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Family Presence during Cardiopulmonary Resuscitation: Clinical Practice Guidelines

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Walden University

College of Nursing

This is to certify that the doctoral study by

Poonam Kalkat

has been found to be complete and satisfactory in all respects,
and that any and all revisions required by
the review committee have been made.

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Walden University
2022

Abstract

Family Presence during Cardiopulmonary Resuscitation: Clinical Practice Guidelines

by

Poonam Kalkat

MSN FNP, University of Phoenix, 2019

BSN, Cal State University of San Bernardino, 2011

Project Submitted in Fulfillment

of the Requirements for the Degree of

Doctor of Nursing Practice

Walden University

August 2022

Abstract

Healthcare providers can be skeptical if not resistant to patient-family centered care if standards of care are not written in a policy or guideline. The 2009 Emergency Nurses Association position statement supports giving families the option to be present during resuscitative measures to meet their emotional needs. However, healthcare organizations are frequently not implementing this statement into their practice. Based on peer-reviewed articles retrieved through an in-depth literature search and using the Appraisal of Guidelines for Research and Evaluation (AGREE) II model, the gap in practice was addressed by creating a clinical practice guideline (CPG). The practice-focused questions addressed what evidence was available to provide healthcare providers with a resource for making decisions to allow family presence during resuscitation (FPDR). A panel of four experts evaluated the CPG using the AGREE II tool. All domains were scored over 90%, with an overall assessment score of 96% for usability of the CPG. Categories which received the lowest scores (90%) were rigor of development and applicability. Experts scored the CPG as high quality, with no revisions needed. Their summative evaluation indicated the project was organized and likely to be highly successful if followed. End users representing nurses, residents, and social workers ($N = 4$) also reviewed the CPG for content and usability and made no additional recommendations. The CPG for FPDR will lead to positive social change by allowing healthcare teams and patient families to collaborate to improve policies, programs, facilities, research, and education.

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Dedication

I would first like to dedicate this paper to the patients and their families who were never given the opportunity to be with each other during the last moments. I am grateful for all experiences that led me to want to create change to improve patient-family and healthcare relationship. I want to pay my respect to all the patients who humbled me in my practice and helped me provide exceptional care to all patients regardless of their situation. I want to dedicate this paper to the ED that allowed me to start my career and continued to support me in my journey to improve patient care. Secondly, I dedicate this paper to my family and friends who provided me with outpouring support during my DNP journey.

Acknowledgments

This project is the product of collaboration between experienced colleagues and professors. I am sincerely grateful to my committee chair Dr. Hayden for her patience, guidance, and tremendous support every time I thought I couldn’t complete this project. Thank you for the mentorship provided by Dr. Hayden for laying down the foundation for my project and understanding that life can get in the way of school and sometimes takes priority. I would like to extend gratitude to all my committee members and Dr. Hahn for her advice and counsel to improve my CPG. A special thank you to the collaborating professionals who worked closely with me to help make this project a success.

Table of Contents

Section 1: Nature of the Project 1

Problem Statement 2

Purpose Statement 3

Nature of the Doctoral Project 4

Significance 5

Summary 7

Section 2: Background and Context 8

AGREE II 8

Relevance to Nursing Practice 10

Background and Context 11

Role of the DNP Student 12

Summary 13

Section 3: Collection and Analysis of Evidence 14

Practice-Focused Questions 14

Sources of Evidence 15

Participants 15

Procedures 16

Protection 16

Analysis and Synthesis 17

Summary 18

Section 4: Findings and Recommendations 20

Findings and Implications....................20
Recommendations....................23
Strengths and Limitations of the Project....................24
Summary....................24
Section 5: Dissemination Plan....................26
Analysis of Self....................26
Practitioner....................27
Scholar....................28
Project Manager....................29
Challenges, Solutions, and Insights....................29
Summary....................30
References....................33
Appendix A: Literature Review Matrix....................37
Appendix B: Melynk & Fineout-Overholt Levels of Evidence....................47
Appendix C: AGREE II Tool....................48
Appendix D: CPGs....................51
Appendix E: Expert Panel Summative Evaluation Questionnaire....................65

Section 1: Nature of the Project

Cardiopulmonary arrest is a common event in hospitals, occurring most frequently in emergency departments (ED). Cardiopulmonary resuscitations (CPR) are sudden and traumatic events that frequently jeopardize patients, causing death. The practice of having family present during CPR is not implemented in all organizations or universally accepted in all acute care settings but is, however, endorsed by several hospitals across the United States (Lederman et al., 2013; Niemczyk & Ozga, 2019). Family presence during resuscitation (FPDR) is defined as the presence of family in a patient care area, in a location that allows family to visualize or have physical contact with the patient during resuscitation events (Daken et al., 2017). FPDR has been an ongoing discussion due to healthcare professionals having mixed feelings about not being able to perform at their highest capability because they may become distracted by distraught family members (Lederman et al., 2013). Having FPDR is more beneficial then harmful to families and healthcare teams, yet it is not widely practiced (Brasel et al., 2016). As changes are occurring in healthcare, providers can be skeptical if not resistant to more patient-family centered care if standards of care are not written via policies or guidelines to support the practice (Larocco & Toronto, 2019). Clinical practice guidelines (CPG) allow healthcare professionals to provide patient-family centered and evidence-based care based on current literature. Meeting the needs of families in times of crisis exemplifies patient-family centered care (Goldberger et al., 2015), leading to potential positive social change. FPDR has a positive effect on families by allowing them to witness the efforts of healthcare teams and have a better understanding and sense of

satisfaction involving care provided for their loved ones (De Stefano et al., 2016; Goldberger et al., 2015); to meet these needs of families, a standardized guideline for FPDR in the ED has been developed.

Problem Statement

This project was not individualized to a specific setting, as the problem of not allowing family at the bedside is widespread, and the policy is appropriate for any and all settings. Foote Hospital in Michigan was the first hospital in the US that allowed family to be present during resuscitation in 1983, after two family members refused to leave the bedside of their loved one during resuscitation (Mutair, 2017). No current literature has been found addressing implementation of guidelines for FPDR, and thus no data are available regarding the extent of the problem. Permitting family members to be present during CPR is usually at the discretion of healthcare providers caring for the patient. Only 5% of hospitals had a policy on family presence, and only 27% of nurses were aware of the guideline issued by the Emergency Nurses Association (ENA) in 1995 (Brasel et al., 2016). The ENA supported giving families who would like to be present during resuscitative measures the option of being at the bedside during CPR to meet the emotional needs of families (American Association of Critical Care Nurses [AACN], 2018).

