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# Critical Care Nurses' Perspectives towards Family Presence during Resuscitation

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## Introduction

As members of the largest health care profession in the nation, registered nurses practice wherever people need nursing care including common sites such as hospitals, homes, schools, workplaces, and community centers and uncommon areas such as children's camp, homeless shelters and tourist sites. Based on the desired outcome, nurses intervene to promote health, prevent illness or assist with activities that contribute to the recovery from illness or to the achievement of a peaceful death. They may initiate treatments themselves or perform interventions initiated by advance practice registered nurses or other licensed health care providers.

Resuscitation can be visually disturbing and stressful, even to the most experienced clinical staff. Allowing family members to remain with patients during resuscitation effort is a relatively new concept. Differing views regarding the presence of family members during resuscitation are being debated. Some of the reasons stated for being against it are that family members would have traumatic memories of the event. Meanwhile, not all family members might confirm this assumption. The majority of family members would prefer to remain with the patient [1-2].

Cardio pulmonary resuscitation (CPR) is an emergency situation of attempting to restore equilibrium by stabilizing vital signs with mechanical, physiological and pharmacological means in case of cardiac arrest. Family presence during resuscitation remains a dilemma for nurses working in critical care areas. The established norm in the departments of hospitals is that relatives are excluded from the resuscitation efforts and are made to wait in the visitors' room. This practice is based primarily on the idea that resuscitation efforts will be traumatic for relatives and that family presence will interfere with staff performance.

Even though the importance of family support is almost the same for most people, there are identified differences with regards to how people experience crisis. Care and culture are inextricably intertwined. Knowledge of practices in diverse cultures is essential to guide nursing decisions and actions in providing culturally congruent care. In depth appreciation of the influence of culture on the critical care nurses' perspectives towards family presence during resuscitation is essential if patients and family are to be managed effectively during resuscitation [3-4].

As the researcher dug deep to the previous studies attempted to begin involvement of patients' family members during resuscitative efforts was first investigated at Foote Hospital in United States, Michigan in 1982. This was to answer the two concerns whereas the family member requested to be present during resuscitation of their loved one. These incidents prompted the emergence of a policy including family members during resuscitation. There was resistance with regards to the formal implementation of the initiation for family presence. As the study was completed, most number of staff nurses showed support of the practice [5].

After the commencement of policy by the Foote Hospital, many hospital have developed, initiated, and implemented formal protocols relating to family presence during resuscitation. The Emergency Nurses' Association in the United States of America, in 1994, initiated an educational booklet to guide the implementation of family presence programs. Meanwhile, in 1995, the association created an official statement with regards to the national provisions for the presence of family members during cardiopulmonary resuscitation. There was also a revision and update done to the policy statement on family presence by the association in July 2001, tackling continued support as an option for family presence during resuscitation [5].

The research revealed the critical care nurses' perspectives towards family presence guidelines during resuscitation. This problem was still new to Middle East and remains world widely controversial. The clear statement of the problem for this study was to justify whether to allow or not to allow family members' presence during resuscitation. The study tried to answer the following research questions: What are the personal information of the respondents; to what extent of the perspectives of critical care nurses in the intensive care unit towards family presence during resuscitation; is there a significant relationship between the level perspectives of the respondents towards family members' presence during resuscitation and their demographic profiles. All these inquiries were addressed and then proper protocol was formulated that

can be beneficial to the patient, their family members and the institution.

There are growing body of evidences suggest that benefits outweighs risks which can be accrued from family presence. The mentioned benefits include the following: Family presence reducesprocess; facilitates the grieving process; Family members can provide comfort and encouragement to their loved one.

On the other hand, the disadvantages of family presence during resuscitation argued that it will lead to: Psychological trauma; Violating patient's right; Confidentiality; Family behavior; Space in the room.

Patients' family members have reported benefits from being present during resuscitations. In Prince Sultan Military Medical City, there is no formulated policy or guidelines that will support allowing family presence during cardiopulmonary resuscitation. Thus, this strongly suggest a study to be conducted in order to further investigate the percentage of positive and negative outcomes about family presence.

The purpose of the study was to evaluate the perspectives of critical care nurses in an adult intensive care unit towards family presence guidelines during resuscitation in Prince Sultan Military Medical City. The evaluation showed how it affects the quality of health care provided with or without family presence during resuscitation. Moreover, it served as a basis for further development of certain aspects needed to be improved as far as the respondents are concerned.

**Theoretical Framework**

The public sees nurses as part of the solution, not the problems and believe that if nurses were allowed to use their skills, they would significantly enhance quality and reduce cost. Nurses are persistently seen as having the highest standards of honesty and ethics. Nursing was the highest ranking of all profession for ethics.

According to Virginia Henderson, "The unique function of the nurse is to assist the clients, sick or well, in the performance of those activities contributing to the health or its recovery. That client would perform unaided if they had the necessary strength, will or knowledge." She further believes that nursing involved assisting clients to achieve peaceful cleat if recovery is no longer possible. Henderson viewed the nursing role as helping the client from dependence to independence [6].

Moreover, Henderson's theory supported wellness by addressing the patient from a multidimensional perspective and encourages them to provide their own care. In Henderson's complex, multidimensional model, she defines health as a person's ability to perform 14 activities independently.

Henderson believes that the nurses' role is to assist patients with the 14 activities when they lack the strength, knowledge, or will. At the same time, she emphasizes that nurses should care for all patients; she believes that basic human needs exist in patients who are sick and patients who are well. She believes that nurses should promote health and prevent disease.

Henderson's theory affirms and mobilizes the strength of patients. She further states that nurses must encourage and empower patients to care for themselves. Nurses should not do everything for a patient; the best care is the care that the patient gives himself or herself. Nurses should recognize that health is multidimensional and affected by variables such as age, environment, genetics, culture, emotional balance, and intellectual abilities.

The structure of this study was also based on Leininger's Culture Care Theory. Leininger underlines the meaning and importance of culture in explaining an individual's health and caring behaviour, and her Culture Care Theory is the only nursing theory that focuses on culture. The roots of the theory are in clinical nursing practice: Leininger discovered that patients from diverse cultures valued care more than the nurses did. Gradually, Leininger became convinced about the need for a theoretical framework to discover, explain, and predict dimensions of care, and developed the Culture Care Theory as the outcome of studies performed in numerous Western and non-Western cultures.

In her Culture Care Theory, Leininger stated that caring is the essence of nursing and unique to nursing. Leininger actually criticizes the four nursing metaparadigm concepts of person, environment, health and nursing. First, Leininger considers nursing a discipline and a profession, and the term 'nursing' thus cannot explain the phenomenon of nursing. Instead, care has the greatest epistemic and ontologic explanatory power to explain nursing. Leininger views 'caring' as the verb counterpart to the noun 'care' and refers it to a feeling of compassion, interest and concern for people. When Leininger's definition of care is compared to other transcultural scholars' definitions, it appears that her view of care is wider than. Second, the term 'person' is too limited and culture-bound to explain nursing, as the concept of 'person' does not exist in every culture. Leininger argues that nurses sometimes use 'person' to refer to families, groups, communities and collectivities, although each of the concepts is different in meaning from the term 'person'. Third, the concept of 'health' is not distinct to nursing as many disciplines use the term. Fourth, instead of 'environment' Leininger uses the concept 'environmental context', which includes events with meanings and interpretation given to them in particular physical, ecological, sociopolitical and/or cultural settings.

Care always occurs in a cultural context. Culture is viewed as a framework people use to solve human problems. In that sense, culture is universal. It is also diverse, as Leininger refers culture to the specific pattern of behaviour which distinguishes any society from others. Transcultural scholars define culture by stressing behavioral aspects as an explicit form of it. Leininger states that culture refers to "the lifeways of an individual or a group with reference to values, beliefs, norms, patterns, and practices" and agrees that culture is learnt by group members and transmitted to other group members or intergenerationally. Leininger distinguishes between emic and etic perspectives of culture. Emic refers to an insider's views and knowledge of the culture, while etic means the outsider's viewpoints of the culture and reflects more on the professional angles of nursing. Apart from culture and environmental context, ethnohistory is also meaningful when examining care from the cultural perspective. The environmental context, which includes physical, ecological, sociopolitical and cultural settings, gives meaning to human expressions of care. Ethnohistory refers to the past events and experiences of individuals or groups, which explain human lifeways within particular cultural contexts over short or long periods.

Leininger has formulated several theoretical assumptions and orientational definitions to guide nurses in their discovery of culture care phenomena. The assumptions and definitions are derived from the theoretical conceptualizations and philosophical

positions of the Culture Care Theory, and they are used as guides to systematic study of the theory. Strictly constructed theoretical formulations would be incongruent with the purposes of the qualitative paradigm. The following assumptions concerning care/caring were significant when planning the study:

- Care (caring) is essential to curing and healing, for there can be no curing without caring
- Every human culture has lay (generic, folk or indigenous) care knowledge and practices and usually some professional care knowledge and practices, which vary transculturally
- Culture care values, beliefs, and practices are influenced by and tend to be embedded in the worldview, language, philosophy, religion (and spirituality), kinship, social, political, legal, educational, economic, technological ethnohistorical, and environmental contexts of cultures
- A client who experiences nursing care that fails to be reasonably congruent with his/her beliefs, values, and caring lifeways will show signs of cultural conflict, noncompliance, stress and ethical or moral concern
- The qualitative paradigm provides ways of knowing and discovering the epistemic and ontological dimensions of human care transculturally

Leininger states that orientational definitions are more appropriate in the qualitative research paradigm than the rigid operational definitions typical of quantitative studies. Orientational definitions are used as guides for studying the domain related to the theory.

**Conceptual Framework**

"In the nature of nursing the nurse should be legally independent practitioner and able to make independent judgments as long as she/he is not diagnosing, prescribing treatment for disease, or making a prognosis, for these are the physicians function. Nurse should have knowledge to practice individualized and human care and should be a scientific problem solver." And nurse has responsibility to assess the needs of the individual patient, help individual meet their health need, and or provide an environment in which the individual can perform activity unaided.

This is true with the perspectives of Critical Care Nurses towards family presence guidelines during resuscitation, since long time ago, there have been growing demands of the development of a concrete supportive statement on the presence of family members during resuscitation especially here in Riyadh, Saudi Arabia. Thus, with this reality, sparking dilemma that requires critical nurses' perspectives toward family members' presence during resuscitation.

Using these theories as premise, the researcher utilized the research paradigm below to direct the research process which is the Critical Care Nurses' perspectives in an adult intensive care unit towards Family Presence Guidelines during Resuscitation in Prince Sultan Military Medical City.

The research process commenced with the inputs or the needed data of the researcher and these are the demographic profile of the respondents which includes the age, gender, educational attainment, religion, experience which is subdivided to the years of nursing experiences and nursing positions, and, country of training. Other essential facts are the identified perspectives of critical care nurses in the intensive care unit towards family presence during resuscitation which includes previous experience with CPR, Preference for Family Witnesses Resuscitation, Policy Preference, Permission, Emotional Stress, Presence of relatives, Trauma to relatives, Benefits for relatives, Litigation, Support of relatives, Staff performance, Duration of Resuscitation and Personal preference. The researcher identified the significant relationship between the level of perspectives of critical care nurses in an adult intensive care unit towards family presence during resuscitation and their profile variables.

These data were subjected to various processes to establish interpreted information. The processes involved the assessment and interactions of nurse researchers through observation, use of questionnaires as the primary tool in data gathering, structured interview, and analysis of literature related to the chosen study, and statistical treatment for analysis of the gathered data.

The data that were interpreted will help the researcher to understand the perspectives of critical care nurses towards family presence during resuscitation, thus, will be the basis in instituting enhancement measures for delivering quality nursing care and formulation of clinical pathway that will guide and give appropriate actions in a family witnessed resuscitation.

**Conceptual Paradigm**

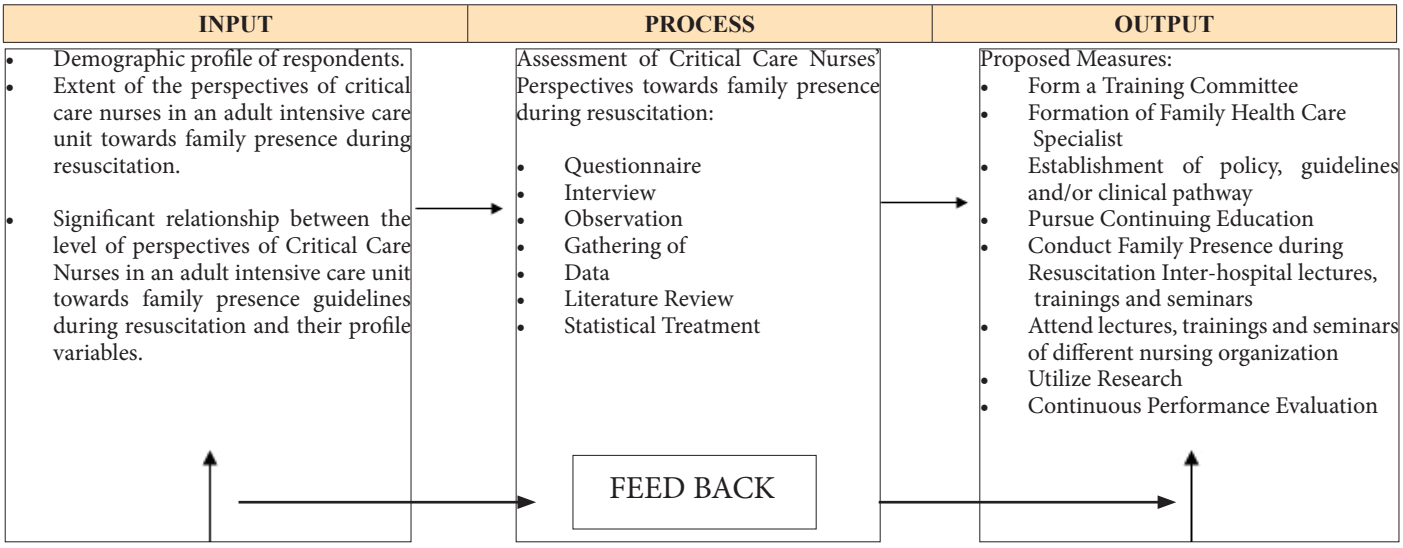


**Figure 1: Critical Care**

**Nurses' Perspectives towards Family Presence during Resuscitation**

**Statement of the Problem**

This study aimed to identify the Critical Care Nurses' Perspectives towards Family Presence Guidelines during Resuscitation in an adult intensive care unit in Prince Sultan Military Medical City and assessed the quality of nursing care they provide.

Specifically, this study focused to answer the following questions:

1. What is the profile of the respondents in terms of:
1.1. Age;
1.2. Gender;
1.3. Education;
1.4. Religion;
1.5. Experience;
1.5.1. Years of experience
1.5.2. Nursing Positions; and,
1.6. Country of Training?

2. To what extent is the perspective of critical care nurses in an adult intensive care unit towards family presence during resuscitation in terms of:
2.1. Previous experience with CPR;
2.2. Preferences for family witnessed resuscitation;
2.3. Policy Preference;
2.4. Permission;
2.5. Emotional Stress
2.6. Presence of relatives
2.7. Trauma to relatives
2.8. Benefits for relatives
2.9. Litigation
2.10. Support of Relatives
2.11. Staff performance
2.12. Duration of resuscitation; and,
2.13. Personal Preference?

1. Is there a significant relationship between the level of perspectives of Critical Care Nurses in an adult intensive care unit towards family presence guidelines during resuscitation and their profile variables?
2. Based on the findings: What clear well established guidelines can be proposed for family presence during resuscitation?

**Hypothesis**

The research study was guided by the research hypothesis.
At 0.05 level of significance, it was hypothesized that there is no significant relationship between the level of perspectives of Critical Care Nurses towards family presence guidelines during resuscitation and their profile variables.

**Significance of the Study**

The study of "Critical Care Nurses' Perspectives towards Family Presence Guidelines during Resuscitation" could lay out significant information, which could be of use as feedback to the hospital, its management, the entire nursing service department, and the other members of the health care team for further service improvement. The researcher assumed that this study would be of great advantage to the following through:

**Hospital Management:** The study will serve as a concrete guide in the development and enhancement of staff programs and strategies. Likewise, the findings of the study can serve as basis in developing policies and procedures of the hospital about family witnessed resuscitation. The study could also improve the management style of the institution to further improve health care services.

