	29 (23.0)	49 (38.9)
10	I could escort family members into the room during resuscitation of their family member.	48 (38.1)	35 (27.8)	43 (34.1)
11	I could announce family member's presence to resuscitation team during resuscitation efforts of their family member.	47 (37.3)	39 (31.0)	40 (31.7)
12	I could provide comfort measures to family members witnessing resuscitation efforts of their family member.	49 (38.9)	36 (28.6)	41 (32.5)
13	I could identify spiritual and emotional needs of family members witnessing resuscitation efforts of their family member.	53 (42.1)	24 (19.0)	49 (38.9)
14	I could encourage family members to talk to their family member during resuscitation efforts.	44 (34.9)	44 (34.9)	38 (30.2)
15	I could delegate tasks to other nurses in order to support family members during resuscitation efforts of their family member.	41 (32.5)	37 (29.4)	48 (38.1)
16	I could debrief family after resuscitation of their family member.	41 (32.5)	39 (31.0)	46 (36.5)
17	I could coordinate bereavement follow-up with family members after resuscitation efforts of their family member, if required.	40 (31.75)	40 (31.75)	46 (36.5)

Annex (7):Participant's responses distribution of items on Family-Presence Risk-Benefit Scale

No.	Items	Strongly disagree/ disagree	Neutral	Strongly agree/ agree
1	Family members should be given the option to be present when a loved one is beingresuscitated.	71 (56.3)	34 (27.0)	21 (16.7)
3	Family members will have difficulty adjusting to the long term emotional impactof watching a resuscitation effort.	27 (21.4)	14 (11.1)	85 (67.5)
4	The resuscitation team may develop a close relationship with family members who witness the efforts, as compared to family members who do not witness the efforts.	49 (38.9)	58 (46.0)	19 (15.1)
5	If my loved one were being resuscitated, Iwould want to be present in the room.	63 (50.0)	42 (33.3)	21 (16.7)
6	Patients do not want family memberspresent during a resuscitation attempt.	21 (16.7)	53 (42.0)	52 (41.3)
7	Family members who witness unsuccessful resuscitation efforts will have a better grieving process.	69 (54.8)	40 (31.7)	17 (13.5)
8	Family members will become disruptive ifthey witness resuscitation efforts.	19 (15.1)	25 (19.8)	82 (65.1)
9	Family members who witness a resuscitation effort are more likely to sue.	20(15.9)	40 (31.7)	66 (52.4)
10	The resuscitation team will not function aswell if family members are present in the room.	19 (15.1)	33 (26.2)	74 (58.7)
11	The resuscitation team will not function aswell if family members are present in the room.	80 (63.5)	33 (26.2)	13 (10.3)
12	The presence of family members duringresuscitation efforts is beneficial to patients.	81 (64.3)	34 (27.0)	11 (8.7)
13	is beneficial to families.	82 (65.1)	30 (23.8)	14 (11.1)
14	is beneficial to nurses.	75 (59.52)	41 (32.54)	10 (7.94)
15	is beneficial to physicians.	82 (65.1)	28 (22.2)	16 (12.7)
16	should be a component of family-centred care.	60 (47.6)	40 (31.8)	26 (20.6)
17	will have a positive effect on patient ratingsof satisfaction with hospital care.	73 (57.9)	31 (24.6)	22 (17.5)
18	will have a positive effect on family ratings of satisfaction with hospital care.	68 (54.0)	34 (27.0)	24 (19.0)
19	will have a positive effect on nurse ratings of satisfaction in providing optimal patientand family care.	67 (53.2)	39 (31.0)	20 (15.9)
20	will have a positive effect on physician ratings of satisfaction in providing optimalpatient and family care.	69 (54.8)	36 (28.6)	21 (16.6)
21	is a right that all patients should have.	66 (52.4)	38 (30.1)	22 (17.5)
22	is a right that all family members should have.	67 (53.2)	44 (34.9)	15 (11.9)