Generally, nursing staff are more accepting of FPDR than physicians who run codes (Toronto & Larcco, 2018). Some physicians have reservations involving nurses, residents, or themselves underperforming; others are anxious about family members' emotional responses to witnessing a loved one's resuscitation. Physicians who practice

patient-family centered care invoke dignity, respect, information-sharing, participation, and collaboration during difficult decision-making, which supports FPDR (Bradley et al., 2017; Niemczyk & Ozga, 2019). Family members who support being at the bedside reported the need to witness efforts of healthcare providers to understand and be present, which helped their grieving process, aided in closure, and provided comfort to patients. Family members who do not support being at the bedside felt that witnessing such an event may cause them to have emotional distress (Bradley et al., 2017; Niemczyk & Ozga, 2019).

A problem was identified throughout acute care settings involving families who are not allowed to be present during CPR, though the literature (Lederman et al., 2013; Niemczyk & Ozga, 2019) supports it (Lederman et al., 2013; Niemczyk & Ozga, 2019). A gap in practice was identified involving a lack of a standardized guideline to direct decision-making in terms of when to allow FPDR. I have developed a CPG for FPDR outlining decision-making for physicians in terms of whether to allow families at bedside or not by providing direction and leading to improved family satisfaction by promoting patient-family centered care. FPDR involves displaying dignity, respect, information-sharing, participation, and collaboration, leading to improvements in healthcare (Niemczyk & Ozga, 2019). Nurses who practice family and patient centered care are more satisfied in their jobs and provide a higher level of care (Goldberger et al., 2015).

Purpose Statement

A gap in practice was identified throughout acute care settings that there was a lack of a standardized guideline involving the decision to allow FPDR. Family members

prefer to be present during their resuscitation periods (Bradley et al., 2017). FPDR is a controversial topic among nurses and physicians. Negative staff attitudes are a barrier to having families present, and staff are often not prepared to have family present at the bedside (Toronto & LaRocco, 2019). Without standardized guidelines, staff have the option to deny families the right to be at the bedside. Developing and implementing a CPG has made making decisions to allow FPDR easier for ED physicians and residents as well as nursing staff. The practice-focused questions that guided this project were: Does the literature support the need for a standardized guideline to address FPDR? and What evidence from the literature is available for the development and validation of a CPG to address FPDR, guided by the Appraisal of Guidelines for Research and Evaluation Instrument (AGREE II) tool? By answering these questions and developing a CPG, I closed the gap by providing hospitals with a standardized guideline to support FPDR.

Nature of the Doctoral Project

In carrying out this Doctor of Nursing Practice (DNP) CPG project, I followed the *Walden University Clinical Practice Guideline Manual* and was guided by the Appraisal of Guidelines for Research and Evaluation (AGREE II) instrument (Hoffmann-Eßer et al., 2018). The gap in practice was identified as there were no standardized guidelines available for acute care settings involving FPDR. The literature search was conducted using Walden University Library databases CINAHL, PubMed, MEDLINE, Journals@Ovid SAGE Journals, National Center of Biotechnology Information (NCBI), and Google Scholar. Keywords were *family presence during resuscitation*, *CPR* AND

family, *physician preferences* AND *family* AND *resuscitation* OR *CPR* OR *code*, *nursing preferences* AND *family* AND *resuscitation* OR *CPR* OR *code*, *clinical practice guidelines* AND *CPR* OR *family presence*, and *patient-family centered care* AND *CPR* OR *code* OR *arrest* were used to search for and retrieve relevant articles.

Retrieved articles were critically appraised by reviewing literature, organizing the literature in a literature review matrix (see Appendix A), and grading evidence using the grading criteria of Melynk et al. (see Appendix B). Evidence from the literature review was used to develop a CPG for FPDR which was reviewed by a panel of experts using the AGREE II tool to validate the content of the CPG. The CPG was revised per recommendations from the expert panel. When the CPG was approved by the panel of experts, it was presented to a group of end users, representing nurses, residents, and social workers, to review for content and useability. After approval by end users, I developed a final report. After graduation, I will present the newly developed CPG to key stakeholders such as management, physicians, nurses, and residents in hospitals in my surrounding areas for consideration for adoption in acute care settings. Providing these settings with a CPG for FPDR will better allow families the opportunity to be present during critical situations and provide guidelines for healthcare teams to follow, making the process of FPDR flow more smoothly.

Significance

The CPG for FPDR will impact stakeholders including physicians, residents, nurses, and patients' family members in acute care settings. Set guidelines to allow families at the beside during critical situations will provide guidance for healthcare staff

to base their decisions, so it is no longer up to the discretion of the physician. FPDR should have a positive impact on physicians, residents, and nurses by encouraging professional behavior among medical staff during resuscitation and developing rapport with families, as well as building confidence care of patients and considering families as part of the care team. FPDR can also have a positive impact on families by allowing them to witness efforts of healthcare teams in order to have a better understanding of care provided to their loved ones (De Stefano et al., 2016; Goldberger et al., 2015).

FPDR is significant to nursing when it comes to family-patient centered care. Patient and family-centered care displays dignity, respect, information sharing, participation, and collaboration which demonstrate improvements in healthcare (Niemczyk & Ozga, 2019). By following the CPG, physicians, residents, and nurses will consider patients' and their families' perspectives and beliefs and incorporate them into care, families receive accurate and appropriate information and are encouraged to participate in decision-making involving care of their loved ones, and collaborate to improve policies, programs, facilities, research, and education, leading to positive social change and improving experiences and rapport between families and healthcare teams (Derosa et al., 2019). This project will lead to positive social change by empowering changemakers and building community through provision of a CPG for FPDR. FPDR guidelines allow families to be present during critical moments in their family members' lives. Standardized guidelines will lead to positive social change by improving human interactions and relationships between healthcare providers and families in more than just the hospital setting. This CPG can be used in EDs across the United States, and not just in

Southern California, as well as various healthcare facilities such as long-term care facilities or subacute care settings. The need for a FPDR CPG is widespread across the country in all settings. All families should be given the choice to be present during critical times in their loved ones' lives (Bradley et al., 2017; Niemczyk & Ozga, 2019).

Summary

This DNP project was designed to address the gap that exists involving no standardized CPG in place for FPDR. Family is an integral part of patient care, and they should be involved during critical moments. A great deal of evidence and professional guidelines support the option of family presence during resuscitation in acute care settings, but many healthcare professionals oppose this due to having concerns involving underperforming and possible negative psychological effects on family members (Lederman et al., 2013). The development of a standardized CPG for FPDR will allow for acceptance by providers to allow families at the bedside, ultimately increasing family satisfaction.