**Nursing Service:** To give them a broader understanding about the performance of staff nurses in the hospital during family witnessed resuscitation and how it affects the health care delivery system and will serve as a basis of enhancement program.

**Nursing Education:** By identifying vital characteristics and attitudes to be developed among staff nurses, particularly in enhancing rapport and harmonious relationship which is part of their potential patient care especially during family witnessed resuscitation.

**Nursing Personnel:** For better understanding and appreciation of their legitimate roles and functions and for them to maximize their efforts in adherence of optimum level of care toward client's condition.

**College of Nursing:** This study will provide data on the status of the quality of education that they may serve as a basis for enhancing and making innovations for empowering the nursing education. This will also give a background of the inclusion of family members towards end of life care.

**Student Nurses:** This study will aid them to be intellectually prepared and morally enlightened future nurses. This will help students have better perspective in their educational endeavor.

**Clients:** As the end users and recipients of care, they will gain to a great extent from caring and competent staff nurses and consequently lead to effective nursing care.

**Family Members:** As the focus of the study, they will benefit essentially from this study. This study will aid in understanding of the resuscitation efforts provided to their sick loved ones. As the main observant of the quality health care, it will help give motivation and awareness to the critical care nurses to have enough courage, acceptance and faith on their chosen profession and to be more eager in providing quality nursing care to their respective clients.

**Future Researchers:** As this will serve as a source of data and information in conducting studies related to this problem and furthermore gave them more ideas in the importance of family witnessed resuscitation.

**Private and Government Hospitals:** Health care institutions can make use of the outcome of this study to enable them to identify factors that greatly affect the care that their respective institutions provide to their patients. Proper assessment and documentation of the needs and expectations of the patients and family members will give the medical institution an idea on the specific factors that their allied health workers must improve or modify to be able to achieve a high patient and family care satisfaction.

**Scope and Delimitation**

This study focused on the perspective of critical care nurses in an adult intensive care unit towards family witnessed resuscitation.

The study aimed to investigate and describe the perspective of critical care nurses towards family presence guidelines during resuscitation. It detailed, validated, and created guidelines on whether to allow or not to allow the family member inside the intensive care unit when there is cardiopulmonary resuscitation.

The study also delved the profile of the respondents on some selected demographic variables such as to age, gender, education, religion, country of training, experience, under this is the years of experience and nursing positions. It also deals with the identified perspectives of critical care nurses towards family witnessed resuscitation. The factors that affect these critical care nurses' perspectives are also determined through this study.

The researchers gathered pertinent information and necessary data through the questionnaire that distributed to the respondents.

Critical care staff nurses were chosen to know their perspectives towards family witnessed resuscitation. The study does not cover the accuracy of the respondents' answers as well as the knowledge and acquisition of the nurses. Likewise, the research measured the perspectives towards family witnessed resuscitation as perceived by staff nurses working in an adult intensive care unit.

**This study is delimited on the following aspects:** setting, where the venue of the study is in a selected hospital, a medical services department of the Ministry of Defense and Aviation, formerly known as the Riyadh Military Hospital, the Prince Sultan Military Medical City with total of one-thousand two-hundred (1200) bed capacity. Additional facilities are being added in order to accommodate the growing needs and demands to improve quality.

**health care:** This government institution can be found in Riyadh of Kingdom of Saudi Arabia. Specifically, the study will take place in adult intensive care unit of the hospital which comprises sixty (60) beds, including general, surgical, burn, maternity, royal and acute intensive care units.

The participants of the study were one-hundred fifty (150) critical care nurses. The respondents should have specialized in an adult intensive care unit and have passed their Basic Life Support and Advanced Cardiac Life Support Courses. The participants should have minimum of 1 year nursing experience either local or abroad. The researcher focused on the qualifications since all the respondent must fall in the said criterions. Identified perspectives towards family witnessed resuscitation will be the basis of the maximizing their nursing care abilities.

The study covered the period from first week of February 2016 to last week of December 2016; hence findings and conclusions were limited only to the samples use in the study.

**Definition of Terms**

For further understanding of the study, terms were given meaning conceptually and operationally.

**Family Presence:** It refers to witnessing the resuscitation efforts made by critical care nurses, physicians and other allied health care professionals. "It is the process of active medical resuscitation in the presence of family members. "It specifically tackles on the privilege of the family members to be part of the resuscitation team as in some cases they will be allowed to decide on the treatment for their loved ones [7].

**Resuscitation:** It is the process of sustaining the vital functions of a person in case of respiratory or cardiac failure while reviving him or her while techniques of artificial respiration and cardiac massage are being implemented. (Mosby's Dictionary 1990:1249). It includes the use of basic life support and advance life support towards restoration to hemodynamic stability.

**Perspective:** It is a particular attitude towards or way of regarding something. It is a point of view (http://www.oxforddictionaries.com/definition/english/perspectives).

**Critical Care Nurses:** It refers to the person who has a specialization in nursing which deals specifically with patients experiencing high-dependency, life-threatening conditions (http://healthtimes.com.au/hub/critical-care/21/guidance/nc1/what-is-a-critical-care-or-intensive-care-nurse/532/).

**Intensive/Critical Care Unit:** It is a unit that caters to patients with severe and life-threatening illnesses and injuries, which require constant, close monitoring and support from specialist equipment and medications in order to ensure normal body functions [8].

**Culture:** It is the sum of total of the learned behavior of a group of people that are generally considered to be the tradition of that people and are transmitted from generation to generation [9].

**Family Members:** It refers to a defined group of relations, used in rules or laws to determine which members of a person's family are affected by those rules. It normally includes a person's parents, spouses, sibling, children and first cousins. It also contains others connected by birth, adoption, marriage, civil partnership, or cohabitation, such as grandparents, great-grandparents, grandchildren, great-grandchildren, aunts, uncles, siblings-in-law, half-siblings, adopted children and step-parents/step-children, and cohabiting partners [10]. In this study these persons are the ones allowed to witness the patient during resuscitation efforts.

**Previous experience with CPR:** It refers to critical care nurses who have experienced the different kinds of scenario happening in a Cardiopulmonary Arrest. In this study, this signifies the proven effects of family presence during resuscitation whether it is negative or positive.

**Preferences for family witnessed resuscitation:** It refers to the critical care nurse's perspective of patient's rights and family's needs, especially, in an event of Cardiopulmonary Arrest.

**Policy Preference:** This refers to critical care nurse's perspective of a formulation of policy regarding family witnessed resuscitation that would be beneficial or non-favorable to family members, nurses, physicians, and other allied health care personnel.

**Permission:** It refers to critical care nurse's perspective that family members cannot interfere with the resuscitative efforts and therefore must be allowed to witness the event with approval in accordance to privacy and confidentiality.

**Emotional Stress:** This refers to a critical care nurse's perspective that mainly concerns on stressful working conditions that may or may not inhibit the team's performance from providing quality resuscitation efforts.

**Presence of relatives:** It refers to critical care nurse's perspective that presence of family members may be a hindrance or may have negative effects to the resuscitation team that having them around will further aggravate the situation.

**Trauma to relatives:** This refers to critical care nurse's perspective that witnessing a cardiopulmonary arrest resuscitation will be an unpleasant experience, that this scenario may cause family distress.

**Benefits for relatives:** It refers to critical care nurse's perspective that family presence during resuscitation will promote acceptance of patient's condition, feeling of active participation during the patient care process, better understanding and recognition of resuscitative efforts and reduction of guilt.

**Litigation:** It refers to critical care nurse's perspective that family presence during resuscitation poses a threat to the patient's information confidentiality and increases healthcare workers liability to malpractice suits.

**Support of Relatives:** It refers to critical care nurse's perspective that family presence during resuscitation meets the family members' needs for understanding, providing comfort and connecting with the patient during crisis.

**Staff performance:** This refers to critical care nurse's perspective that during a resuscitation, the team will be encouraged to show professional behavior and have effective communication at the bedside; increased attention to patient's dignity and privacy; provision of holistic care and reaffirmation of nurses' role as patient advocate.

**Duration of resuscitation:** It refers to critical care nurse's perspective that presence of family during resuscitation might change medical personnel's decision and may disrupt organization of resuscitation process.

**Personal Preference:** This refers to critical care nurse's perspective that they would prefer to have their family member being present if they were the one being resuscitated and that they would also want to be present during their loved one resuscitation.

**Review of Related Literature and Studies**

This chapter contains the literature review composed of pertinent readings, published or unpublished, in local and foreign settings. All the materials analyzed included concepts derived from books, articles, theses, and other publications.

**Topical Approach**

**Family Witnessed Resuscitation**

As main topic of this study, this will include the studies and literature that will present the advantages and disadvantages of family presence during resuscitation. It will further explain the effect to the health care providers and the patients' families.

Public opinion overall is in favor of allowing family members at the bedside during cardiopulmonary resuscitation (CPR). Many believe that it is a right rather than a privilege to be with one's loved one during what may be his or her last moments. In a survey, 38 of 39 relatives questioned thought that they had a right to be present [11].

Moreover, family presence was defined as the attendance of one or more family members in a location that afforded visual or physical contact with a patient during an invasive procedures or Cardio Pulmonary Resuscitation. Family members were defined as people who were relatives or significant others with whom the patient shared an established relationship [9].

Also, current evidence implicated that most families want to be present during resuscitation. The Emergency Nurses Association (ENA) formulated clinical guidelines supporting the option of family presence during resuscitation and invasive procedures. Now both the American Association of Critical Care Nurses and the American Heart Association have issued and presented guidelines supporting family presence at bedside during resuscitation [12]. Furthermore, hospitals should consider establishing formal programs for allowing family members to be present during resuscitation procedures. Such programs should include mechanisms to limit participation only to immediate family members, to determine their emotional suitability to witness the resuscitation, and to have trained staff who are immediately available to prepare the family members for what they will witness and to support them during and after the experience [13].

When a patient arrests in a hospital the family is guided away from their loved one into the waiting room while life-saving measures are initiated. As a nurse is able to break away from the resuscitation, she updates the family on the patient's status. But the scene is changing as families exercise their right to be present during resuscitation – in the same way they once did in the delivery room. Allowing family members to be present at the bedside during cardiopulmonary resuscitation is a contentious issue in the United States and has stimulated widespread debate. In less than two decades however, the movement to allow family presence has steadily evolved because of support from professional organizations, attention from the media, and research on the topic [14].

Moreover, it was determined that hospitals with a Family Presence during Resuscitation (FPDR) policy had similar rates of return of spontaneous circulation (ROSC) and survival to discharge as hospitals without such a policy, based on data from >200 hospitals in the United States. A lack of statistically significant differences in outcomes across hospitals was also reflected by the similar characteristics of the arrests and the resuscitation efforts within hospitals differing by FPDR policy. In detail, the resuscitation quality, pharmacological and non-pharmacological interventions were not different between hospitals with and without an FPDR policy. Though there were statistical differences in some facility-reported potential resuscitation systems errors, these did not meaningfully differ between hospitals with and without an FPDR policy. To the knowledge of the researchers, this is the first large, multicenter study to determine that an FPDR policy does not negatively affect the outcomes and quality of in-hospital resuscitative efforts.

Some might be surprised that an FPDR policy may have no significant effect on resuscitation practice. Especially, in-hospital cardiac arrests often rely on the coordinated efforts of several providers, including physicians, nurses, pharmacists, and trainees, and often occur in space constrained environments. These factors highlight that in-hospital arrests allow for greater opportunity for FPDR to affect resuscitation safety. For example, if family presence directly or indirectly increases stress or disrupts communication or coordination of efforts among providers during the resuscitative attempt, providers may be more likely to commit errors during resuscitation. Furthermore, providers may be compelled to deliver more aggressive and potentially unwanted care in the presence of family members. At the same time, a potential benefit may arise if efforts are ceased when family members change goals of care while witnessing the resuscitation. Although such mechanisms may affect individual resuscitations, our data suggest that these mechanisms do not affect aggregate resuscitation efforts across adult patients in hospitals with differing FPDR policies. Thus, concluding that hospitals with an FPDR policy generally have no statistically significant differences in outcomes and processes of care as hospitals without this policy, suggesting such policies may not negatively affect resuscitation care [15].

Moreover, a couple of researchers in their study about family presence program within the Emergency Department (ED) at Massachusetts General Hospital. The authors focused on the attitudes of nurses as well as physicians before and after the launch of the program. An anonymous three-part survey was administered to all ED nurses, attending physicians, and residents on two separate occasions: prior to the start of the program and one year after induction of the program. The survey measured the healthcare professionals' willingness to adopt family presence, personal and professional experience of family presence, and demographics. Education was conducted with the staff over a three-month period. The sessions included descriptions of current research findings, a brief video of an actual family describing their own personal experience, and findings from the survey. Members of the investigating team during resuscitations would ask the participating team members if they would be comfortable offering family presence. If the team agreed, the researching group functioned as a support/advocate for the family members. After completion of the resuscitation, the researchers provided feedback from the family members to the resuscitating team [16].

However, families appear to agree with the associations which have strong proponents of family presence during invasive procedures and resuscitations. However, health care providers, especially physicians, are more skeptical and inconsistent in their support of such practices. Before providers can be convinced to change their minds and the practice can be adopted with confidence, more sophisticated research needs to be conducted that convincingly demonstrates tangible, measurable benefits to the patient, family, and/or provider [17].

In addition, a study have presented that up to 80% of surveyed relatives would wish to be present while their loved one was undergoing CPR or would at least like to be offered the opportunity. Although not all relatives would want to enter the resuscitation room, most believe that they have a right to be there and want the opportunity to do so [18].

As discussed in other studies, the issues of Family presence during resuscitation in emergency departments is a relatively new concept among medical professionals, questioning the historical practice of families not being allowed present during medical procedures and whether this theory provides the holistic approach to care of the patient and their families [1-19].

Meanwhile, family presence during resuscitation was first introduced in Foote Hospital in the United States in 1992 following a nine year study where staff in the emergency department where educated on how to deal with the issues arising from family presence, and families who had witnessed or wished to witness the resuscitation of a loved one were evaluated to determine the long term psychological effects of this ordeal. A follow up study showed that both staff and family members benefited from this (Foote Hospital Survey, 1992). Staff nurses who had more compassion and professionalism towards the patient and family are relatively implicating that it was a method of aid in letting go and being of help with the grieving process made the Foote Hospital study lead to a number of American, British and Australian hospitals implementing the same polices to give family members the right to choose to be present [42].

Active resistance to its introduction by those at the forefront of providing emergency resuscitative care directly opposes the views of family members who have reported on the positive benefits of this experience [20]. Moreover, some 20 years after its inception, witnessed resuscitation remains a highly emotive and controversial concept. Intense disagreement is seen to exist between accident and emergency healthcare staff who choose to deny family members access to their loved one during an adult resuscitation attempt and the lay public who appear to favor the premise of presence.

In the study of, they discovered that one of seventeen nurses particularly opposed family presence during resuscitation or invasive procedures. They found the ability for the nurse to forge a positive connection with families, the ability to engage the family in care, and transition to acceptance of family presence by the nurses were major themes in this study. Another major theme of caution revealed mixed feelings of the nurses regarding times or circumstances when family presence may be inappropriate. These include family behavior, staff safety, staff behavior or expertise, traumatic and bloody procedures, forensic cases and lack of time to establish a relationship with the family [21].

In addition, it was found that the majority of patients supported family presence during resuscitation. Three themes were shared by participants who were resuscitated and participants who were not. Being there (i.e., to understand the situation, offer encouragement, emotional support and advocacy) was identified as a positive theme, although the idea of advocacy was challenged by some as potentially leading to irrational family decisions or conflicts of interests. The theme of welfare of others included some concern about the possible emotional consequences for relatives. Lastly, a theme of professionals' management of the resuscitation revealed concerns that professional efforts are unimpeded and focused on the patient, who takes precedence over family needs. Participants felt there may be reasons for family members to be asked to leave the bedside [22].

**Critical Care Nurses' Perspectives towards Family Presence during resuscitation**

As family presence during resuscitation efforts continuously form as a controversial issue among healthcare providers. A study explored the advantages and disadvantages to this concept from the healthcare provider and family's perspective, and addressed the patient's viewpoint. The advantages listed were emotional support for patients and families; a positive experience for families, patients, and healthcare professionals; guidance and increased understanding of the patient's condition; facilitated decision-making regarding resuscitation efforts; assisted patient's family members to know that everything was done to save their loved one. The disadvantages listed are resuscitators may be distracted by a family member's observance of their efforts, possibly impairing or interfering with the process; the fear is that family member's presence can increase the code team's anxiety, hindering their performance; actions or interventions may be misinterpreted, leading to the assumption that the code team is incompetent. The information provided demonstrated that family presence during resuscitation efforts is a necessary and ethical standard in healthcare practices today and can help nurses feel more comfortable facilitating this process [23].