Meeting the needs of families in times of crisis exemplifies patient-family centered care. CPGs that provide standards of practice to allow families to be present during resuscitation can lead to guidance for healthcare providers. In Section 2, I discuss the local background and context, the AGREE II instrument that was used to guide this project, relevance to nursing practice, and my role as the DNP student.

Section 2: Background and Context

The problem that was identified throughout acute care settings is that families are not allowed to be present during CPR. The gap in practice that I addressed in this DNP project is that there were no standardized guidelines for FPRD in many facilities across the US, even though the ENA recommended families should be given the opportunity to be present during critical moments in their loved ones' lives (AACN, 2018). Since there are no standardized guidelines for physicians and other healthcare staff to follow, families of patients who are resuscitated are not given the option to be present during CPR. The purpose of this project was to develop an evidence-based CPG for FPDR that can be presented to local hospitals for adoption to answer the following practice-focused questions:

Does the literature support the need for a standardized guideline to address FPDR? and What evidence from the literature is available for the development of a CPG to address FPDR which will be validated by using AGREE II model? In this section, I discuss the AGREE II instrument that was used to guide the project. Furthermore, relevance of the study, my role as the DNP student, and background and contextual information are also discussed.

AGREE II

The AGREE II instrument (Hoffmann-Eßer et al., 2018) was used to guide this CPG project. The AGREE II Instrument is a tool developed in 2003 by an international evolving group of developers and researchers to provide a framework for assessing the quality of CPGs and is the most applied and comprehensively validated guideline

appraisal tool used worldwide by health professionals, researchers, educators, and stakeholders who are interested in developing guidelines (Hoffmann-Eßer et al., 2018). The AGREE II tool consists of 23 appraisal criteria items that are organized into six domains: scope and purpose, stakeholder involvement, rigor of development. clarity of presentation, applicability, and editorial independence. The six domains are followed by two additional items for overall assessment: rating of the overall quality of the guideline and whether the guideline would be recommended for use in practice. Items within each domain are rated on a 7-point scale ranging from strongly disagree to strongly agree.

Since the 1990s, over 114 guidelines have been developed following the AGREE criteria, for implementing evidence-based practices to manage low back pain. The low back pain management guidelines incorporated several clinical indicators, treatment options, and diagnostic instruments. In 2009, Doniselli et al. revised eight of the previously developed guidelines for the management of lower back pain following the AGREE II model, making them more clinically oriented and easier to use. Of all the eight guidelines that were appraised only one was rated at less than high quality (Doniselli et al., 2018).

The AGREE II tool was used to assess the quality of methodological rigour and transparency of four different World Health Organization (WHO) guidelines (Polus et al., 2012) published between 2007 and 2011. As shown in literature, the AGREE II tool can be used to guide development and assess quality of guidelines as well as indicate needed improvements.

Relevance to Nursing Practice

Allowing family members to be present at a patient's bedside during CPR is a controversial issue among physicians, nurses, and family members (Bshabshe et al., 2021). FPDR has been a focus of ongoing arguments due to healthcare professionals having mixed feelings about not being able to perform at their highest capability because they may become distracted by distraught family members (Lederman et al., 2013). Though healthcare teams may have mixed feelings about FPDR, literature over the past 20 years has demonstrated that having FPDR is more beneficial then harmful to families and healthcare teams (Brasel et al., 2016). Bshabshe et al. (2021) said family members prefer to be involved in the final moments of their loved one's life in order to allow religious or cultural closure, and FPDR contributes to developing confident and peaceful environments that are supportive for families. In 1983, the Foote Hospital in Michigan was the first hospital in the US to allow families to be present during resuscitation after two family members refused to leave the bedside during resuscitation of their loved one (Mutair, 2017). There is no current literature addressing implementation of guidelines for FPDR, and thus no data are available to know the extent of the problem. The development and implementation of the CPG will make the decision to allow FPDR easier for physicians and residents as well as nursing staff. FPDR impacts families by giving them the option to be present during critical times and allowing them to be in the presence of their loved ones during what may be their last moments together as families (Bradley et al., 2017; Niemczyk & Ozga, 2019). FPDR has an impact on healthcare teams by reminding clinicians of patients' personhood and encourages more professional

behavior at the bedside and education about patients' conditions, and families can provide information about patients and act as their advocates (Goldberger et al., 2015).

Background and Context

According to data for 2020, the target hospital where this DNP project was implemented received approximately 1,092 patients with CPR in progress upon arrival to the ED, and most of these resuscitations did not allow for families to be present at the bedside. ER physicians and trauma surgeons who ran these codes only allowed family based on providers' comfort levels. Lack of a CPG for FPDR has been a major barrier in terms of allowing FPDR (Bshabshe et al., 2021). There is no FPDR CPG in place for hospitals in Southern California. The newly developed CPG involves standards to have FPDR throughout Southern California and decision will no longer be left at the discretion of providers running the code.

In 2009, the ENA presented a position statement for use to improve chances of US families being present during resuscitative measures, if desired, to meet the emotional needs of families (AACN, 2018). These guidelines are not currently being implemented in acute care settings across California, and no literature has been found which shows any hospitals are using ENA position statement recommendations. Working in the acute care setting and realizing how many patients arrive in the ER in cardiac arrest with family showing concern about not being able to see their loved one has demonstrated to me how the issue contradicts family/patient centered care. Not being able to see their loved ones can increase family members' feelings of helplessness, anxiety, panic, and guilt (Mutair, 2017). Allowing families to be present for their loved ones during their final moments,

even in small ways such as saying goodbye, can reduce these feelings and help family members through the grieving process (Mutair, 2017).

Role of the DNP Student

As a trauma nurse practitioner, I provide care to many critical trauma patients who are actively fighting for their lives. I also work closely with their families as they arrive in the trauma bay, many with CPR in progress with family either in the ambulance or in the waiting room. The trauma team, made up of me, my trauma surgeon, a resident, an ED physician, at least two trauma ED nurses, and a trauma social worker, is waiting for these patients. The social worker is responsible for getting families from the waiting room when the trauma surgeon allows them to be present. While some trauma surgeons and ED physicians prefer families to be at the bedside as they resuscitate patients because they want families to understand what is happening and what the prognosis would be if their family member were to have return of spontaneous circulation (ROSC), not all support the decision, hence the need for a standardized CPG for FPDR.