Moreover, Research suggested that family presence at the bedside during resuscitation is beneficial for both family members and healthcare professionals. Education of health care personnel will help them communicate effectively with and guide distraught family 12 members during a code. Family presence provides the ability to see that everything is done for the patient, a sense of closeness, decreased fear and anxiety, and a way for the families to say goodbye. Attitudes of family members also have been

studied, with more than 90% of subjects favoring presence during resuscitation as a means of coping with grief, providing support and comfort, and being able to say goodbye. The hospice and palliative care have promoted the presence of family members to provide support for dying loved ones. Nurses and other health care providers can empower family members to make informed decisions regarding the care of their loved ones or share moments during times of crisis [24].

In addition, it was concluded that the most of patients supported family presence during resuscitation. Many patients felt that it was important for their families to be there to understand the situation, offer emotional support and to be a patient advocate. In some cases, other patients were concerned about the welfare of their family members and their emotional behaviors and feelings. There was also a small group that was concerned that the family members' needs or feelings may take precedence over the needs of the patient [22].

In contrary, it is stated that 'if knowledge is power, true carers will aim to share their knowledge and skills with vulnerable individuals so as to empower them to reassert control'. This points me to believe that the hallmark of any ethical decision-making process with regards to a relative's right to witness resuscitation is the mutually interactive process of communication which assists individuals in making an informed, voluntary decision regarding their presence [7].

Another study revealed 301 relatives were polled to find their opinions on family presence during resuscitation. The study showed discrepancies in the results regarding discouragement of family presence from the nurses but patients encouraging their families to be present. The patients felt more comfortable, safe, and secure with their family members near them. Evidence continues to show that family presence is beneficial to both the patients and their families [25]

Likewise, a quantitative study by [19] where 90 sample questionnaires there distributed to 90 nurses in one Cork based hospital to establish staff nurses views on the subject. The main findings from this study showed the need for development of written policies and guidelines regarding family witnessed resuscitation, along with the need for educational program for nurses to enable them to deal with situations as they arise. The study showed 58.9% of nurses already do allow family members to be present during resuscitation however the majority are senior nurses where as 42% would prefer to see written policies in place. The limitations of this study require a follow up qualitative study to enhance findings while getting the nurses perception in detail. Fear seemed to be an ongoing theme in this study: fear of legal issues, pressure of being watched, hysterical family members interfering in procedures, lack of space in the resuscitation room and lack of staffing issues.

Moreover, a quantitative study in which 375 nurses in Muncie completed a survey on staff attitude towards patient autonomy. The findings of the survey indicate the decision to allow relatives in the resuscitation room lies with the personal preference of the nursing team. Whether they feel it is appropriate in a given situation. The need for further training and education is vital for staff to make an informed decision in the best interests of the patient and the effect on the family members [18].

In addition, a study revealed in a university-affiliated level-1 trauma center to determine the attitudes, benefits and problems associated with family presences during CPR. 43 patients who survived were interviewed and a questionnaire was given to recall experiences with family presences during resuscitation. The results showed that family witnessed resuscitation as a right. The general theme of family presence is a welcome one in relation to the patients' perspective as they expressed feelings of being afraid, hurt, and in pain during the event they related feeling safer, less scared and comforted when family members were there. Feeling like they had a sense of hope and security appeared to help them giving them the strength to pull through reporting that their family members act as advocates during the event giving vital information regarding the patient's condition to aid the emergency team to provide effective care and humanize the patient in the eyes of their careers [11].

In addition to staff preferences, trauma staff members initially feel that the relatives could bevisually and auditory disturbance by the experience with patients crying out in pain, hypoxic confusion or anxiety [26]. However,some researchers revealed that 39% of nurses found that family presences gave them the opportunity to promote open communication between family members and staff. To advocate for the patient, assist with end of life decisions, provide emotional and spiritual support to the patient and facilitates closure and healing for the relative, leading to the term family presence is a 'right not an option' [27].

Furthermore, a study was made to explore the nurses' beliefs andexperiences concerning family presence at the bedside during resuscitation efforts. The study used a 16-question qualitative interview and assessed for common themes. The sample included 10 registered nurses with a minimum of four years of clinical experience who worked in an acute care setting. The nurses were selected using variation sampling. Four themes emerged: the conditions during which family presence is an option; using family presence to force family decision making; staff feelings of being watched; and the impact of family presence on a family. The first theme was recognized as 'conditions during which family presence was not a practical option'. Certain participants noted that allowing a loved one at the bedside during resuscitation was dependent on the conditions or situations that contributed to the need for resuscitation. Many nurses were worried with the potential of family interference at the bedside. Family members could sometimes be out of control, not know how to deal with their emotions, and possibly get in the way. Other nurses felt that the family presence was contingent on the situation surrounding the need for resuscitation. The second theme was 'an influential tool to help families decide to carry on or cease resuscitative efforts'. The attendance of family in the room during resuscitation allowed the visualization of what was involved during resuscitation and assisted the family to decide if all heroic measures should be performed at length. The third theme was awareness of being watched by family and the staffs' behavior. Some of the respondents felt an increase in anxiety and a hovering feeling. This theme was especially felt when certain interventions failed to result in a positivechange in the patients' condition. Many of the nurses stated that they perceived themselves as the focus of attention, with everyone watching their performance. While some nurses felt empathy for the loved ones watching their family members, some expressed that they felt as if their attention was divided between 'two' instead of 19 concentrating on 'one'. Additionally, several nurses expressed that staff behavior was often different with family presence.

Usually during resuscitation, the room was reported as being loud. With family presence, it was noted too often be quiet, for the fear

of the nurse/medical team saying something inappropriate and the family misconstruing what was said as being disrespectful. Respondents noted that to get through difficult situations, the medical staff can be unpolished and verbal and not realize what is being said in the heat of the moment. Staff also stated that in some instances the providers might have performed an outstanding job and the family would be eternally grateful. The final theme was the 'impact of family presence on the family'. Many of the respondents felt that family presence could provide insight about the care that their loved one had received and closure for the family. Numerous participants stated the importance of family members being able to be present and visualize the immediate attention provided by many staff members [28].

**Personal Information of Critical Care Nurses with regard to Family Witnessed Resuscitation**

Critical Care Nurses' personal information are essential in obtaining a more concrete basis of comparison with regards to their own perspective towards presence of family members during resuscitation. This will depict the variables of age, gender, culture and religion as affecting factors of the study, which are relevant data especially in the country Saudi Arabia.

Family presence is highly suggested by many health organizations worldwide for several reasons including patient and family rights. There are no written policies or guidelines in Saudi Arabia to guide health professionals in their practice regarding the option of family being present during resuscitations. A study was reviewed in order to identify the attitudes of nurses towards family presence during resuscitation in the Muslim community of Saudi Arabia. This is a descriptive study using data from a convenience sample of 132 nurses using a self-administered questionnaire. The study took place in two major trauma centers in the eastern region of Saudi Arabia. The analysis of the data revealed that nurses had negative attitudes towards family presence during resuscitation. A high percentage agreed that witnessing resuscitation is a traumatic experience for the family members. Almost all participants disagreed with the statement that the practice of allowing family members to be present during the resuscitation of a loved one would benefit the patient and 78% disagreed with the statement that it would benefit families. The majority of the participants revealed that the presence of family would negatively affect the performance of the resuscitation team. However, almost half of the sample would prefer a written policy allowing the option of family presence during resuscitation in Saudi Arabia. The findings of the study strongly suggested the need for the development of written policies offering families the option to remain with patients during resuscitation in Saudi Arabia. The study further recommended the development of policies for healthcare professionals and the public for the safe implementation of the practice [29].

In a significant positive relationship was found between spirituality and support for family presence during resuscitative efforts in adults and a significant negative correlation was found between support for family presence and the age of the health care professional [30].

According to almost 72% of the respondents wanted a family member present. While, 21% did not wish any family member to be present. Positive responders tended to be younger and non-white than negative responders [31].

Moreover, emphasized that during resuscitative attempts of patients, family members are often excluded, although the Arab culture has a strong family ties. Illness and wellness are essential part of the Arab culture. Lack of cultural awareness and the inability to provide culturally competent care can lead to conflict, increase level of anxiety and stress among both nurses and family members [32].

To discuss further, some researchers evaluated the performance of two scales that assessed perceptions of family witnessed resuscitation among a sample of health professionals, in an Australian non-teaching hospital, and explored differences in perceptions according to socio-demographic characteristics and previous experience. An anonymous survey was distributed to 221 emergency department clinicians. Socio-demographic characteristics and perceptions of family witnessed resuscitation using the Family Presence Risk–Benefit and Family Presence Self-confidence Scales were assessed. Approximately two-thirds of participants considered that family presence was a right of patients and families, and almost a quarter of respondents had invited family presence during resuscitation on more than five occasions. They found no significant differences in scale scores between doctors and nurses. Their findings confirmed the need to support clinicians in the provision of family witnessed resuscitation to all families [33].

Moreover, two groups were matched by age and gender at a ratio of 1:2. Data was collected by face-to-face interviews using a standardized 22 item questionnaire. Data analysis was used to identify differences between the two groups. The results demonstrated that both groups were broadly supportive of the practice. Meanwhile, resuscitated patients were more likely to favor witnessing the resuscitation of a family member, preferred to have a relative present in the event they required resuscitation, and believed that relatives benefited from such an experience. Likewise, both groups indicated that staff nurses should seek patient preferences about family witnessed resuscitation following hospital admission, and stated that they were unconcerned about confidential matters being discussed with family members present during resuscitation [22].

However, a study which focuses on the demographic characteristics as part of health care professionals' willingness to allow family to stay during invasive procedures and resuscitation. This study suggests a link between a holistic perspective and support for family presence. The higher the scores of spirituality for the health care professionals, the more likely they were to believe that family presence is a patient's right and in the provision of holistic care. Heath care professionals seem to personally prefer to have the option as both a family member and as a patient to allow patient's family members to stay [30].

Likewise, Family presence during cardiopulmonary resuscitation was related with positive results on psychological variables and did not interfere with medical efforts, increase stress in the health care team, or results in medical conflicts. In this study, offering family members of patients undergoing CPR the option of witnessing the resuscitation efforts was significantly lower incidence of PTSD-related symptoms than was following standard practice regarding family presence. There were also no claims for damages from any participants nor were there any medico-legal conflicts. Also, whether the family members were offered the choice, more favorable results of psychological testing were noted when family members were present [34].

In addition, a study conducted in Jordanutilized Molter's Critical Care Family Needs Inventory (CCFNI) to examine the needs of 158family members who were visiting their critically ill relatives.

The researchers reported that the majority of the respondents perceived 16 need statements as important or very important. The needs for assurance, information and proximity were ranked the highest. The need to receive information about the patient's condition was the most important need for most of the respondents. Interestingly, needs for support and comfort were the lowest amongst the relatives' needs. This was explained by the fact that Jordanian family members received greater support from other relatives. It was a one of the few studies that evaluated the Jordanian critically ill patients' families' needs. There are several specific Jordanian cultural, social and religious issues were raised in this study. Most importantly, although this study used the CCFNI which was used by several Western studies, the researchers reported some differences between Jordanian families' needs and the needs of Western families. Despite the raising of many cultural and religious issues, the study failed to address families' special cultural and religious needs. This might have resulted from their use of a quantitative design and using an instrument that was based on studies conducted to assess Western families' needs [35].

Family members explained that religion is an essential part in the daily life of the Jordanian population. They indicated the importance of religion in formulating other life aspects such as the interaction between people, the relationships between family members, the interaction with illnesses and crisis, and the end-of-life issues. All family members identified religious reasons for their desires to stay beside their loved ones during CPR, such as praying for God to help and support their loved ones. These activities were thought to support patients and their relatives. No precedent in the literature examined the influence of religion on families' needs during CPR. Despite this, the findings of this study reveal that people's religion and beliefs should be considered when we deal with CPR and end-of-life care. It also concludes the importance of considering the cultural and religious dimensions in any family-witnessed resuscitation programs. The study recommends that family members of resuscitated patients should be treated properly by professional communication and involving them in the treatment process. The implications concentrate on producing specific guidelines for allowing family-witnessed resuscitation in the Jordanian context. Finally, attaining these needs will in turn decrease stress of those witnessing resuscitation of their relative [36].

**Synthesis**

Family witnessed resuscitation has plotted controversy worldwide as to whether it is essential for the improvement of provision of care or will further aggravate stressful situations. This is true in the western states, but here in Middle East, there are limited studies that covers family presence during resuscitation so the need for supplementary researchers is vital to be able to determine its significance.

As the authors of the studies gathered stated, the right of the family to be present in a cardiopulmonary situation is important as long as there are guidelines supporting this such as hospital policies and procedure that will protect the health care providers and the institution itself from any medical liabilities. On the patients' perspectives, safety, less anxiety, sense of hope and security are the main issues that during the resuscitation event, feelings of being afraid, hurt and in pain surmounts over them.

One of the researchers clearly specify the involvement of the family in an event of cardiopulmonary arrest is relevant to having programs that will allow the hospital to set a specific time in which the family members are allowed to see their loved ones. There should be a trained professional that will be willing to support them and explain to them the occurrences which is happening in a cardiopulmonary resuscitation.

Some hospitals in western countries have already implemented the family presence during resuscitation policy and a few studies have proven that there were no difference if the institutions have or does not have formulated FPDR policy. Having the policy had no adverse effects to the hospital or will form any medical liabilities to health care professional included in the resuscitation.

Skepticism is inevitable with family presence during resuscitation. Some health care providers, to be certain, the physicians, were harder to convince with regards to the benefits of having family members witnessing the resuscitation of their loved ones. In contrary with the critical care nurses, who were more capable of giving compassion and practicing professionalism towards family and patients, have been the pioneering idealism that family members can witness the care being provided during a cardiopulmonary arrest. This is beneficial in a way that it will help them during grieving process and exercising the principle of autonomy.

There are negative issues discussed involving nurses that will explore further the emotional and psychological aspects of nursing. The acceptance of family presence during resuscitation may be hindered by mixed feelings or uncertainty towards family behavior, staff safety, staff behavior or expertise, traumatic and bloody procedures, forensic cases and lack of time to build a relationship with family.

Critical care nurses' perspectives towards family presence during resuscitation is a broad concept which is delimited to specifications which are often encountered opinions by nurses experiencing resuscitation with and without family presence. Researchers had summarized positive and negative sides of having family members witnessed the resuscitation. Emotional support, guidance and increased in autonomy had surfaced as the main beneficial points for the family members as perceived by critical care nurses. Visually and auditory interference on the performance of the code team and increased in anxiety are the primary disadvantages that were cumulatively stated by the researchers. These concerns made the healthcare providers worried of the possibilities that having family members will not be helpful for the whole resuscitation process.

Education will also play an important role to the success of implementation of family witnessed resuscitation. With proper communication, the family members will be empowered and aware of the surrounding, procedures and protocols, that is being done to their relatives. This event will help them to easily accept what is happening and a way for them to say goodbye to their loved ones. Meanwhile, with this ease of access may be abused by the relatives or may let them be vulnerable to emotional instability for the prioritization of feelings. Emotions of the relatives may be overwhelming during the inevitable end of life scenario.

Critical care nurses were also evaluated by some researchers as having the concept of "constant fear". This is an ongoing barrier for nurses to promote professionalism and to be a health advocate. It includes fear of legal issues, pressure of being watched, hysterical family members interfering in procedures, lack of space in the resuscitation room and lack of staff issues. On the other hand, as the nurses practiced autonomy, family members may be given the opportunity to witness the resuscitation given that it is an appropriate situation.

Some demographic profile of the nurse may greatly implicate the responses towards family presence during resuscitation. Spirituality came to be of great significance to the researchers and age has no correlation to whether family members can be allowed to be present in a resuscitation process. Religion played an important factor that it served as a foundation of way of life especially in the middles east countries. The desire to stay beside their loved ones during cardiopulmonary resuscitation. The practices include praying for God to help and support their loved ones. The Arabian culture is also discussed by one of the authors that the culture has strong family ties. Lack of cultural awareness and inability to meet cultural care expectation may cause a conflict which may affect both the nurses and family members. With accordance to results gathered by a researcher in a western country gender differences do not affect the preferences during resuscitation. In fact, age and gender variables was relatively in favor of family witnessed resuscitation. Still there are limited literatures to support the relationship of demographic profile of critical care nurses towards family presence during resuscitation.

**Utilization**

This study is significant to the Kingdom of Saudi Arabia as there are little knowledge known about this issue of family witnessed resuscitation. This will be a breakthrough to the healthcare system as whenever this study resulted a positive outcome. Implementation of the recommendations will be beneficial to the country especially to the family members of the patients. This will be a progress due to the involvement of the family not only to the patient's care but till end of life scenario. This will educate the people of Saudi Arabia on what to expect during resuscitation. This might also prove that family witnessed resuscitation will alleviate suffering and decrease the level of anxiety, promote comfort, grief and acceptance. For the hospital management, the study will serve as a concrete guide the development and enhancement of staff programs and strategies. Likewise, the findings of the study can serve as basis in developing policies and procedures of family witnessed resuscitation in the hospital. For the nurses, for better understanding and appreciation of their legitimate roles and functions and for them to maximize their efforts in adherence of optimum level of care toward client's condition. Implementation of this study will maximize the sources data and information related to this problem and furthermore, it will give the future researchers more idea on the importance of family witnessed resuscitation.

**Research Methodology**

This chapter presents the research methods and procedures, the subjects of the study, the research instruments, the research procedure, the sources of data and the statistical treatment.

**Research Design**

The study utilized the descriptive and qualitative methods of research. It was descriptive with recording, analysis and interpretation of data gathered about the profile of the respondents, their manifestations of empowerment and the clinical teaching strategies utilized by the nurse educator. Qualitative research was also employed since documentary analysis will be further utilized to strengthen the framework of the study, states that descriptive research design is used to observe, describe, and document aspects of a situation as it naturally occurs. It provides an accurate portrayal of the characteristics of the persons, situations or groups and the frequency with which certain phenomenon occurs. Specifically, the descriptive evaluative research involves finding out a program practice or policy if it is working. Its goal is to assess or evaluate the success of the program [37].

Validated questionnaire was the main tool used, and followed-up by interviews. The questionnaire was the most appropriate, practical and economical tool to gather data needed in the study. The researcher conducted structured interview technique to clarify and verify the answers of the respondents to the questionnaire.

The study recognized and described the level of perspectives of Critical Care Nurses in an adult intensive care unit towards family presence during resuscitation which was the basis in formulation of established guidelines aimed to have excellent provision of nursing care.

**Locale and Population**

This study involved one-hundred fifty (150) critical care staff nurses who were currently employed in an adult intensive care unit in Prince Sultan Military Medical City at Riyadh, Kingdom Saudi Arabia. They were chosen as respondents of the study because of their accessibility and relevance to the study.

The adult intensive care unit in this hospital includes; General Intensive Care Unit, Fast Track Intensive Care Unit, Trauma Intensive Care Unit, Neurological Intensive Care Unit, Royal Intensive Care Unit, Surgical Intensive Care Unit, Maternity Intensive Care Unit and Burn Intensive Care Unit. This comprised a total of sixty (60) beds. This selected hospital is a medical services department of the Ministry of Defense and Aviation, formerly known as the Riyadh Military Hospital. It is a government institution with total of one-thousand two-hundred (1200) bed capacity. Additional facilities are being added in order to accommodate the growing needs and demands to improve quality health care.

The purposive sampling technique was applied based on certain criteria set for the study. Purposive sampling is a non-probability sampling method in which the researcher selects participants based on personal judgment. It included the selection of the most readily available persons as participants in the study. It used in the study wherein the identified clients who met the criteria set by the researcher and those who were available during the data gathering period were chosen as respondents.

However, the study did not involve head nurses and student nurses under the hospital administration of Prince Sultan Military Medical City. The respondents had specialized in an adult intensive care unit and have passed their Basic Life Support and Advanced Cardiac Life Support Courses. The participants had minimum of 1 year nursing experience either local or abroad. The researcher focused on the qualifications since all the respondent must fall in the said criterions.

**Instrumentation and Validation**

After a thorough review of related literature and studies, the questionnaire were formally drafted. Observation, interview, pamphlets, and previous research studies were utilized to supplement the data gathered from the questionnaires in order to assess the perspective of critical care nurses in adult care unit towards family presence during resuscitation.

The self-made questionnaire that was used in the study consists of three parts and these are the following: Part I-Consent Form, Part II-Personal Information Sheet of the respondents, and Part III-Modified Critical Care Nurses' Perspectives Questionnaire towards Family Presence during Resuscitation. It was patterned in a checklist type of questionnaire also called "matrix questionnaire", items were presented in two-dimensional pattern. Questions were written horizontally while answers vertically.

Part I, The Consent Form contained the written agreement between the researcher and the respondents regarding the study. The signature of the nurses will not be secured due to the principle anonymity. The respondents had to encircle the words,"I do" or "I do not", if they wished to participate or refuse from being selected in the study.

Part II, the Personal Information Sheet contained items which will determine the profile of the respondents in terms of age, gender, working experience, nursing position, religion, education and country of training.

Part III, the Modified Critical Care Nurses' Perspective Questionnaire. It was composed of fifty (50) items distributed accordingly among thirteen (13) identified perspectives: Previous experience with CPR (3 items), Preferences for family witnessed resuscitation (5 items), Policy Preference (3 items), Permission (3 items), Emotional Stress (4items), Presence of relatives (4 items), Trauma to relatives (3 items), Benefits for relatives (5 items), Litigation (4 items), Support of Relatives (4 items), Staff performance (4 items), Duration of resuscitation (3 items) and Personal Preference (5 items). The questionnaire was written in English and Translated in Arabic. The critical care nurses were instructed to check the box that corresponds to their personal answers.

**Data Gathering Procedure**

To comply with the data needed, the researchers were able to know the needed requirements to obtain data.

As soon as the sets of survey questionnaire are completed, series of research activities carried out to fulfill the requirement of the research ethics committee. The researcher requested for the approval as regards to the proposed title of this study. It underwent content analysis done by series of experts which are nurse administrators, hospital administrators, selected senior nurses and staff nurses. Their comments and suggestions for the improvement and presentations were considered. Then, the researcher edited and finalized the survey questionnaire for pre-testing to twenty (20) critical care nurses in different adult intensive care units. The researcher observed the respondents expression about the questions and also, assessed if they had difficulty in answering the questionnaire. The twenty (20) chosen respondents were excluded in the actual survey.

Then, the results of the dry run was analyzed as to whether the groups of respondents found difficulty in answering the question taking in consideration the clarity of items, vagueness of statements, time element in answering questions, and other related problems. The researcher, upon the recommendation of the head of the research team, the clinical director of the Intensive Care Services, finalized then distributed the instrument for evaluation.

Prior to this activity, the researcher submitted a letter to address the administrator of selected hospital especially to the head nurses of the intensive care services to conduct the study. The said study was about critical care nurses' perspectives towards family presence during resuscitation. When the researcher, got permitted to conduct the study, questionnaires were personally distributed to the staff nurses of the different intensive care units. The respondents were informed about the purpose and importance of the study conducted. They were also informed that all their answers will be kept confidential. The necessary data obtained were analyzed, assessed statically and presented with interpretation.

**Statistical Treatment of Data**

After the data had been collected, the researchers started to tabulate the data gathered from the respondents. The tabulated data were subjected to statistical treatment for better analysis and interpretation.

**Frequency:** This tool was used in order to determine the total number of respondents which falls on one category. It was used when data has relatively small number of the value for a variable.

**Percentage:** This was one convenient way to express many proportions. It was computed by dividing the number of respondents to the total number of respondents.
This was best illustrated using the formula:

$$P = \frac{F}{N} \text{ X } 100$$

Where: P = percentage
F = number of respondents
N = total number of respondents

**Weighted mean:** It was used in the study define the summation of the products of each observation multiplied by its associated weight, then divided by the summation of all values of weights in the distribution.

**Formula:**

$$\bar{x}_w = \frac{\sum_{i=1}^{n} w_i x_i}{\sum_{i=1}^{n} w_i} = \frac{(w_1 x_1 + w_2 x_2 + \ldots + w_n x_n)}{(w_1 + w_2 + \ldots + w_n)}$$

Where: $x_i$ = represent the values of observation
$w_i$ = represent the weights associated to x

**Analysis of Variance or ANOVA:** It was used to describe the technique whereby the total variation in the response measurements is divided into portions that may be attributed to various factors of interest to the experimenter.

**ANOVA Table**

| Sources of Variation | Degrees of Freedom (df) | Sum of Squares (SS) | Mean Square (MS) | F-value |
|---|---|---|---|---|
| Treatments | k-1 | SSTr | MStr= SSTr/(k-1)= | $S^1_2 / S^2_2$ |
| Error | n-k | SSE | MSE= SSE/(n-k)= | |
| Total | n-1 | Total SS | | |

Where: Correction for the Mean (CM) = $\frac{(\sum x_{ij})^2}{n}$

Total SS = $\sum x_{ij}^2 - CM$

SSTr = $\sum \frac{Y_{i.}^2}{n_i} - CM$

SSE = Total SS – SSTr
MSTr = SSTr / (k-1)
MSE = SSE/ (n-k)
F-value = MSTr/MSE

Where: $Y_i$= Total of all observations in sample i

$n_i$ = Number of observations in sample i

$$n = n_1 + n_2 + ... + n_k$$

**Critical Region:** f-value > f-tabular $_{(\alpha,v1,v2)}$

**The t-test for Two Independent samples (Unknown Equal Variance):** It was utilized in the study to compare two independent random samples of size n1 and n2, drawn from two populations with means and , and unknown but assumed equal variances.

$$t = \frac{(\bar{x}_1 - \bar{x}_2) - (\mu_1 - \mu_2)}{S_p \sqrt{\frac{1}{n_1} + \frac{1}{n_2}}} \qquad df = n_1 + n_2 - 2$$

Where: $S_p^2 = \frac{s_1^2(n_1 - 1) + s_2^2(n_2 - 1)}{n_1 + n_2 - 2}$

$S_1^2$ and $S_2^2$ are sample variances

The responses of the respondents were scored using the Likert's Scale Values of 1 to 5, 1 as the lowest and 5 as the highest score and giving corresponding verbal descriptions.

| Option | Verbal Interpretation | Scale |
|---|---|---|
| 5 | High Extent | 4.20 - 5.00 |
| 4 | Moderate Extent | 3.40 - 4.19 |
| 3 | Low Extent | 2.60 – 3.39 |
| 2 | Some extent | 1.80 – 2.59 |
| 1 | No extent at all | 1.00 - 1.79 |

**Presentation, Interpretation and Analysis of Data**

This chapter presents the analysis and interpretation of data based on the responses of the one-hundred fifty (150) respondents in Prince Sultan Military Medical City in Riyadh, Kingdom of Saudi of Arabia.

**What is the profile of respondents in terms of:** The following table and discussion presented the profile of the critical care nurses in terms of age, gender, education, religion, years of experience, nursing position, and country of training.

**Table 1: Summary of the Demographic Profile (N = 150)**

| Demographic Profile | Frequency | Percentage (%) |
|---|---|---|
| **Age** | | |
| 20 – 25 years old | 7 | 4.67 |
| 26 – 30 years old | 96 | 64 |
| 31 – 35 years old | 20 | 13.33 |
| 36 – 40 years old | 16 | 10.67 |
| 41 – 45 years old | 9 | 6 |
| 46 years old and above | 2 | 1.33 |
| **Gender** | | |
| Male | 44 | 29.33 |
| Female | 106 | 70.67 |
| **Education** | | |
| With Diploma | 12 | 8 |
| Bachelor's Degree | 125 | 83.33 |
| With Units in Masters | 4 | 2.67 |
| Master's Degree | 9 | 6 |
| **Religion** | | |
| Roman Catholic | 77 | 51.33 |
| Muslim | 33 | 22 |
| Christian | 38 | 25.33 |
| Hindu | 0 | 0 |
| Others | 2 | 1.33 |
| **Years of Experience** | | |
| 1 – 5 years | 70 | 46.67 |
| 6 – 10 years | 58 | 38.67 |
| 11 – 15 years | 22 | 14.67 |
| **Nursing Positions** | | |
| Staff Nurse 2 | 114 | 76 |
| Staff Nurse 1 | 27 | 18 |
| Charge Nurses | 9 | 6 |
| **Country of Training** | | |
| Saudi | 22 | 14.67 |
| Philippines | 113 | 75.33 |
| India | 11 | 7.33 |
| Jordan | 4 | 2.67 |

**Age: The first factor considered was the age of respondents. The level of maturity of a person has something to do with the outlook in life. It is understood, that matured people have more varied experiences in life than the young ones. This is the reason why it is important that the age ranges of respondents be included as a factor in this study. The distribution of the age of respondents is presented in Table** Table above presented the frequency and percentage distribution of critical care nurses when grouped according to age. The data showed that out of 150 respondents, 96 or 64% belonged to age 26 – 30. This group is closely followed by those who are 31-35 years old at 20 or 13.33%; 36-40 years old at 16 or 10.67%; 41-45 years old at 9 or 6%; 20-25 years old at 7 or 4.67%; and 46 years old above at 2 or 1.33%. Majority of the critical care nurses belong to the younger bracket, 26-30 years old. The findings suggest that majority of the critical care nurses are young adults. On the other hand, it also shows that the least of the critical care nurses were on the age bracket of 46 years old and above. During the data gathering, the staff nurses mentioned that new nurses tend to have a positive or more open view to different situations or has the capacity to cope to change easily. These findings are also expected since there is a fast turnover in the nursing profession and that most of the nurses migrate to different countries. Some also have already decide to retire to their home country. In this era of early adulthood, important choices regarding marriage, family, work and lifestyle should be made before the young adults have the maturity of life experiences to choose wisely. Early adulthood era comprises of avid quests for intimate relationship and other major commitments involving career and life goals. According to Erik Erikson's stages of development, there is also "a parallel pursuit for the formation of a set of moral values. This is the time that "ideological mind" of adolescece gives way to the ethical sense which is the mark of an adult [6].

**Gender: Gender differences have an impact to one values and perspectives especially here in Kingdom of Saudi Arabia. It involves to group the different roles of men and women, as determined by the society in which they live and eventually determine the differences in perspectives. Table 1 presents the percentage and distribution of the respondents when grouped according to gender**. The table reveals that 29.33% were males and 70.67% were females. From the table, it shows that majority of the critical care nurses were females. This findings indicate that in this country the nursing profession is affected by gender differences. The females are the ones preferred to be employed because they can handle both male and female patients. Gender differentiations takes on added importance because many of the attributes and roles selectively promoted in males and females tend to be differentially valued with those ascribed to higher status [39].

**Education: Table 1 also presents the respondents' profile when grouped according to educational attainment**. 125 or 83.33% have bachelors' degree which ranked first because as a requirement to be hired to practice their respective profession is that a nurse who is a bachelor degree holder.12 or 8% has diploma and the respondents who were accounted for in this bracket came from India whereas in the country, diploma graduate are accepted to practice the profession. Some of the staff nurses, 9 of 6% are pursuing continuing education by enrolling to advance courses such as Master of Nursing. There are staff nurses who are enhancing their personal and professional growth. Most critical care nurses who have Bachelor's Degree are also planning to pursue Master's Degree once they have enough finances and have adjusted to the lifestyle of the profession.

**Religion: Belief can affect ones norm and judgment. The table below presents the frequency and percentage and percentage distribution of critical care nurses – respondents when grouped according to religion**. Results revealed that 51.33% were Roman Catholic, 25.33% were Christian, 22% were Muslim and 1.33% were in other religion such as. Results showed that majority of the critical care nurses were Roman Catholic. Considering the reality that Saudi Arabia is predominantly Muslim. The high number can be justified because in this institution the employed critical care nurses were from registered catholic countries in Asia. These findings were also expected due to the global competitiveness of the profession and for the reason that this country has been known for catering workers from different countries.

Religion is a worldwide phenomenon that has played a par in human culture and so is a much broader, more complex category than the set of beliefs or practices found in any single religious tradition. An adequate understanding of religion must take into account. Its distinctive qualities and pattern as a form of human experience, as well as the similarities and differences in religious across human cultures [39].