Of all the resuscitations I have participated in over the last 10 years with family at the bedside, only a handful of family members have had poor experiences. Most are grateful that they were able to see their loved one and were able to hold their hand and speak to them and say their feelings. Family was also grateful that the physician was able to give them a step-by-step description of what was happening during the resuscitation. The hospital I currently work at and other hospitals around the area do not have a CPG for FPDR, this decision is left solely to the physician running the codes. My role in this DNP project was to search the literature for peer reviewed evidence to support FPDR and

develop a new CPG for FPDR. After development, I choose a group of content experts to evaluate the CPG, made revisions as indicated, and presented the revised CPG to a group of end users to review for content and usability. My goal is to present the newly developed CPG to facilities in the Southern California area for healthcare teams to adopt in their practice. There were no foreseeable biases in the development of the CPG for FPDR.

Summary

My goal for this DNP project was to develop a CPG to allow FPDR in all healthcare settings. Over 1,000 patients arrive in EDs across the nation in cardiac arrest annually and family is often not allowed to be at the bedside during resuscitation despite the literature supporting FPDR (Lederman et al., 2013; Niemczyk & Ozga, 2019). The newly developed CPG will aid the healthcare team in making the decision to allow family members to be present for their loved one during their final moments. In Section 3, I provide an overview of the practice-focused questions and sources of evidence along with methods used to collect and analyze the evidence for this DNP project.

Section 3: Collection and Analysis of Evidence

Since there were no standardized guidelines for physicians and other healthcare staff to follow for FPDR, the purpose of this DNP project was to develop a CPG for FPDR. EDs across Southern California and the US receive cardiac arrest patients daily, and there are no standardized guidelines in place to allow FPDR. The ENA has presented a position statement to meet the emotional needs of families in the US who would like to be present during resuscitative measures to have the option of being at the beside (AACN, 2018); however, the position statement is rarely being used. and family needs are currently not being met. I developed a CPG for FPDR and will present it for use throughout Southern California and nationally. In Section 3, I discuss practice-focused questions, sources of evidence, and analysis and synthesis.

Practice-Focused Questions

FPDR has been an ongoing argument in healthcare due to healthcare professionals having feelings of not being able to perform at their highest capability because they may become distracted by distraught family members (Lederman et al., 2013). Due to these feelings of healthcare professionals, and despite literature showing that family prefers to be at the bedside (Bradley et al., 2017), there are no standardized guidelines in place to allow FPDR. To address this gap, I answered the following practice focused questions:

Does the literature support the need for a standardized guideline to address FPDR? and What evidence from the literature is available for the development of a CPG

to address FPDR which will be validated by using AGREE II model? By developing and implementing a CPG, decisions to allow FPDR should be made easier for ED physicians, residents, and nursing staff, and the gap will be closed by providing hospitals with a standardized guideline to support FPDR. The AGREE II instrument was used to guide me in developing, and the content experts in the evaluation of the CPG.

Sources of Evidence

I developed the CPG based on evidence-based literature described in Section 2. The AGREE II tool guided a panel of four content experts who currently work in the ED setting and provide direct care for patients coming in with CPR in progress to address quality, methodological rigor, and transparency of the newly developed CPG (AGREE, 2017). The AGREE II scores were used to address needed revisions of the CPG. After the CPG was evaluated by the expert panel, modifications reflected their recommendations. To have input from stakeholders, the CPG was sent to a group of end users to review for content and usability. These content experts were also asked to provide a formative evaluation of the process and project as well as my leadership abilities in terms completing this DNP project, including my strengths and weaknesses for future projects.

Participants

Four content experts, following the recommendation from the AGREE II instrument (AGREE, 2017), were chosen to review the newly developed CPG for quality and rigor. This panel included an emergency physician who is a doctor of osteopathic medicine, a trauma surgeon medical doctor who specializes in general surgery and trauma and currently works at two hospitals in Southern California, an ED postgraduate

year 3 resident, and a registered nurse with a master's degree in education who is an ED educator. These participants were chosen because they are a direct part of the resuscitation process and work closely with other healthcare team members present for the codes and can address the practice-focused question. A group from the remaining healthcare team were asked to provide end user reviews of the CPG for content and useability.

Procedures

After a thorough literature search, I developed a literature review matrix using Fineout-Overholt's (2010) grading criteria. I developed a CPG for FPDR based on peer-reviewed and evidence-based literature. After I developed the CPG, a packet of information was provided to the panel of experts including a preapproved disclosure form, an introductory letter, AGREE II tool scoring instructions, the AGREE II tool, the literature review matrix, and the newly developed CPG. The expert panel was asked to review the CPG using the AGREE II tool by assessing the quality of the CPG and provide feedback within 3 weeks of receiving the packet. After feedback was received, I made recommended revisions and then presented the CPG to the remaining healthcare team who reviewed the CPG for content and useability. Following their recommendations, no revisions to the CPG were made. I will present the CPG to multiple healthcare settings in Southern California for implementation.

Protection

There were no ethical risks identified while developing the CPG for FPDR. I obtained ethical approval from Walden's Institutional Review Board (IRB) for this DNP

project to meet ethical requirements. Each expert received a preapproved disclosure form with an introductory letter introducing them to the AGREE II tool website. The reviews will remain anonymous as the AGREE site collected no identifying data; all electronic files will be stored for 5 years on a password-protected computer that only I have access to and then deleted following the IRB's recommendations.

Analysis and Synthesis

A thorough literature search was conducted where I developed a literature review matrix which involved grading selected articles using Fineout-Overholt's (2010) grading criteria. I then developed a CPG for FPDR (see Appendix D) based on peer-reviewed and evidence-based literature. After the CPG was developed, an expert panel was selected to evaluate the quality of the CPG. The expert panel used the AGREE II instrument (see Appendix C) via their web site (https://www.agreetrust.org/) to evaluate and score the new CPG for FPDR. I received a report which provided scores for each of the six domains as well as an overall assessment of the guideline. The AGREE II instrument is comprised of 23 items within six domains: scope and purpose, stakeholder involvement, rigor of development, clarity of presentation, applicability, and editorial evidence. Domain scores are calculated by summing up all individual items in each domain with a maximum score of 7 (strongly agree) and scaling the total as a percentage of the maximum possible score for that domain (AGREE Enterprise Trust, 2009). Data analysis was a two-step process which involved first collecting individual domain scores and then an overall evaluation on the validity of the guideline and recommendations for use or revisions. No recommended modifications were made to the CPG per the expert

panelists. AGREE II tool results were saved on the AGREE II site on a password-protected computer.

After end users assessed the CPG to see if it would be user-friendly and pertinent to their clinical practice, I assessed their comments, and no modifications of the CPG were needed. A summative evaluation questionnaire was distributed to the expert panel after evaluation of the CPG was completed to evaluate my leadership skills, ability to communicate with all parties involved, and how well I conducted this DNP project. All comments were positive to include the project being an excellent topic to implement into practice.

Summary

The ENA developed a position statement in 1995 and revised the statement in 2009, supporting giving families who would like to be present during resuscitative measures the option of being at the beside during CPR to meet their emotional needs (AACN, 2018). However, recommendations are not currently being followed in patient care settings due to healthcare professionals having mixed feelings about not being able to perform at their highest capability; however, medical literature for over 20 years has shown that having FPDR is more beneficial then harmful to families (Brasel et al., 2016). Organizations are lacking standardized guidelines to follow through with the ENA recommendations. This project involved addressing lack of standardized guidelines involving allowing FPDR. Evidence I used to develop a CPG was obtained through an in-depth literature review. The AGREE II tool was used to collect data from the expert panel who rated the quality and transparency of the CPG. Expert panel responses included an

overall assessment of the CPG. No modifications to the CPG were made, and a group of end users reviewed the CPG for content and usability. Thematic evaluation of the content experts' summative evaluation (see Appendix E) was used to highlight my strengths as a leader and how it has prepared me for future projects and leadership roles. In Section 4, I discuss findings and implications of data and strengths and limitations of this DNP project.

Section 4: Findings and Recommendations

The problem that was identified throughout acute care settings is that families are not allowed to be present during CPR though the literature supports it (Lederman et al., 2013; Niemczyk & Ozga, 2019). I addressed the lack of a standardized guideline for FPRD for facilities across the US by developing a CPG to assist in making the decision to allow FPDR more objective and easier for ED physicians, residents, and nursing staff in order to answer the following practice-focused questions:

Does the literature support the need for a standardized guideline to address FPDR? and What evidence from the literature is available for the development of a CPG to address FPDR which will be validated by using AGREE II model?

The Walden Library was used to retrieve peer-reviewed articles to address the gap in practice and develop a CPG. After the CPG was developed, it was appraised by a panel of 4 experts. The panel was provided with the CPG and references via a literature matrix to evaluate the CPG for authenticity and support the gap in practice. Panelists used the AGREE II tool to score the CPG in 6 domains. Scores in each domain were percentages which showed if each domain met criteria for usability.

Findings and Implications

Four expert panelists used the AGREE II tool to provide an evaluation of the CPG. Results included data from 23 items within six individual domains with a total percentage score for each domain. Per the AGREE II tool (Hoffmann-Eßer et al., 2018), any domain scoring 50% or above is considered acceptable; however, any domains

scoring under 75% should be reviewed and changes should be considered. Scores ranged from 90-95%, surpassing the minimum acceptable score see Table 1.

Table 1

AGREE II tool scores

Domain	Question #	Expert 1	Expert 2	Expert 3	Expert 4	Individual Scores %	Total%
I Scope and practice	Question 1	7	7	6	7	Expert 1- 88%	93%
	Question 2	6	7	6	7	Expert 2- 100%	
	Question 3	6	7	6	7	Expert 3- 83%	
						Expert 4- 100%	
II Stakeholder and Involvement	Question 4	7	7	7	7	Expert 1- 100%	95%
	Question 5	7	7	5	7	Expert 2-100%	
	Question 6	7	7	6	7	Expert 3- 83%	
						Expert 4-100%	
III Rigor of Development	Question 7	6	7	6	7	Expert 1-89%	90%
	Question 8	6	7	6	7	Expert 2-100%	
	Question 9	7	7	6	6	Expert 3-81%	
	Question 10	7	7	6	6	Expert 4-91%	
	Question 11	6	7	6	6		
	Question 12	6	7	6	7		
	Question 13	6	7	6	6		
	Question 14	7	7	5	6		
IV Clarity of Presentation	Question 15	7	7	7	7	Expert 1-93%	94%
	Question 16	7	6	5	7	Expert 2-93%	
	Question 17	6	7	7	7	Expert 3-88%	
						Expert 4-100%	
V Applicability	Question 18	6	7	5	6	Expert 1-90%	90%
	Question 19	7	7	6	6	Expert 2-100%	
	Question 20	7	7	6	7	Expert 3-80%	
	Question 21	6	7	6	7	Expert 4-90%	
VI Editorial and Independence	Question 22	7	7	6	6	Expert 1-100%	95%
	Question 23	7	7	6	6	Expert 2-100%	
						Expert 3-83%	
						Expert 4-83%	
Overall assessment		6	7	6	7	Expert 1-83%	95%
						Expert 2-100%	
						Expert 3-83%	
						Expert 4-100%	

All domains scored over 90% with an overall assessment score of 96% for usability of the CPG. The lowest scores, 90%, were for rigor of development and applicability. Questions 5, 14 and 16 were scored at 5 of 7 possible points by expert panelist 3. Question 5 was addressed in the key evidence portion of the CPG where I provide an explanation of why the CPG is needed based on family views. Content experts and end users are also part of the target population, and their input was gathered during the evaluation process. Question 14 involved procedures for updating the guideline; the CPG states guidelines should be reevaluated every 3 years or when new recommendations arise regarding the process of FPDR. Question 16 was about if different options for management of conditions or health issues are clearly presented; the CPG addresses when families can and cannot be present during resuscitation and what procedures are when inviting them to be at the bedside. These are the only options for families during CPR.

Expert panelists said the CPG was well written, clear to understand, well-articulated, and well thought out. One panelist commented on the debriefing after a code being an excellent idea for evaluating the code. Another panelist commented on how well the CPG was organized and said it was excellently done and likely to be highly successful if followed. End users also reviewed the CPG and stated guidelines were appropriate for implementation and should be considered. A summative evaluation completed by the expert panel was used to evaluate my strengths as well as leadership and communication skills for this project. Panelists provided positive feedback in all categories (see Appendix E).

Overall high scores were surprising as I did not expect panelists to have no recommendations for change; I was prepared to review the CPG and make appropriate modifications based on panelists' recommendations. This CPG will benefit not only the acute care setting but also be appropriate for use in long term care facilities and subacute settings. FPDR can be beneficial for families regardless of where their loved one is receiving care. The CPG will provide healthcare providers a new perspective family belief to incorporate into care, give families the option to participate in decision-making for their loved one's care, and collaborate to improve policies, programs, facilities, research, and education in order to create positive social change and improve experiences and rapport between families and healthcare teams.

Recommendations

I recommend implementing the CPG throughout healthcare settings with a follow-up evaluation by healthcare providers involving how the CPG impacted their practice by allowing families at bedside during resuscitation after a 6-month period. The gap in practice was addressed by developing a CPG for allowing FPDR which can be used in any healthcare setting. These developed guidelines will help support the ENA (AACN, 2018) position statement, giving families the option of being at the beside during CPR. The standardized CPG will guide all healthcare providers in terms of providing patient-family centered care through meeting emotional needs of families. The CPG also provide guidance in terms of when families should not be allowed to be at the bedside. Following the guideline, families will be provided full emotional support from healthcare providers and social services.