On the other hand, the Muslim religion garnered third in the rank, as some of the Nationals of the country chose to practice the profession with commitment and dedication.

**Years of Experience. Table 1 reveals the Critical Care Nurses' Perspectives when they are grouped according to their years of experience.** Results showed that 46.67% had 1-5 years of experience, 38.67% had 6-10 years of experience and 14.67% had 11-15 years of experience.

As the value of years of experience can be explained whenever a new nursing graduate may have a strong theoretical understanding of the body of nursing knowledge, experiential (practice) knowledge is essential for the new graduate to progress to safer levels of practice. Experiential knowledge is characterized by skillful execution of nursing procedures as well as the ability to perform complex, multidisciplinary assessments and to recognize early signs of deterioration in the condition of a patient. Nurses who are both well-educated and experienced are in the position to give the highest quality of care [38].

Results also showed that majority of the critical care nurses had years of experience which is 1-5 years. Based on these findings, it can be inferred that nurses would not reach the number of years in their profession if they did not pass the necessary evaluations conducted by the licensure committee or employer to determine their professional growth and performance. This significant number is also expected due to the migration of nurses with at least 2 years of experience as a requirement to be able to work abroad. And for most of the new nurses who seek higher salaries or compensation and better opportunities outside of their own countries. Higher learning between this age bracket can also be goal because of the constant exposure to different cases, equipment and sociocultural practices.

**Nursing Positions: Table 1 reflects the critical care nurses' perspectives when they are grouped according to their nursing positions**. The data showed that out of 150 respondents, 114 or 76% are staff nurse 2 whom are doing patient care and bedside procedures, 27 or 18% are staff nurse 1 whom are having more years of experience and qualified to be assigned with team leader duties, 9 or 6% are charge nurses whom are captain of the ship inside the Critical Care Units. They are the ones entitled with the overall management of the unit in every shift.
Results showed that majority are staff nurses 2, which is an expected number because they are the nurses assigned to handle critically ill patients. Their views are an utmost value because they are the ones who are caring for the patients in case there are resuscitation events.

On the other hand, the preceding table also showed that the least of the respondents were charge nurses.

**Country of Training: The same table illustrates the profile of respondents according to country of training. Nursing as being a globally competitive profession, majority of the Critical Care Nurses in Prince Sultan Military Medical City had their training from different countries**. Results showed that the country of Philippines had 113 or 75.33%, the country of Saudi Arabia had 22 or 14.67%, the country of India had 11 or 7.33% and the country of Jordan had 4 or 2.67%. These findings are expected because Saudi Arabia has currently been the largest hirer of Overseas Filipino Workers [40].

Cultural values refer to enduring ideals or belief systems to which a person or a society is committed. Some cultures value the ideals of individualism, "that individuals have the ability to pull themselves up by their bootstraps" and that an individual's rights are more important than a society's. This is different with other cultures that are collectivistic, in which health decisions are not made by an individual but by a group: family, community and/or society. In this case ethical thoughtfulness is a requirement to be globally competitive. That is to attain an education, visit, and read about other cultures, ones that does not predominate [43].

**To what extent is the perspectives of Critical Care Nurses towards family presence during resuscitation in terms of?**

**Previous Experience of CPR (Table 2.1)**
**Weighted Mean Distribution of the Critical Care Nurses' Perspectives towards Family Presence during Resuscitation in terms of Previous Experience of Cardiopulmonary Resuscitation**

| Previous Experience of CPR | Weighted Mean | Verbal Interpretation |
|---|---|---|
| 1. I consider the negative effects of witnessed resuscitation to family members. | 3.43 | Moderate Extent |
| 2. I consider the positive effects of witnessed resuscitation to family members. | 3.57 | Moderate Extent |
| 3. I feel the same way I usually do during family witnessed resuscitation. | 3.71 | Moderate Extent |
| Composite Mean | 3.57 | Moderate Extent |

**Legend:**

| | |
|---|---|
| 4.20 - 5.00 | High Extent |
| 3.40 - 4.19 | Moderate Extent |
| 2.60 – 3.39 | Low Extent |
| 1.80 – 2.59 | Some extent |
| 1.00 - 1.79 | No extent at all |

Previous Experience of CPR: When asked about their previous experience with Cardiopulmonary Resuscitation; it can be gleaned in table 2.1 that the respondents showed moderate extent in this perspective after assessing themselves. From scale of one to five, one being lowest and five the highest; a score of x = 3.57 was revealed. Individually, "I consider the negative effects of witnessed resuscitation of family members" is at x = 3.43; "I consider the positive effects of witnessed resuscitation of family members", x = 3.57; and "I feel the same way I usually do during family witnessed resuscitation" is at 3.71. The respondents showed that whether the family is present during resuscitation, there will be no difference. They are considering both the negative and positive effects of family witnessed resuscitation. This can be attributed to previous studies from Royal College of Nursing (2002), American Heart Association (2005), and European Resuscitation Council (2015). These organizations have accepted the effects of presence of family during cardiopulmonary resuscitation. On the other hand, there are many institutions which is doubtful about the issue. The most common reasons of arguing with family presence during resuscitation consist of harmfulness for family members, increased stress, uncontrollable grief, and ethical and legal problems [15].

There are also numerous studies which showed scores that were leaning on the positive effects of family resuscitation and that the benefits outweighed the risks of having a family member witness an ongoing resuscitation.

Preference for Family Witnessed Resuscitation

**2.2 Preference for Family Witnessed Resuscitation**
**Table 2.2**
**Weighted Mean Distribution of the Critical Care Nurses' Perspectives towards Family Presence during Resuscitation in terms of Preference for Family Witnessed Resuscitation**

| Preference for Family Witnessed Resuscitation | Weighted Mean | Verbal Interpretation |
|---|---|---|
| 1. I uphold the rights of every individuals. | 4.58 | High Extent |
| 2. I agree that in general family members should be present during resuscitation if they wish to be. | 3.43 | Moderate Extent |
| 3. I believe that family presence during resuscitation will further expose the probability of legal charges. | 3.69 | Moderate Extent |
| 4. I feel the need to provide a staff to be a family support person at the bedside. | 4.00 | Moderate Extent |
| 5. I am aware that there might be no enough space to accommodate the family. | 3.73 | Moderate Extent |
| Composite Mean | 3.57 | Moderate Extent |

**Legend:**

| | |
|---|---|
| 4.20 - 5.00 | High Extent |
| 3.40 - 4.19 | Moderate Extent |
| 2.60 – 3.39 | Low Extent |
| 1.80 – 2.59 | Some extent |
| 1.00 - 1.79 | No extent at all |

**Preference for Family Witnessed Resuscitation:** An expected weighted mean (x = 3.89, interpreted as moderate extent) was revealed by the study when the respondents were asked regarding the extent of their preference for family witnessed resuscitation. Specifically, the respondents has garnered an interpretation of moderate extent when it comes to "I agree that in general family members should be present during resuscitation if they wish to be" (x =3.43); " I believe that family presence during resuscitation will further expose the probability of legal charges" (x = 3.69); "I feel the need to provide a staff to be a family support person at the bedside" (x = 4.00); and "I am aware that there might be no enough space to accommodate the family" (x = 3.73). The respondents have who answered "I uphold the rights of every individuals" (x = 4.58) have a verbal interpretation of high extent.

This is true with the study involving 39% of nurses showed that presence of family during resuscitation provides opportunity to encourage open communication between family members and staff nurses. To be a patient's advocate, to assists with end of life decisions, to give emotional and spiritual support to the patient and to facilitate closure for the relatives, which concludes that family presence is a "right not an option" [27].

Another study supported that patients' families have rationally been excluded from the resuscitation room due to a number of concerns among staff nurses such as fears that families emotions may take over resulting in them interrupting care of the patient resulting to liabilities, along with insufficient staffing levels and restricted room in the resuscitation room [27].

The high regard for a family support person is essential in witnessed resuscitation. Numerous articles proves the same thing because of the need for careful explanation and emotional support to the relatives all throughout the event of a cardiopulmonary resuscitation.

**Policy Preference (Table 2.3)**
**Weighted Mean Distribution of the Critical Care Nurses' Perspectives towards Family Presence during Resuscitation in terms of Policy Preference**

| Policy Preference | Weighted Mean | Verbal Interpretation |
|---|---|---|
| 1. I prefer a written policy allowing the option of family presence during CPR. | 3.99 | Moderate Extent |
| 2. I prefer a written policy prohibiting the option of family presence during CPR. | 3.45 | Moderate Extent |
| 3. I prefer no written policy but an agreement in the unit to allow the option of family presence during CPR. | 2.58 | Some Extent |
| Composite Mean | 3.34 | Low Extent |

**Legend:**

| | |
|---|---|
| 4.20 - 5.00 | High Extent |
| 3.40 - 4.19 | Moderate Extent |
| 2.60 – 3.39 | Low Extent |
| 1.80 – 2.59 | Some extent |
| 1.00 - 1.79 | No extent at all |

**Policy Preference:** It can be gleaned on table 2.3 that the respondents have low extent with this perspective (x = 3.34). In detail, they scored "I prefer a written policy allowing the option of family presence during CPR" the highest (x = 3.99);"I prefer a written policy prohibiting the option of family presence during CPR" (x = 3.45). Both were interpreted as moderate extent. And "I prefer no written policy but an agreement in the unit to allow the option of family presence during CPR" garnered the lowest (x = 2.58) which is verbally interpreted as some extent.

With only an agreement, the family may disregard the rules that has been set by both parties. Thus, a written policy is required whether to allow or prohibit relative in witnessing a cardiopulmonary resuscitation. This issue has been the ongoing trend as it is important for a hospital institution to have in order to serve as guideline in decision making of their staff nurses. A quantitative study conducted in Europe where there are 90 respondents which focuses on the views on nurses. The findings from this study revealed the need for development of written policies and guidelines regarding family witnessed resuscitation, along with the need for educational program for nurses to enable them to deal with situations as they arise. The study presented 58.9% of nurses already do allow family members to be present during resuscitation however the majority are senior nurses where as 42% would prefer to see written policies in place [19].

**Permission (Table 2.4)**
**Weighted Mean Distribution of the Critical Care Nurses' Perspectives towards Family Presence during Resuscitation in terms of Permission**

| Policy Preference | Weighted Mean | Verbal Interpretation |
|---|---|---|
| 1. I prefer that families should be welcomed during resuscitation even without permission. | 2.57 | Some Extent |
| 2. I see to it that permission should be secured. | 4.29 | High Extent |
| 3. I know the importance of maintaining privacy and confidentiality to patients. | 4.72 | High Extent |
| Composite Mean | 3.86 | Moderate Extent |

**Legend:**

| | |
|---|---|
| 4.20 - 5.00 | High Extent |
| 3.40 - 4.19 | Moderate Extent |
| 2.60 – 3.39 | Low Extent |
| 1.80 – 2.59 | Some extent |
| 1.00 - 1.79 | No extent at all |

**Permission:** Table 2.4 showed that the respondents scored mean (x = 3.86; interpreted as moderate extent). Moreover, "I prefer that families should be welcomed during resuscitation even without permission" had the least (x = 2.57) which is verbally interpreted as some extent; both "I see to it that permission should be secured" and "I know the importance of maintaining privacy and confidentiality to patients" (x = 4.29 and x = 4.72, respectively) garnered to a high extent. This respondents' scores illustrated that in an event of cardiopulmonary resuscitation permission should be obtained. The most common reason for permitted and accompanied witnessed resuscitation was to provide explanation, prevent interference and to provide emotional support [27].

Even though there were articles stating that family presence during resuscitation may violate this ethical principles, the table also showed that privacy and confidentiality is of greater importance to the critical care nurses.

**Emotional Stress (Table 2.5)**
**Weighted Mean Distribution of the Critical Care Nurses' Perspectives towards Family Presence during Resuscitation in terms of Emotional Stress**

| Emotional Stress | Weighted Mean | Verbal Interpretation |
|---|---|---|
| 1. I am capable of handling a crisis situation and not distracted. | 4.50 | High Extent |
| 2. I can maintain professional behavior and effective communication. | 4.56 | High Extent |
| 3. I take into consideration that family presence in the resuscitation room causes increased anxiety and/or stress of the resuscitation team. | 3.55 | Moderate Extent |
| 4. I am cautious that family witnessed resuscitation might be a threat to staff and is harmful to implement. | 3.43 | Moderate Extent |
| Composite Mean | 4.01 | Moderate Extent |

**Legend:**

| | |
|---|---|
| 4.20 - 5.00 | High Extent |
| 3.40 - 4.19 | Moderate Extent |
| 2.60 – 3.39 | Low Extent |
| 1.80 – 2.59 | Some extent |
| 1.00 - 1.79 | No extent at all |

**Emotional Stress:** It can be gleaned in table 2.5 that respondents interpreted themselves as moderated extent at x = 4.01. This means that "I am capable of handling a crisis situation and not distracted" (x = 4.50, high extent); "I can maintain professional behavior and effective communication' (x = 4.56, high extent); "I take into consideration that family presence in the resuscitation room causes increased anxiety and/or stress of the resuscitation team" (x = 3.55, moderate extent); and the least "I am cautious that family witnessed resuscitation might be a threat to staff and is harmful to implement" (3.43, moderate extent). Personally, as critical care nurses they were not affected by family presence during resuscitation in terms of dealing with stress.

Family witness Cardiopulmonary Resuscitation did not affect resuscitation characteristics, patient survival, or the level of emotional stress in the medical team and did not result in medico-legal claims. Although some literatures claimed that staff nurses were hampered in their activities, mainly by anxiety about being observed or by concern about possible emotional or disruptive behavior on the part of family members [8].

**Presence of Relatives (Table 2.6)**
**Weighted Mean Distribution of the Critical Care Nurses' Perspectives towards Family Presence during Resuscitation in terms of Presence of Relatives**

| Presence of Relatives | Weighted Mean | Verbal Interpretation |
|---|---|---|
| 1. I know the presence of relatives will increase spiritual connectedness felt with the patient. | 3.95 | Moderate Extent |
| 2. I am certain that family may misinterpret the activities of the code team that occur during resuscitation as harmful. | 3.75 | Moderate Extent |
| 3. I felt that presence of relatives during cardiopulmonary arrest may interfere with the resuscitative efforts. | 3.64 | Moderate Extent |
| 4. I am certain that family presence during resuscitation will strengthen a patient's will to live. | 3.35 | Low Extent |
| Composite Mean | 3.67 | Moderate Extent |

**Legend:**

| | |
|---|---|
| 4.20 - 5.00 | High Extent |
| 3.40 - 4.19 | Moderate Extent |
| 2.60 – 3.39 | Low Extent |
| 1.80 – 2.59 | Some extent |
| 1.00 - 1.79 | No extent at all |

**Presence of Relatives:** When the respondents were asked on their perspective regarding the presence of relatives; it can be illustrated from table 2.6 that the composite mean of x = 3.67 which can be interpreted as moderate extent. To discuss individually, "I know the presence of relatives will increase spiritual connectedness felt with the patient" (x = 3.95, moderate extent); "I am certain that family may misinterpret the activities of the code team that occur during resuscitation as harmful" (x = 3.75, moderate extent); "I felt that presence of relatives during cardiopulmonary arrest may interfere with the resuscitative efforts" (x = 3.64, moderate extent); and the least "I am certain that family presence during resuscitation will strengthen a patient's will to live" (x = 3.35, low extent).

This revealed that spirituality is great factor for the patients if their relatives were around with them especially in here Saudi Arabia. In this country family and religion is the patient's primary support system. Patients wanted to have a familiar face during the event, to support and give them a sense of hope during the life and death situations. According to, the general theme of family presence is a welcome one in relation to the patients' perspective as they expressed feelings of being afraid, hurt, and in pain during the event they related feeling safer, less scared and comforted when family members were there. Feeling like they had a sense of hope and security appeared to help them giving them the strength to pull through reporting that their family members act as advocates during the event giving vital information regarding the patient's condition to aid the emergency team to provide effective care and humanize the patient in the eyes of their careers [9].

As the media played along with this scenario, some literatures believed that it is not a shock for a relative to see a cardiopulmonary event as they see it regularly on various television programs so they know what to expect. It is also discussed that family members no longer agree to take the traditional method of "shielding" them from the situation of their loved ones. Some studies also state that there were no significant evidence of any family member interfering with resuscitative efforts.