Strengths and Limitations of the Project

A strength of this project was the willingness of the expert panel to participate and provide positive feedback regarding the CPG. Their input was valuable for evaluating it. These panelists' experiences made it easier for understanding the need for the CPG. Their personal experiences, feelings, and understanding of what patient-centered care should look like helped shape the CPG in terms of addressing patient and family emotional needs. Panelists were also patient when using the AGREE website and challenges they faced despite having a difficulty of logging in and completing the appraisal with automatic scores showing on the website and met the deadline of scoring the CPG within 3 weeks after it was provided.

The limitations for this project were directly related to the difficulty the expert panelists had with the AGREE website. The panelists were sent multiple reminders due to their not receiving an email from the AGREE website. Creating a log in was also difficult for some panelists, and one was unable to upload the scores onto the AGREE website despite multiple attempts, making it necessary for me to do the analysis by hand. A future project will be an evaluation of the new policy created by the CPG after 6 months of implementation by comparing family and healthcare team satisfaction before and after. Future projects such as developing a CPG for FPDR for the pediatric population and debriefing after a code can also be considered.

Summary

The findings for this project were dependent on the scores from the four expert panelists using the AGREE website. The scores of all 6 domains were 90% or higher

determining that the CPG is acceptable for implementation. The panelists also provided positive feedback for implementation of the CPG and confirmed that the debriefing after resuscitation would be beneficial for everyone involved. The strength of this project was the panelists' appraisal of the guidelines, their positive feedback, and their timeliness in returning the scores within the given time frame. The limitations included the AGREE website being difficult to navigate but overall, the panelists were able to appraise the guidelines. The gap in practice was addressed and the practice-focused questions answered, with hopes for dissemination to multiple healthcare settings after graduating from Walden University. In Section 5, I will provide a self-analysis and summary of this project to include challenges, solutions, and insights gained from this DNP project.

Section 5: Dissemination Plan

All healthcare facilities have different processes when it comes to implementing new policies, procedures, and guidelines. When trying to implement new practice guidelines for improvement in patient care in Southern California hospitals, guidelines must be reviewed by the specific department committee and then approved by the facility's IRB before implementation. My plan is to present the newly developed CPG for FPDR to hospital stakeholders in Southern California for implementation in practice. I will submit an abstract to present the CPG at critical care and emergency care conferences to reach a wider audience across the US for adoption, after which I anticipate the CPG will aid healthcare teams to be more receptive to families being present during all resuscitations and allowing them to be present for their loved ones during their final moments in all acute care settings, long term care facilities, and subacute care facilities across the United States. I will also send a query letter to the *Journal of Professional Development* for potential publication of the CPG.

Analysis of Self

I began my career as a registered nurse at a skilled nursing facility in Palm Springs, California with hopes of gathering enough experience to apply for a position in an ED. Three months into my career, I was asked to join a local ED and could not pass up the opportunity. I was very lucky to have joined the ED team at a level II trauma center. As the years passed, I felt burnt out and had a sense of how I could further my education and provide better care for patients and advance my skill set. I started a family nurse practitioner (FNP) program and learned that I could go even further and obtain a DNP.

After I completed my FNP program, I immediately began the DNP program. I knew I could provide my patients, peers, and community with the best care by making changes beyond the bedside by pursuing higher education.

Practitioner

As an ER nurse for many years, I was able to provide care for many different types of patients and have a wide variety of experiences that made me rethink how I viewed patient and family-centered care. I participated in patient resuscitations often, which led to open discussions about allowing families at the bedside for these situations. This was a new concept to me in the beginning, and I had mixed feelings, mostly due to not understanding why the family was a key component in the care of patients and because most providers and nurses did not favor the idea.

As the years went by, more ED providers allowed family to be present; at this point, I realized that having the family present was a way to maintain patient dignity for healthcare teams because they were able to say their goodbyes. Soon after I became an FNP, I joined the trauma team as their trauma NP and continued to participate in resuscitating patients. In the DNP program, I chose to develop a CPG for FPDR because none of the three facilities I work for have an evidence-based written protocol stating families should be given the option of being at the bedside during resuscitation.

The *DNP Essentials* (Hathaway et al., 2006) that I addressed in this DNP CPG project included Essential IV (Interprofessional Collaboration for Improving Patient and Population Health Outcomes) when I employed effective communication between all collaborative team members to create positive change for patients and their family

members. I incorporated Essential VIII (Advanced Nursing Practice), when I developed and sustained therapeutic relationships and partnerships with patients (individual, family, or group) and other professionals to facilitate optimal care and patient outcomes, demonstrating skills of the advance practice nurse. The *DNP Essentials* provide foundational competencies that are key to all advanced nursing practice roles and prepare DNP graduates to take on leadership roles to better practice, patient, and community outcomes (Hathaway et al., 2006).

Scholar

My goal to attain my DNP has been a challenging and exhausting experience. I started this program with the expectation of only learning how to conduct research and apply it to my clinical practice considering that was what I was told. This DNP program offered more than just learning about research. Over the course of the program, I was able to identify issues within the company I am employed with and take a leadership role and develop multiple protocols specific to trauma patients using evidence-based practices, as well as provide appropriate education to nursing staff and collaborate with stakeholders to implement protocols to create change and improve patient care. This DNP degree has instilled new skills in order to acknowledge a problem, develop a plan to create a change to address the problem, and implement the plan. I have learned new ways to communicate with my colleagues and other collaborative members of the healthcare team. While obtaining the DNP degree, I was able to develop new protocols specific to trauma patients involving venous thrombosis embolism prophylaxis, central line associated blood infections, and catheter associated urinary tract infections to improve

patient outcomes. Overall, I have developed confidence to improve my practice and not fear new challenges to improve patient care.

Project Manager

As the leader of this DNP project, I was able to determine the need for a CPG for FPDR, develop the CPG which can be used in any acute care or outpatient rehab/long-term setting, and determine my panel of experts to help improve the developed CPG for use. When completing the literature review matrix, I learned how to organize data and extract important information I needed for my project. While developing the guideline, I gained insights regarding steps it takes to develop a CPG after identifying a problem. I chose 4 expert panelists who had different roles in the ED. I learned that panelists had the same goal, which was to improve patient and family experiences, but no one knew where to start. Their positive feedback has given me motivation to take my project to stakeholders in many facilities for implementation and shown me how my project can improve the patient-family experience. This project allowed me to expand my thinking and open myself to develop relationships with key stakeholders such as administration, physicians, residents, and educators.

Challenges, Solutions, and Insights

The biggest challenge I faced while completing this project was time management due to working full time in three different facilities, commuting over an hour, and trying to have time for family. Managing being a student and professional and tending to my family was difficult, but my mentor was very supportive and walked me through every step and motivated me to push through and complete this project.

Academically, I had a difficult time writing my prospectus and proposal. I found both challenging because writing was very different from any other paper I have ever written. I found myself confused about what was important to discuss even though I was following the checklist. My mentor made corrections to my work and helped me understand and address important information. I also faced a challenge due to changing my project from staff education to a CPG after my prospectus was approved due to new organizational policies. I had some trouble changing gears, but my mentor assured me that creating a CPG would also address the gap in practice to allow FPDR. Completing this project has given me insights regarding what it takes to develop new policies, procedures, and guidelines for implementation into practice. The experience has given me the tools for future projects and experience with the process of change in large organizations.

Summary

With this DNP project, I addressed a gap in practice throughout acute care settings that there was a lack of a standardized guideline to follow when making the decision to allow FPDR. To address this gap, I developed a CPG for FPDR to direct the healthcare team in terms of giving families the option to be present during resuscitation and how to provide the best experience possible by being present for their loved ones during their final moments. This newly developed CPG will help lead to positive social change for healthcare teams and families by improving human interactions and relationships between healthcare providers and family. Patient and family-centered care has become the cornerstone of healthcare, and allowing families to be present during

critical moments is a way to convey dignity and respect as well as share information, participate, and collaborate, which will lead to improvements in healthcare. The newly developed CPG for FPDR will allow for more acceptance by providers to allow families at the bedside, increasing family satisfaction.

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Appendix A: Literature Review Matrix

Reference	Theoretical/ Conceptual Framework	Research Question(s)/ Hypotheses	Research Methodology	Analysis & Results	Conclusions/Recommendations for future research/practice	Grading the Evidence
AACN Nursing (2018). Defining scholarship for nursing academic. https://www.aacnnursing.org/News-Information/Position-Statements-White-Papers/Defining-Scholarship-Nursing	N/A	Position statement from the Emergency Nurses Association (ENA) regarding giving family the option to be at the bedside during CPR	Position statement	Updated the ENA guidelines to allow family to be present during CPR.	As of 2009 The ENA made a position statement about allowing family to be present during CPR	Level VII
Bradley, C., Keithline, M., Petrocelli, M., Scanlon, M., & Parkosewich, J. (2017). Perceptions of adult hospitalized patients on family presence during cardiopulmonary resuscitation. *American Journal of Critical Care, 26*(2), 103-110. https://*doi*.org/*10.4037/ajcc2017550*.	Patient-family centered care	What are the perceptions of patients on general medical units and to find factors independently associated with family presence during cardiopulmonary resuscitation.	Cross-sectional study	A cross-sectional study of 117 randomly selected adult patients were conducted at an academic medical center. Participants were interviewed via a survey to obtain information on demographics, knowledge of cardiopulmonary resuscitation,	Patients have strong preferences about family presence during cardiopulmonary resuscitation, and they should have the opportunity to make the decision about having family present.	Level IV

				sources of information on resuscitation, and preferences for family presence. 52.1% of participants agreed or strongly. agreed that family presence during cardiopulmonary resuscitation was important. 50.4% of patients should have the opportunity to give consent ahead of time.		
Brasel, K. J., Entwistle, J. W., & Sade, R. M. (2016). Should family presence be allowed during cardiopulmonary resuscitation? *The Annals of Thoracic Surgery, 102*(5), 1438-1443. https://doi:10.1016/j.athoracsur.2016.02.011	Family presence during CPR	What are the personal feelings of family members given the opportunity to be present during CPR?	Qualitative research	Survey of pros and cons conducted by family members who were present during CPR	If FPDR is permitted by a facility, specific guideline should be documented in a written policy that provides many constraints. Family members have mixed feelings about FPDR. Trained support staff designated to accompany family members must be always available and present during the resuscitation and must be	Level V

					available to continue to provide support and answer questions after the event and patient's caregivers must have absolute veto power on family presence.	
Bshabshe A. A., Nadeem M., Bahis M.A., Wani J.I., Aziz S., Sabah Z., Tabinda A. S. (2021). Family opinion regarding their presence with the physicians during active cardio-pulmonary resuscitation of their realtives. *Middle East Journal of Internal Medicince,* 14(1), 3-8. https://www.researchgate.net/publication/354373112_Family_opinion_regarding_their_presence_with_the_physicians_during_active_cardio-pulmonary_resuscitation_of_their_relatives	Family presence during CPR	This study assessed and formed conclusions on the practice of allowing family members to be present at the time of resuscitation.	Qualitative research	Participants answered basic questions about their opinions regarding family presence during cardiopulmonary resuscitation.	FPDR shows promising benefits and family members must be offered the option to witness the efforts the medical team and their wishes must be respected.	Level V
Daken, L., Rayan, A., Abu- Snieneh,H., Al-Dweik, G., Atoum,M., Katib, A., & Mogli. F.	Family presence during CPR/	A policy has been developed regarding family presence during resuscitation in Jordan.	Qualitative Research/ Policy Development	This paper used the step wise process (stage sequential model)	It is suggested that policy makers who are going to develop policies regarding family members presence	Level VII

(2017). Policy development: Family presence during resuscitation procedure. *International Journal of Nursing and Health Science, 4*(2), 22-30.	religious reasons	To explore family members' needs during resuscitation in adult critical care settings.	-Step wise process (stage sequential model used to develop policy and stakeholders interviewed	to develop policy about the presence of family during the cardiopulmonary resuscitation procedure in Jordanian hospitals. Stage sequential model is an approach used to understand policy process which focuses on clarifying policy problem so that it gains the attention of stakeholders and policymakers. The findings in this study show that most of the family members wanted to stay beside their loved ones during CPR; many of them wanted this option for religious purposes.	during resuscitation carefully consider cultural and legal aspects. The recommended solution was allowing family members of all patients undergoing resuscitation to be given the option of presence at the bedside during CPR, and family members decide if they want to attend CPR situation or not.	