**Trauma to Relatives (Table 2.7)**
**Weighted Mean Distribution of the Critical Care Nurses' Perspectives towards Family Presence during Resuscitation in terms of Trauma to Relatives**

| Trauma to Relatives | Weighted Mean | Verbal Interpretation |
|---|---|---|
| 1. I am aware that family presence during resuscitation will be traumatic. | 3.80 | Moderate Extent |
| 2. I agree that family presence during resuscitation will give them peace of mind. | 3.57 | Moderate Extent |
| 3. I am concern that relatives' emotional responses will become uncontrollable during resuscitative efforts. | 3.79 | Moderate Extent |
| Composite Mean | 3.72 | Moderate Extent |

**Legend:**

| | |
|---|---|
| 4.20 - 5.00 | High Extent |
| 3.40 - 4.19 | Moderate Extent |
| 2.60 – 3.39 | Low Extent |
| 1.80 – 2.59 | Some extent |
| 1.00 - 1.79 | No extent at all |

Trauma to Relatives. Table 2.7 showed the composite mean of x = 3.72, which is interpreted as moderate extent. Specifically, "I am aware that family presence during resuscitation will be traumatic" (x = 3.80); "I agree that family presence during resuscitation will give them peace of mind" (x = 3.57); "I am concern that relatives' emotional responses will become uncontrollable during resuscitative efforts" (x = 3.79) in which all questions were

verbally interpreted as moderate extent.

As for the critical care nurses' perspective, having relatives during cardiopulmonary resuscitation can cause trauma. Although, some researches showed that family members are able to withstand the trauma of witnessing resuscitation efforts without long-lasting effects can help dispel the fears of healthcare workers [21].

Studies also showed that there were minimal degrees of intrusive imagery, post traumatic disorder, and grief related symptom during and event of cardiopulmonary resuscitation. It is also illustrated that peace of mind cannot solely be achieved from presence of relatives.

**Benefits for Relatives (Table 2.8)**
**Weighted Mean Distribution of the Critical Care Nurses' Perspectives towards Family Presence during Resuscitation in terms of Benefits for Relatives**

| Benefits for Relatives | Weighted Mean | Verbal Interpretation |
|---|---|---|
| 1. I prefer family presence during resuscitation because it can facilitate closure of the family and decreased levels of anxiety and grief. | 3.77 | Moderate Extent |
| 2. I know that it minimizes the agony of having to wait. | 3.64 | Moderate Extent |
| 3. I consider the feeling of satisfaction of the relatives that everything possible was done. | 3.97 | Moderate Extent |
| 4. I know that it will help the family realize the seriousness of the condition. | 3.90 | Moderate Extent |
| 5. I am aware that this will help the family members feel that they are involved in patient care management. | 3.75 | Moderate Extent |
| Composite Mean | 3.81 | Moderate Extent |

**Legend:**

| | |
|---|---|
| 4.20 - 5.00 | High Extent |
| 3.40 - 4.19 | Moderate Extent |
| 2.60 – 3.39 | Low Extent |
| 1.80 – 2.59 | Some extent |
| 1.00 - 1.79 | No extent at all |

Benefit for Relatives. A composite mean (x = 3.81, interpreted as moderate extent) was revealed in table 2.8. Individually, "I prefer family presence during resuscitation because it can facilitate closure of the family and decreased levels of anxiety and grief" (x = 3.77); "I know that it minimizes the agony of having to wait" (x = 3.64); ". I consider the feeling of satisfaction of the relatives that everything possible was done" (x = 3.97); "I know that it will help the family realize the seriousness of the condition" (x = 3.90); and "I am aware that this will help the family members feel that they are involved in patient care management" (x = 3.75).

The respondents recognized the importance of the relatives being present during cardiopulmonary resuscitation and considers the benefits it can provide. Same with other literatures which revealed that in terms of psychological effects by being able to say their good byes, and give them a sense of worth in a time of helplessness. Being present during cardiopulmonary resuscitation (CPR) may help the family member understand that everything possible to bring the patient back to life has been implemented [16].

In addition to behind closed - doors resuscitation efforts and unrealistic expectations of such efforts, the family member's presence may offer the opportunity for a last goodbye and help that person grasp the reality of death, with the hope that the bereavement process will not be prolonged or complicated by pathologic mourning or post-traumatic stress disorder (PTSD) [8].

In a literature which focused about the family-centered approach, it moves toward care that is driven by the needs of the patient and his family rather than controlled by health care providers. Family needs during medical crises focus on maintaining the relationship with their loved one and being with him or her at the time of death. It identified several family needs at end of life: to be kept informed of the patient's condition; to be aware of the patient's impending death in order to anticipate the loss; and to be with the dying person [14].

**Litigation (Table 2.9)**
**Weighted Mean Distribution of the Critical Care Nurses' Perspectives towards Family Presence during Resuscitation in terms of Litigation**

| Litigation | Weighted Mean | Verbal Interpretation |
|---|---|---|
| 1. I am concern that presence of family member during resuscitation would increase legal liabilities. | 4.02 | Moderate Extent |
| 2. I respect the "Patients' Bill of Rights" in the delivery of nursing care. | 4.68 | High Extent |
| 3. I perform my professional duties in conformity with existing laws, rules regulations, measures, and generally accepted principles of moral conduct and proper decorum. | 4.57 | High Extent |
| 4. I believe that it will encourage professional behaviour at the bedside. | 4.21 | High Extent |
| Composite Mean | 4.37 | High Extent |

**Legend:**

| | |
|---|---|
| 4.20 - 5.00 | High Extent |
| 3.40 - 4.19 | Moderate Extent |
| 2.60 – 3.39 | Low Extent |
| 1.80 – 2.59 | Some extent |
| 1.00 - 1.79 | No extent at all |

**Litigation:** It can be gleaned in table 2.9 have a composite mean (x = 4.37) which is verbally interpreted overall as high extent. Specifically, "I am concern that presence of family member during resuscitation would increase legal liabilities" (x = 4.02, moderate extent); "I respect the "Patients' Bill of Rights" in the delivery of nursing care" (x = 4.68, high extent); "I perform my professional duties in conformity with existing laws, rules regulations, measures, and generally accepted principles of moral conduct and proper decorum" (x = 4.57, high extent); and "I believe that it will encourage professional behaviour at the bedside" (4.21, high extent).

The negative effect of failed resuscitation is associated with litigation, this is true to a study presented by [33]. It was emphasized that there are various factors that can serve as barriers to involving family members during the resuscitation process. These comprise of possible negative emotional effect on family members, family behaviour, lack of a nominated staff member to support family, increased stress for staff, the risk of litigation, an overcrowded resuscitation room, resuscitation being stopped too soon or continued longer than necessary, and staff appearing uncaring. As a result of these beliefs staff may have anxieties related to FWR and view the practice negatively.

According to, twenty two percent of the respondents were having concerns of legal wrangling when the family members are allowed to witness the resuscitative events. On the other hand, claimed that fear of litigations are unfounded. In her study, it was found out that there are comparative results but strongly showed that nurses should recognize that the decision to remain in the resuscitation room is not an attempt to detect mistakes or assess the nurses competence in CPR skills, but rather it is indicative of their need to remain with their loved one [11].

**Support of Relatives (Table 2.10)**
**Weighted Mean Distribution of the Critical Care Nurses' Perspectives towards Family Presence during Resuscitation in terms of Support of Relatives**

| Support of Relatives | Weighted Mean | Verbal Interpretation |
|---|---|---|
| 1. I know that it will help family members feel like active participants in the care process. | 3.85 | Moderate Extent |
| 2. I need to update, prepare and educate the relatives on what to expect and see during resuscitation. | 4.01 | Moderate Extent |
| 3. I know the relatives need to be physically and spiritually connected with their loved one. | 4.21 | High Extent |
| 4. I provide the patients or their families with all pertinent information except those which may be deemed harmful to their well-being. | 3.97 | Moderate Extent |
| Composite Mean | 4.01 | Moderate Extent |

**Legend:**

| | |
|---|---|
| 4.20 - 5.00 | High Extent |
| 3.40 - 4.19 | Moderate Extent |
| 2.60 – 3.39 | Low Extent |
| 1.80 – 2.59 | Some extent |
| 1.00 - 1.79 | No extent at all |

**Support of Relatives:** Table 2.10 showed that the respondents garnered a composite mean (x = 4.01) which is interpreted as moderate extent. Furthermore, "I know the relatives need to be physically and spiritually connected with their loved one" to be a high extent (x = 4.21); "I need to update, prepare and educate the relatives on what to expect and see during resuscitation" to a moderate extent (x = 4.01); "I provide the patients or their families with all pertinent information except those which may be deemed harmful to their well-being" to a moderate extent (x = 3.97); and "I know that it will help family members feel like active participants in the care process" to a moderate extent (x = 3.85).

Such evidences agree that having a proper and formal education about family witnessed resuscitation will aid in the success of the support for relatives through such crisis events.

A study reviewed by a research about nurses' perceptions of family presence during resuscitation found that certificated nurses and registered nurses perceived more benefits and fewer risks, as well as more confidence in their ability to manage FWR compared to other nurses who were not certificated or registered [33].

**Staff Performance (Table 2.11)**
**Weighted Mean Distribution of the Critical Care Nurses' Perspectives towards Family Presence during Resuscitation in terms of Staff Performance**

| Staff Performance | Weighted Mean | Verbal Interpretation |
|---|---|---|
| 1. I am certain of the need to give more attention to patient's privacy and dignity. | 4.58 | High Extent |
| 2. I am aware that family presence during resuscitation will recognize staff nurses' efforts to save the patient. | 4.18 | Moderate Extent |
| 3. I am aware that it is important to promote a more careful choice of words with less black humor. | 4.31 | High Extent |
| 4. I know that relatives may inhibit the performance of the code team during resuscitation. | 3.49 | Moderate Extent |
| Composite Mean | 4.14 | Moderate Extent |

**Legend:**

| | |
|---|---|
| 4.20 - 5.00 | High Extent |
| 3.40 - 4.19 | Moderate Extent |
| 2.60 – 3.39 | Low Extent |
| 1.80 – 2.59 | Some extent |
| 1.00 - 1.79 | No extent at all |

**Staff Performance:** Table 2.11 resulted to a composite mean of (x = 4.14) which is interpreted as moderate extent. This means that the respondents are at high mediocrity level when it comes to their performance in resuscitation in front of relatives. Specifically, "I am certain of the need to give more attention to patient's privacy and dignity" (x = 4.58, high extent); "I am aware that it is important to promote a more careful choice of words with less black humor" (x = 4.31, high extent); "I am aware that family presence during resuscitation will recognize staff nurses' efforts to save the patient" (x = 4.18, moderate extent); and "I know that relatives may inhibit the performance of the code team during resuscitation" (x = 3.49, moderate extent).

As staff performance maybe affected especially when the respondents know that they were being "watched". As privacy and dignity of the patient is the most concern, the benefits prevail over the risks of having relatives during the resuscitation process. However, according to, in previous researches revealed that code team members' performance was affected by family presence, other concerns were communication can be misunderstood by the family, such as inappropriate humor or laughing that is actually a coping mechanism in the face of severe stress, feelings of helplessness, or fatigue [41].

**Duration of Resuscitation (Table 2.12)**
**Weighted Mean Distribution of the Critical Care Nurses' Perspectives towards Family Presence during Resuscitation in terms of Duration of Resuscitation**

| Duration of Resuscitation | Weighted Mean | Verbal Interpretation |
|---|---|---|
| 1. I am concerned that having relatives around will make the resuscitation efforts difficult to stop. | 3.47 | Moderate Extent |
| 2. I am worried that the presence of the relatives will prolong suffering. | 3.49 | Moderate Extent |
| 3. I know that this will improve the decision making of the relatives in stressful situations. | 3.78 | Moderate Extent |
| Composite Mean | 3.58 | Moderate Extent |

**Legend:**
4.20 - 5.00 High Extent
3.40 - 4.19 Moderate Extent
2.60 – 3.39 Low Extent
1.80 – 2.59 Some extent
1.00 - 1.79 No extent at all

**Duration of Resuscitation:** Results revealed the composite mean of 3.58 which has a verbal interpretation of moderate extent. Individually, "I know that this will improve the decision making of the relatives in stressful situations" (x = 3.78) to a moderate extent; "I am worried that the presence of the relatives will prolong suffering" (x = 3.49) to a moderate extent; and "I am concerned that having relatives around will make the resuscitation efforts difficult to stop" (x = 3.47) to a moderate extent.

As the resuscitation process may be hard to explain during the event it is also a concern that the duration of the crisis may be prolonged due to relatives having difficulty in terms of decision making. In addition, desperate resuscitation attempts by providers who are inexperienced or unwilling to end a resuscitation, for a variety of reasons, might occur because of presence of the family members [42].

**Personal Preference (Table 2.13)**
**Weighted Mean Distribution of the Critical Care Nurses' Perspectives towards Family Presence during Resuscitation in terms of Personal Preference**

| Personal Preference | Weighted Mean | Verbal Interpretation |
|---|---|---|
| 1. I am supportive of the fact that I, myself can be present during resuscitation of my loved one. | 3.59 | Moderate Extent |
| 2. I am anxious to see my loved one suffering from pain | 3.91 | Moderate Extent |
| 3. If I were being resuscitated, I would want my family to have the option of being present. | 3.31 | Low Extent |
| 4. If I were being resuscitated, I would want my family to be present. | 3.11 | Low Extent |
| 5. If I were being resuscitated, I am afraid that my family might interfere with the code team's management. | 3.27 | Low Extent |
| Composite Mean | 3.44 | Moderate Extent |

**Legend:**
4.20 - 5.00 High Extent
3.40 - 4.19 Moderate Extent
2.60 – 3.39 Low Extent
1.80 – 2.59 Some extent
1.00 - 1.79 No extent at all

**Personal Preference:** It can be gleaned in table 2.13 that the respondents garnered a composite mean (x = 3.44) which is interpreted as moderate extent. Moreover, "I am anxious to see my loved one suffering from pain" (x = 3.91, moderate extent); "I am supportive of the fact that I, myself can be present during resuscitation of my loved one" (x = 3.59, moderate extent); "If I were being resuscitated, I would want my family to have the option of being present" (x = 3.31, low extent); "If I were being resuscitated, I am afraid that my family might interfere with the code team's management" (x = 3.27, low extent); and "If I were being resuscitated, I would want my family to be present" (x = 3.11, low extent).

As part of the healthcare team, nurses witness several resuscitation attempts, as it may be successful or failed. The nurses with their rational understanding of the nature of the situation may choose to exclude themselves from the resuscitative events as evidenced by the above results. This is opposed by a study made in New Jersey which findings concluded the 58% of certified registered nurses, when asked if they themselves would like to be present during a CPR attempt on members of their family, 87% indicated they would like to be present. The results was in favor of family presence and had much more positive attitude towards family presence [27].

**Is there significant relationship between the level of perspectives of Critical Care Nurses in an adult intensive care unit towards family presence guidelines during resuscitation and their profile variables?**

**HO: There is no significant relationship between the level of perspectives of Critical Care Nurses in an adult intensive care unit towards family presence guidelines during resuscitation and their profile variables.**

**Table 3.1**
**Relationship between the level of perspectives of Critical Care Nurses in an adult intensive care unit towards family presence guidelines during resuscitation and their Age profile.**

| Perspectives | F value | P value | Decision | Interpretation |
|---|---|---|---|---|
| Previous experience with CPR | 1.056 | 0.397 | Accept HO | There is no significant relationship |
| Preferences for family witnessed resuscitation | 1.851 | 0.008 | Reject HO | There is a significant relationship |
| Policy Preference | 1.231 | 0.245 | Accept HO | There is no significant relationship |
| Permission | 0.843 | 0.629 | Accept HO | There is no significant relationship |
| Emotional Stress | 0.868 | 0.629 | Accept HO | There is no significant relationship |

| | | | | |
|---|---|---|---|---|
| Presence of relatives | 0.847 | 0.656 | Accept HO | There is no significant relationship |
| Trauma to relatives | 0.926 | 0.535 | Accept HO | There is no significant relationship |
| Benefits for relatives | 0.927 | 0.567 | Accept HO | There is no significant relationship |
| Litigation | 0.838 | 0.667 | Accept HO | There is no significant relationship |
| Support of relatives | 1.405 | 0.114 | Accept HO | There is no significant relationship |
| Staff Performance | 0.820 | 0.690 | Accept HO | There is no significant relationship |
| Duration of resuscitation | 1.448 | 0.122 | Accept HO | There is no significant relationship |
| Personal Preference | 1.092 | 0.347 | Accept HO | There is no significant relationship |

Legend: P value = 0.05 level of significance

The table 3.1 presented the significant relationship between the level of Critical Care Nurses perspectives and their age profile. It can be noted in the table above that only in the perspective of preferences for family witnessed resuscitation, the null hypothesis (HO) has been rejected since the computed P value is 0.008 which is less than the 0.05 level of significance. This means that there is a significant relationship between the preferences for family witnessed resuscitation perspective and age profile.

While, the null hypothesis was accepted in the perspectives of previous experience with CPR (P = 0.397), policy preference (P =0.245), permission (P = 0.629), emotional stress (P = 0.629), presence of relatives (P = 0.656), trauma to relatives (P = 0.535), benefits for relatives (P = 0.567), litigation (P = 0.838), support of relatives (P = 0.114), staff performance (P = 0.690), duration of resuscitation (P = 0.122), and personal preference (P = 0.347), since all the computed P values were greater than 0.05 level of significance. This further means that in general, there's no significant relationship between the critical care nurses' perspectives towards family presence guidelines and their age profile.

With the variation of ages discussed in this study it focused on the maturity of old age nurses in terms of decision making in sensitive situations. Same with a Canadian study, in which, nurses of seniority basis balances the benefits and risks of allowing family members during cardiopulmonary resuscitation. But in general, senior nurses, with their experiences in the nursing profession, they are in favor of family presence during resuscitation [15].

In contrast, nurses who are new to the profession may perceived the family members as threatening [39]. This is explained by the lack of confidence to what they are doing. As fresh nurses from orientation program, still the experiences are requiring guidance and more adaptation with the clinical area.

**Table 3.2**
**Relationship between the level of perspectives of Critical Care Nurses in an adult intensive care unit towards family presence guidelines during resuscitation and their Gender profile.**

| Perspectives | F value | P value | Decision | Interpretation |
|---|---|---|---|---|
| Previous experience with CPR | 0.225 | 0.879 | Accept HO | There is no significant relationship |
| Preferences for family witnessed resuscitation | 0.247 | 0.941 | Accept HO | There is no significant relationship |
| Policy Preference | 2.661 | 0.050 | Accept HO | There is no significant relationship |
| Permission | 1.317 | 0.271 | Accept HO | There is no significant relationship |
| Emotional Stress | 0.765 | 0.550 | Accept HO | There is no significant relationship |
| Presence of relatives | 0.351 | 0.843 | Accept HO | There is no significant relationship |
| Trauma to relatives | 1.562 | 0.201 | Accept HO | There is no significant relationship |
| Benefits for relatives | 0.126 | 0.986 | Accept HO | There is no significant relationship |
| Litigation | 1.904 | 0.113 | Accept HO | There is no significant relationship |
| Support of relatives | 0.840 | 0.502 | Accept HO | There is no significant relationship |
| Staff Performance | 1.115 | 0.352 | Accept HO | There is no significant relationship |
| Duration of resuscitation | 0.348 | 0.791 | Accept HO | There is no significant relationship |
| Personal Preference | 0.640 | 0.670 | Accept HO | There is no significant relationship |

Legend: P value = 0.05 level of significance

The above table showed the relationship among Critical Care Nurses' perspectives and their gender profile. It can be seen that in all the perspectives, the null hypothesis (HO) is accepted for the reason that all computed P values (0.879, 0.941, 0.050, 0.271, 0.550, 0.843, 0.201, 0.986, 0.113, 0.502, 0.352, 0.791, and 0.670) were greater than 0.05 level of significance. This means that there's no significant relationship between the Critical Care Nurses' perspectives towards family presence during resuscitation guidelines and their gender profile.

Gender differences is not affected in how the nurses perceived the outcome of having a guidelines for family members inside the resuscitation room. This is true in the study, which showed changing the negative perceptions of family members requires new policy establishment, health education focusing on benefits

of family members, and training for family care support during cardiopulmonary resuscitation [8]. Even if gender is an issue here in the Kingdom Saudi Arabia, the nurses dealt the concern positively as whether male or female, especially if there is proper health education and training.

**Table 3.3**
**Relationship between the level of perspectives of Critical Care Nurses in an adult intensive care unit towards family presence guidelines during resuscitation and their Education profile.**

| Perspectives | F value | P value | Decision | Interpretation |
|---|---|---|---|---|
| Previous experience with CPR | 1.373 | 0.176 | Accept HO | There is no significant relationship |
| Preferences for family witnessed resuscitation | 0.659 | 0.866 | Accept HO | There is no significant relationship |
| Policy Preference | 1.447 | 0.142 | Accept HO | There is no significant relationship |
| Permission | 1.535 | 0.109 | Accept HO | There is no significant relationship |
| Emotional Stress | 1.062 | 0.390 | Accept HO | There is no significant relationship |
| Presence of relatives | 0.722 | 0.772 | Accept HO | There is no significant relationship |
| Trauma to relatives | 1.562 | 0.201 | Accept HO | There is no significant relationship |
| Trauma to relatives | 1.373 | 0.176 | Accept HO | There is no significant relationship |
| Benefits for relatives | 0.969 | 0.500 | Accept HO | There is no significant relationship |
| Litigation | 0.695 | 0.799 | Accept HO | There is no significant relationship |
| Support of relatives | 1.365 | 0.155 | Accept HO | There is no significant relationship |
| Staff Performance | 1.025 | 0.429 | Accept HO | There is no significant relationship |
| Duration of resuscitation | 0.274 | 0.993 | Accept HO | There is no significant relationship |
| Personal Preference | 0.756 | 0.767 | Accept HO | There is no significant relationship |

Legend: P value = 0.05 level of significance

In this table, it clearly illustrated the relationship between Critical Care Nurses' perspectives and their educational attainment profile. It can be gleaned that the null hypothesis (HO) is accepted because all the computed P values (0.176, 0.866, 0.142, 0.109, 0.390, 0.772, 0.176, 0.500, 0.799, 0.155, 0.429, 0.993, and 0.767) are above the 0.05 level of significance. This table showed that there is no significant relationship between the identified Critical Care Nurses' perspectives towards family presence during resuscitation guidelines and the education profile.

Family presence guidelines during resuscitation was a positive experience as perceived by health care professionals. Educational attainment of nurses does not have an impact with regards to family witnessed resuscitation [13]. It had been explained that having the family members inside the resuscitation room, humanized the patient and promotes dignity. It creates an atmosphere which enhances communication and facilitates education. Most nurses dealt with the concern empathetically. They view the situation as an opportunity to say good-bye and to promote of acceptance.

**Table 3.4**
**Relationship between the level of perspectives of Critical Care Nurses in an adult intensive care unit towards family presence guidelines during resuscitation and their Religion profile.**

| Perspectives | F value | P value | Decision | Interpretation |
|---|---|---|---|---|
| Previous experience with CPR | 1.373 | 0.176 | Accept HO | There is no significant relationship |
| Preferences for family witnessed resuscitation | 0.659 | 0.866 | Accept HO | There is no significant relationship |
| Policy Preference | 1.447 | 0.142 | Accept HO | There is no significant relationship |
| Permission | 1.535 | 0.109 | Accept HO | There is no significant relationship |
| Emotional Stress | 1.062 | 0.390 | Accept HO | There is no significant relationship |
| Presence of relatives | 0.722 | 0.772 | Accept HO | There is no significant relationship |
| Trauma to relatives | 1.373 | 0.176 | Accept HO | There is no significant relationship |
| Benefits for relatives | 0.969 | 0.500 | Accept HO | There is no significant relationship |
| Litigation | 0.695 | 0.799 | Accept HO | There is no significant relationship |
| Support of relatives | 1.365 | 0.155 | Accept HO | There is no significant relationship |
| Staff Performance | 1.025 | 0.429 | Accept HO | There is no significant relationship |
| Duration of resuscitation | 0.274 | 0.993 | Accept HO | There is no significant relationship |
| Personal Preference | 0.756 | 0.767 | Accept HO | There is no significant relationship |
| Personal Preference | 0.756 | 0.767 | Accept HO | There is no significant relationship |

Legend: P value = 0.05 level of significance

In this table, it clearly illustrated the relationship between Critical Care Nurses' perspectives and their educational attainment profile. It can be gleaned that the null hypothesis (HO) is accepted because all the computed P values (0.176, 0.866, 0.142, 0.109, 0.390, 0.772, 0.176, 0.500, 0.799, 0.155, 0.429, 0.993, and 0.767) are above the 0.05 level of significance. This table showed that there is no significant relationship between the identified Critical Care Nurses' perspectives towards family presence during resuscitation guidelines and the education profile.

Family presence guidelines during resuscitation was a positive experience as perceived by health care professionals. Educational attainment of nurses does not have an impact with regards to family witnessed resuscitation [13]. It had been explained that having the family members inside the resuscitation room, humanized the patient and promotes dignity. It creates an atmosphere which enhances communication and facilitates education. Most nurses dealt with the concern empathetically. They view the situation as an opportunity to say good-bye and to promote of acceptance.

**Table 3.4**
**Relationship between the level of perspectives of Critical Care Nurses in an adult intensive care unit towards family presence guidelines during resuscitation and their Religion profile.**

| Perspectives | F value | P value | Decision | Interpretation |
|---|---|---|---|---|
| Previous experience with CPR | 0.895 | 0.530 | Accept HO | There is no significant relationship |
| Preferences for family witnessed resuscitation | 1.205 | 0.265 | Accept HO | There is no significant relationship |
| Policy Preference | 0.528 | 0.854 | Accept HO | There is no significant relationship |
| Permission | 0.716 | 0.694 | Accept HO | There is no significant relationship |
| Emotional Stress | 1.220 | 0.267 | Accept HO | There is no significant relationship |
| Presence of relatives | 1.322 | 0.203 | Accept HO | There is no significant relationship |
| Trauma to relatives | 1.249 | 0.264 | Accept HO | There is no significant relationship |
| Benefits for relatives | 1.067 | 0.386 | Accept HO | There is no significant relationship |
| Litigation | 1.138 | 0.327 | Accept HO | There is no significant relationship |
| Support of relatives | 0.699 | 0.753 | Accept HO | There is no significant relationship |
| Staff Performance | 1.119 | 0.343 | Accept HO | There is no significant relationship |
| Duration of resuscitation | 1.072 | 0.383 | Accept HO | There is no significant relationship |
| Personal Preference | 1.081 | 0.372 | Accept HO | There is no significant relationship |

Legend: P value = 0.05 level of significance

Table 3.4 presented the relationship among Critical Care Nurses' perspectives when grouped according to religion. It demonstrated that the null hypothesis (HO) is accepted. This is due to the results of all the computed P values (0.530, 0.265, 0.854, 0.694, 0.267, 0.203, 0.264, 0.386, 0.327, 0.753, 0.343, and 0.383) which were above the 0.05 level of significance. The outcome of these results implied that the relationship between all the perspectives in terms of religion is not significant.

Even if with the diversity of opinion in terms of religion, it is showed that this demographic profile is not an emphasis when family presence during resuscitation is the issue. It has been presented that the development of policies and guidelines for safe implementation of the practice is more important [8].

In another study, religion cannot affect the decision making of critical care nurses. In critical care unit, the nurses are more focused with the unit policy discussed with them. Staff nurses supported the concept of policy to provide consistency [19].

**Table 3.5**
**Relationship between the level of perspectives of Critical Care Nurses in an adult intensive care unit towards family presence guidelines during resuscitation and their Years of Experience profile.**

| Perspectives | F value | P value | Decision | Interpretation |
|---|---|---|---|---|
| Previous experience with CPR | 0.952 | 0.495 | Accept HO | There is no significant relationship |
| Preferences for family witnessed resuscitation | 1.269 | 0.195 | Accept HO | There is no significant relationship |
| Policy Preference | 0.756 | 0.696 | Accept HO | There is no significant relationship |
| Permission | 0.946 | 0.500 | Accept HO | There is no significant relationship |
| Emotional Stress | 0.766 | 0.724 | Accept HO | There is no significant relationship |
| Presence of relatives | 1.178 | 0.282 | Accept HO | There is no significant relationship |
| Trauma to relatives | 0.756 | 0.696 | Accept HO | There is no significant relationship |
| Benefits for relatives | 0.610 | 0.906 | Accept HO | There is no significant relationship |
| Litigation | 1.608 | 0.063 | Accept HO | There is no significant relationship |

| | | | | |
|---|---|---|---|---|
| Support of relatives | 0.850 | 0.628 | Accept HO | There is no significant relationship |
| Staff Performance | 1.433 | 0.122 | Accept HO | There is no significant relationship |
| Duration of resuscitation | 1.130 | 0.334 | Accept HO | There is no significant relationship |
| Personal Preference | 1.049 | 0.402 | Accept HO | There is no significant relationship |

Legend: P value = 0.05 level of significance

The table above showed the relationship between Critical Care Nurses' perspectives toward family presence resuscitation guidelines when grouped according to their years of experience profile. This means that the null hypothesis (HO) is accepted which confirmed that all the computed P values (0.495, 0.195, 0.696, 0.500, 0.724, 0.282, 0.696, 0.906, 0.063, 0.628, 0.122, 0.334, 0.402) are greater than the level of significance of 0.05. The results of the discussed table inferred that there is no significant relationship between the Critical Care Nurses' perspectives and their years of experience profile.

Decision making is an important factor to family presence during resuscitation. To be able to weight the risks and benefits of this matter. This is an advantage of a more experienced Critical Care unit nurse. Though, experiences does not depend on the years but with the cases handled, and with the willingness to learn or update herself/himself to current healthcare trends. This is supported with a study, which stated that educational programs for staff nurses and proper implementation of policies will give a positive view for family presence during resuscitation [29].

**Table 3.6**
**Relationship between the level of perspectives of Critical Care Nurses in an adult intensive care unit towards family presence guidelines during resuscitation and their Nursing Positions profile.**

| Perspectives | F value | P value | Decision | Interpretation |
|---|---|---|---|---|
| Previous experience with CPR | 0.952 | 0.458 | Accept HO | There is no significant relationship |
| Preferences for family witnessed resuscitation | 1.123 | 0.344 | Accept HO | There is no significant relationship |
| Policy Preference | 1.372 | 0.226 | Accept HO | There is no significant relationship |
| Permission | 1.597 | 0.148 | Accept HO | There is no significant relationship |
| Emotional Stress | 0.721 | 0.673 | Accept HO | There is no significant relationship |
| Presence of relatives | 0.751 | 0.646 | Accept HO | There is no significant relationship |
| Trauma to relatives | 3.038 | 0.007 | Reject HO | There is a significant relationship |
| Benefits for relatives | 1.204 | 0.288 | Accept HO | There is no significant relationship |
| Litigation | 0.726 | 0.669 | Accept HO | There is no significant relationship |
| Support of relatives | 1.194 | 0.302 | Accept HO | There is no significant relationship |
| Staff Performance | 1.388 | 0.201 | Accept HO | There is no significant relationship |
| Duration of resuscitation | 1.308 | 0.253 | Accept HO | There is no significant relationship |
| Personal Preference | 1.136 | 0.335 | Accept HO | There is no significant relationship |

Legend: P value = 0.05 level of significance

The table 3.6 presented the significant relationship between the level of Critical Care Nurses perspectives in terms of nursing position profile. It can be demonstrated in the table above that only in the perspective of trauma to relatives, the null hypothesis (HO) has been rejected since the computed P value is 0.007 which is less than the 0.05 level of significance. This means that there is a significant relationship between the preferences for family witnessed resuscitation perspective and nursing position profile.

On the other hand, the null hypothesis was highly accepted in the perspectives of previous experience with CPR (P = 0.458), preferences for family witnessed resuscitation (P = 0.344), policy preference (P =0.226), permission (P = 0.148), emotional stress (P = 0.673), presence of relatives (P = 0.646), benefits for relatives (P = 0.288), litigation (P = 0.669), support of relatives (P = 0.302), staff performance (P = 0.201), duration of resuscitation (P = 0.253), and personal preference (P = 0.335), since all the computed P values were above the 0.05 level of significance. This further illustrates that there's no significant relationship between the critical care nurses' perspectives towards family presence guidelines and their age profile.

Trauma to relative is one of the major setback that concerned critical care nurses. Moreover, in different nursing levels, it may differ in this perspective. This is in accordance to nursing responsibilities. "Respondeat Superior", which means the nurse manager is responsible for the care provided by his/her nurses within the hours of work [41]. Nursing positions may view the trauma to relatives' perspective differently. This is because of the scope and accountabilities which are specifically set to each nursing level.

**Table 3.7**
**Relationship between the level of perspectives of Critical Care Nurses in an adult intensive care unit towards family presence guidelines during resuscitation and their Country of Training profile.**

| Perspectives | F value | P value | Decision | Interpretation |
|---|---|---|---|---|
| Previous experience with CPR | 1.330 | 0.220 | Accept HO | There is no significant relationship |
| Preferences for family witnessed resuscitation | 1.167 | 0.295 | Accept HO | There is no significant relationship |
| Policy Preference | 2.198 | 0.022 | Reject HO | There is a significant relationship |
| Permission | 1.076 | 0.379 | Accept HO | There is no significant relationship |
| Emotional Stress | 0.513 | 0.906 | Accept HO | There is no significant relationship |
| Presence of relatives | 1.342 | 0.192 | Accept HO | There is no significant relationship |
| Trauma to relatives | 2.737 | 0.004 | Reject HO | There is a significant relationship |
| Benefits for relatives | 0.600 | 0.875 | Accept HO | There is no significant relationship |
| Litigation | 0.599 | 0.843 | Accept HO | There is no significant relationship |
| Support of relatives | 0.889 | 0.558 | Accept HO | There is no significant relationship |
| Staff Performance | 0.974 | 0.473 | Accept HO | There is no significant relationship |
| Duration of resuscitation | 1.888 | 0.053 | Accept HO | There is no significant relationship |
| Personal Preference | 1.814 | 0.031 | Reject HO | There is a significant relationship |

Legend: P value = 0.05 level of significance

The above table showed the significant relationship between the perspectives of Critical Care Nurses when grouped according to country of training profile. It can be demonstrated in the presented table that the perspectives of policy preference (P = 0.022), trauma to relatives (P = 0.004) and personal preference (P = 0.031), the null hypothesis (HO) has been rejected since the computed P values were less than the 0.05 level of significance. This means that there is a significant relationship between the preferences for family witnessed resuscitation perspective and nursing position profile.

On the other hand, the null hypothesis was significantly accepted in the perspectives of previous experience with CPR (P = 0.220), preferences for family witnessed resuscitation (P = 0.295), permission (P = 0.379), emotional stress (P = 0.906), presence of relatives (P = 0.192), benefits for relatives (P = 0.875), litigation (P = 0.843), support of relatives (P = 0.558), staff performance (P = 0.473), and duration of resuscitation (P = 0.053) , since all the computed P values were above the 0.05 level of significance. This further means that there's no significant relationship between the critical care nurses' perspectives towards family presence guidelines and their age profile.

Policy for family presence during resuscitation, as a controversial view was discussed throughout the entire healthcare community. For those countries that have primitive or traditional opinions in medicine, having a policy for family presence during resuscitation will still be a debate. Also, with the upbringing and individualities of people, their beliefs may differ from norms. Nurses came from different communities and it will rely on their adaptiveness whether they will be willing to accept change or not. Empathy, as defined as "putting yourself in another person's shoes", is one of the best qualities of a nurse. Being a human being, trauma is inevitable but what comes after it is the most important and it is acceptance [29].

With these concerns, it is safe to say that acceptance of the policy for this issue, widely depends on the critical care nurses' place of training and personal preferences. There will always be setbacks and conflicts but with the implementation of legal documentation, as healthcare providers, will be able to fulfill the responsibilities to the clients and their families.

**What clear well established guidelines can be proposed for family presence during resuscitation?**
The study, as shown in the results, almost all enumerated values are in moderate extent which presents ambivalence. That the call of family presence during resuscitation may vary from situations and thus this will be an indication to raise the bar of nursing care and service especially when family members are around. Regardless of any given situation, nurses' oath to serve and save life, still one mistake can cause fatality.

In addition, guidelines should be based to the patient's rights and with the right of every individual which was interpreted as "high extent". Placing the rights as a person first will be the principle for the nurses in order for them to agree to the fact that family involvement during resuscitation is essential to promote acceptance.

Moreover, the study, specifically focuses on the formulation of policy that will serve as a guide for the health care providers in rendering the necessary care for families involve during resuscitation. As presented in the results, it is interpreted as "low extent", which means proper education and adequate reinforcement should be done in order to have an effective policy implementation. This policy will be based on the critical care nurse's perspectives as the emphasis of this study.

Creation of family support care person, as part of the guidelines, it is determined from the results that the need for a health care provide who understand the situation is at "moderate extent". The importance of this guideline is to have a person who will support the relative through the difficulties of witnessing cardiopulmonary resuscitation.

Furthermore, learning the language, in order to understand the families of our patients, verbal understanding is important. It is not enough that we are able to determine their non-verbal reactions but

most essentially to comprehend them through their own language.

Promotion of safe and secure environment because of the unexpected reactions of the patients' relatives. As part of the healthcare team, we must always make our clients safe from harm. This will comfort the feelings of the families and will give them assurance that everything will be done and everyone will provide quality health care.

To make it something positive, every commendations coming from the relatives must be posted in certain board to boost the ego of the nurses because this kind of gesture is beyond financial reward. Lastly, further training and research must always evolve base from the data of the hospital. This will make the institution moving forward as a team, updated and willing to undergo change.

**Summary, Findings, Conclusions and Recommendations**

This chapter presented the summary, findings, conclusions and recommendations derived from the data gathered in the study. These were based on the interpretations of data collected in the study.

**Summary**

The success of the improved quality care service rendered depends on critical care nurse's perspectives and acceptance of legal documentation on family presence during resuscitation. In this study, the descriptive and qualitative methods were used to determine the critical care nurses' perspectives towards family presence guidelines during resuscitation in an adult intensive care unit in Prince Sultan Military Medical City. These types of research answered the questions and satisfied curiosity about a certain phenomenon. The researchers gathered pertinent information and necessary data through the questionnaire that was distributed to the respondents. The study revealed the profile of the respondents as to age, gender, working experience, nursing position, religion, education and country of training. Critical Care Nurses were chosen as the respondents because of their accessibility and relevance to the study.

This study aimed to identify the Critical Care Nurses' Perspectives towards Family Presence Guidelines during Resuscitation in an adult intensive care unit in Prince Sultan Military Medical City and to assess the quality of nursing care provided.

Specifically, this study focused to answer the following questions:

1. What is the profile of the respondents in terms of
1.7. Age;
1.8. Gender;
1.9. Education;
1.10. Religion;
1.11. Experience;
1.11.1. Years of experience
1.11.2. Nursing Positions; and,
1.12. Country of Training?

To what extent is the perspective of critical care nurses in an adult intensive care unit towards family presence during resuscitation in terms of

2.14. Previous experience with CPR;
2.15. Preferences for family witnessed resuscitation
2.16. Policy Preference
2.17. Permission
2.18. Emotional Stress
2.19. Presence of relatives
2.20. Trauma to relatives
2.21. Benefits for relatives
2.22. Litigation
2.23. Support of Relatives
2.24. Staff performance
2.25. Duration of resuscitation; and,
2.26. Personal Preference?

1. Is there a significant relationship between the level of perspectives of Critical Care Nurses in an adult intensive care unit towards family presence guidelines during resuscitation and their profile variables?
2. Based on the findings: What clear well established guidelines can be proposed for family presence during resuscitation?

Statistical treatments composed of frequency, percentage, weighted mean, Analysis of Variance (ANOVA), and T- test for two independent variables (Unknown Equal Variance) were utilized after data tabulation.

**Findings**

**Demographic Profile of the Respondents**

The findings revealed that in terms of profile, majority of the respondents are in the young adulthood stage of growth and development. More than half of them are female and one fourth of them are male; almost all have Bachelor's Degree in Nursing, only few have units in Master's degree. Most of the critical care nurses are catholic, the rest are divided into Muslim, Christian and Others. Also because of age bracket, many of the nurses have 1-5 years of working experience and others have 6-10 and 11-15 years; with total of seventy six percent (76%) are Staff nurse 2 respondents and the rest are either Staff nurse 1 or Charge nurses. It further revealed that most of the critical care nurses have trained in the Philippines, while the remaining have experience in Saudi Arabia, Jordan, and India.

**Extent of the Perspectives of Critical Care Nurses**

**Previous Experience of CPR**

The results showed that there are no difference whether the family is present or not. The Critical Care Nurses considered both the advantages and disadvantages of having family members during cardiopulmonary resuscitation. With this perspective in the study, scores were leaning on the positive and negative effects. Benefits and risks are both being looked at during an ongoing resuscitation.

**Preference for Family Witnessed Resuscitation**

"I uphold the rights of every individuals" have a verbal interpretation of high extent. As part of the right to be involved in his/her family member's care, Critical Care Nurses also took the oath to respect each and every individual they encountered as part of their profession. Still due to lack of knowledge, the nurses are still ambivalent with the answers. Although studies supported that family presence during resuscitation was concluded as a "right not an option". It encouraged communication, facilitated closure for relatives and helps in end of life decisions. With the results, family health care support person is important with the Critical Care Nurses in family witnessed resuscitation. Although the space inside the resuscitation room is also remarkably significant in this study that the nurses consider it as need to be improved.

**Policy Preference**

The results showed that legal documentation is important. Written policies were preferred by Critical Care Nurses to serve as guidelines for safe practice.

**Permission**

Critical Care Nurses greatly valued privacy and confidentiality of the patients. As part of the Code of Ethics, permission should

be secure in order to protect the patients from harm and in order to build trust.

**Emotional Stress**

The results presented that the level of stress were not affected if family members were present during the resuscitation. The nurses capable of handling critically ill patients are flexible enough to deal with anxiety and different crisis situations. Also Critical Care Nurses always remain professional under stress.

**Presence of Relatives**

Spirituality as a factor had been a significant benefit of having the relatives present during resuscitation. But as beneficial as this issue can be, Critical Care Nurses viewed this perspective as risky. The family members will be negative in terms of having to witness a cardiopulmonary resuscitation though this was already being showed in television and most probably most people have an idea about it. The nurse also believed that having relatives around can give hope to the patient.

**Trauma to Relatives**

Critical Care Nurses believed that being present during Cardiopulmonary resuscitation is traumatic and often give a peace of a mind for the family members. The relatives may show hysteria and may be uncontrollable during the resuscitation. While in some studies there were no evidence of traumatic experience from the relatives.

**Benefits for Relatives**

The results presented that Critical Care Nurses acknowledged the importance of the benefits to family presence during resuscitation focusing on lessening of anxiety levels and aid in the bereavement process. The nurses viewed the situation as helpful and that the family members were informed that everything possible was done to bring the patient's life back.

**Litigation**

Legal liabilities came to be interpreted as the "high extent". This can be explained that the Critical Care Nurses were concerned with legal responsibilities which accompanies family presence during resuscitation. As one of the negative effects, failing resuscitation will be equivalent to additional investigation and fear of litigation. Though the nurses believed that as professionals, safe nursing practice can be achieved with the Patients' Bill of rights as a basis and being able to follow the principles of proper decorum especially at bedside.

**Support of Relatives**

Critical Care Nurses will also be the advocate for the family members of the critically ill dying patients. "I know the relatives need to be physically and spiritually connected with their loved one", interpreted to be a high extent which relevant here in Saudi Arabia. Families are bound with spirituality and religion.

**Staff Performance**

Being watched by relatives does not affect how the Critical Care Nurses performed during Cardiopulmonary Resuscitation. Although majority of them thought that being observed by the relatives can promote good communication preventing unprofessional behavior. The nurses are more concern on the privacy of the patient.

**Duration of Resuscitation**

The critical care nurses are not worried that the resuscitation will be prolonged of there are relatives around. In addition, the nurses also do not agree that having families present during cardiopulmonary resuscitation will further prolong the suffering of the patients. Being present in the crisis situation have been helpful to the families in terms of decision making process. Inside the resuscitation room, the relative will be able to understanding the situation that everything has been done and they will have acceptance.

**Personal Preference**

As many of the respondents who were raised with great value to family especially in a religious country of Saudi Arabia. Nurses as part of the healthcare team and very knowledgeable to the process of resuscitation, as per their experiences, they do not want to see their loved ones suffer. Being familiar with the situation, the nurses agreed that family can be a big part of the resuscitation process but they are still ambivalent with this experience because they viewed the scenario as a crisis. The families were the ones mainly affected by this situation and being exposed to this kind of circumstances may escalate different emotions that might be unacceptable in an intensive care unit.

Relationship between the Level of Critical Care Nurses' Perspectives and their Profile Variables.

Overall, using ANOVA and t- test for two independent variables as statistical treatments, it was revealed that majority of the level of critical care nurses' perspectives has no significant relationship when grouped according to profile variables. Hence, the null hypothesis is accepted.

While between the Age profile and the perspective of preferences for family witnessed resuscitation has a significant relationship thus null hypothesis is rejected. Also, there is a significant relationship between Nursing positions profile and the perspective of trauma to relatives and between the country of training profile and the perspectives of permission, trauma to relatives and personal preference, therefore the null hypotheses are rejected,

**Conclusions**

Majority of the respondents are in young adulthood growth of development and are mostly female. The predominant religion was Roman Catholic. Most of the respondents have obtained Bachelors' degrees, have one to five years of experience and are working in the institution as Staff Nurse 2, and majority of them trained from the Philippines.

Findings revealed that composite means of the perspectives of previous experience of CPR, preference for family witnessed resuscitation, permission, emotional stress, presence of relatives, trauma to relatives, benefits for relatives, support of relatives, staff performance, duration of resuscitation and personal preference gained "moderate extent" which mean the critical care nurse are positive with change but ambivalent due to lack of knowledge.

The respondents exhibit a positive attitude towards family presence during resuscitation that the options specifically identified in each perspective were greatly possessed by the critical care nurses.

On the other hand, the respondents prefer a written policy regarding the family presence during resuscitation and gained "some extent" on the option that is no written policy and only providing agreement to allow families during resuscitation which revealed that the perspective of policy preference gained "low extent".

In addition, the critical care nurses believed that legal responsibilities is of great concern with the family presence during resuscitation, thus the perspective of litigation gained a composite mean of "high extent".

Findings showed that in totality there is no significant relationship between the level critical care nurses' perspectives and their demographic profile. Although it is highly significant between the age profile and level of perspective of preferences for family witnessed resuscitation. Moreover, there is a significant relationship between the level of critical care nurses' trauma to relatives perspective in terms of nursing positions profile. Lastly, there is a significant relationship between the country of training profile and the level of critical care nurses' perspectives of trauma to relatives, permission and personal preference.

The results of the study will provide clear well established guidelines that will serve as the basis for the critical care nurses' performance of their duties, how they interact with the families during cardiopulmonary resuscitation and other areas of improvement as well as the formulation of policy and creation of a family care health specialist that will cater the families during crisis scenario.

**Recommendations**

Considering the following recommendations are offered to the sectors concerned.

**For the Critical Care Nurses**

Perform self-assessment and have active participation in professional development to increase level of knowledge, skill and attitudes in nursing practice. To have strict compliance to the theories and principles of the nursing profession and periodic self-evaluation in order to assess the performance level. To serve as advocates for the families in order to protect the right of every individual and role models to impart values needed by future nurse professionals. And to have continuing development to enhance status and prestige to society such as researches conducted.

**For the Hospital Administration**

Form a training committee within the hospital staff who will conduct in-house lectures, training and seminars. Organize a research team to help the critical care nurses with the policy implementation and to further update in order to improve the existing guidelines. Encourage and fund staff development programs.

**For the Nursing Managers**

Provide educational incentives such as study grants, educational travels, and professional enhancement programs. To have recognition program to motivate the team in order to facilitate better working environment. To have periodic evaluation to access the level of perspectives towards family presence during resuscitation.

**For the Clinical Resource Nurses**

Design or implement programs to teach critical care nurses on building rapport or working relationship in rendering interventions to the patients and their loved ones. Provide adequate library resources and reading materials to have access to information.

**For the Public**

Orient and be informed to obtain the best quality care from competent critical care nurse and be assured of their rights to a healthful life.

**For the Future Researchers**

Conduct trainings and symposia regarding the importance of family presence during cardiopulmonary resuscitation with focus on the benefits of the relatives and give further enlightenment to fellow critical care nurses in order to improve work performance.

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