De Stefano, C., Normand, D., Jabre, P., Azoulay, E., Kentish-Barnes, N., Lapostolle, F., Baubet, T., Reuter, P., Javaud, N., Borron, S., Vicaut, E., & Adnet, F. (2016, June 02). Family presence during resuscitation: A qualitative analysis from a national multicenter randomized clinical trial *PloS one*, *11*(6), e0156100. https://doi.org/10.1371/journal.pone.0156100	Family presence during CPR	The aim of this ancillary study of our clinical trial was to understand, through a systematic qualitative analysis, how families experience CPR of a relative, by detailing the emotional meaning of the benefits and disadvantages of their presence.	Qualitative research/ randomized multicenter trial	There were four themes identified in the study: 1- choosing to be actively involved in the resuscitation; 2- communication between the relative and the emergency care team; 3- perception of the reality of the death, promoting acceptance of the loss; 4- experience and reactions of the relatives who did or did not witness the CPR, describing their feelings.	Family presence can help to ameliorate the pain of the death, through the feeling of having helped to support the patient during the passage from life to death and of having participated in this important moment. The results showed the central role of communication between the family and the emergency care team in facilitating the acceptance of the reality of death.	Level V
Derosa, A. P., Nelson, B. B., Delgado, D., Mages, K. C., Martin, L., & Stribling, J. C. (2019). Involvement of information professionals in patient- and family-centered care	Patient and family-centered care	Data collected on a patient- and family-centered care (PFCC) programs and initiatives that have included the direct involvement of librarians and information professionals.	Systematic Review	All included studies identified patient education or information-sharing as an integral component of their PFCC initiatives.	librarians and information professionals should focus on patient education and information-sharing to support both patients or caregivers and clinical staff.	Level I

initiatives: A scoping review. *Journal of the Medical Library Association, 107*(3), 314-322. http://doi:10.5195/jmla.2019.652						
Doniselli, F. M., Zanardo, M., Manfrè, L., Papini, G. D. E., Rovira, A., Sardanelli, F., Sconfienza, L. M., Arana, E. (2018). A Critical appraisal of the quality of low back pain practice guidelines using the AGREE II Tool and Comparison with Previous Evaluations: A EuroAIM Initiative. *European Spine Journal*, 27(11), 2781–2790. http://doi:10.1007/s00586-018-5763-1	Evaluate the quality of methodological rigour and transparency of guidelines for the management of low back pain (LBP).	What are the AGREE II assessment findings of methodologic quality of guidelines for the management of low back pain (LBP) and compare their recommendations performed in 2004 and 2009.	Tool assessment, committee report	Only two guidelines reached a level of "acceptable" in every domain; the others had at least one domain with low scores. Compared to previous assessments, low-level guidelines were 53% in 2004, 36% in 2009	Only one had a "low" overall score, while half of them were rated as of "high" quality.	Level I
Dwyer, T., & Friel, D. (2016). Inviting family to be present during cardiopulmonary resuscitation: Impact	Family-centered care	Explore the influence of education on changing HCPs attitudes and intent to provide families with the option	Quasi-experimental design 18 of the original 29	Most participants in this study had previous experience with FPDR (62%) and	Most participants strongly supported the development of a dedicated family support person during CPR.	Level III

of education. *Nurse Education in Practice, 16*(1), 274-279. http://doi:10.1016/j.nepr.2015.10.005		to be present at the next cardiac arrest.	HCP completed both the education package and the post-test questionnaire	supported FPDR (69%). While participants had slightly more positive attitudes towards FPDR post education, this change was not significant.		
Goldberger, Z. D., Nallamothu, B. K., Nichol, G., Chan, P. S., Curtis, J. R., & Cooke, C. R. (2015). Policies allowing Family presence during resuscitation and patterns of care during in-hospital cardiac arrest. *Circulation: Cardiovascular Quality and Outcomes, 8*(3), 226-234. http://doi:10.1161/circoutcomes.114.00	Patient-family centered care	Hospitals have begun to implement policies allowing for family presence during resuscitation (FPDR) but the effect on resuscitation of these policies is unknown.	Observational cohort study The cohort study was conducted of 252 hospitals in the United States with 41, 568 adults with cardiac arrest.	There were no significant differences in facility characteristics between hospitals with and without an FPDR policy, nor were there significant differences in return of spontaneous circulation) or survival to discharge.	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.	Level IV
Lederman, Z., Garasic, M., & Piperberg, M. (2013). Family presence during cardiopulmonary	Family presence during CPR.	Examines the issue of FPDR from the patient's point of view and discuss the Autonomy Principle and the Three-	Integrative review	Three-tiered decision-making model concluded that model is satisfactory in	Using the three-tiered decision-making model, healthcare providers should approach relatives during CPR and briefly	Level IV

resuscitation: Who should decide? *Journal of Medical Ethics, 40*(5), 315-319. http://doi:10.1136/medethics-2012-100715		Tiered process for surrogate decision making.		taking the patient's true wishes under consideration and encourages a joint decision-making process by all parties involved.	ask them about the patient. Then, if both professionals and family deem it fit for family members to be present in the room, the team should describe to them in detail the entire process and guarantee they know what to expect.	
Mutair, A. A.(2017). Should family be allowed during resuscitation? *Resuscitation Aspects,* IntechOpen. https://www.intechopen.com/chapters/56463	Family presence during resuscitation	Identified 35 studies that highlighted family's desire to be present during resuscitation and healthcare workers opinions on having family at bedside.	Qualitative Research/ Descriptive Studies 35 studies were reviewed which consisted of questionnaire given to healthcare providers and family members.	Family members in the studies indicated their desire and supported their presence during resuscitation. The findings highlight the importance of giving the health care providers the confidence in including the family during the care of the patient and considering them as part of the caring team. The studies also demonstrated that healthcare providers have significantly	Family members advocated to be present during resuscitation which helped them with the grieving process. Healthcare provided endorsed the need for written policies to allow family at bedside during resuscitation.	Level V

				different opinions regarding family.		
Niemczyk, E., & Ozga, D. (2019). Attitudes of intensive care unit nurses to family involvement and their presence during cardiopulmonary resuscitation. *Dimensions of Critical Care Nursing, 38*(2), 113-114. http://doi:10.1097/dcc.0000000000000345	Perception of staff and self confidence	Aimed to assess the factors related to nurses' perception and self-confidence and the invitation of the family to be present during intensive care unit (ICU) resuscitation.	Integrative Review	Cross-sectional studies More than half of the participants (61%) reported a request from a family member to be present during resuscitation. In a group of 465 ICU nurses, only 179 (38.66%) had experienced in the presence of family members during CPR.	It is recommended to develop detailed recommendations on clinical practice, including principles based on clinical experience, and nurse education. Competences in the field of knowledge, skills, and social competences, as well as conducting multinational research, will further expand knowledge about the family and its presence during CPR.	Level IV
Polus, Stephanie, et al. "Appraisal of WHO Guidelines in Maternal Health Using the AGREE II Assessment Tool." *PLoS ONE*, vol. 7, no. 8, 2012, doi:10.1371/journal.pone.0038891	Evaluate the quality of methodological rigor and transparency of four different WHO guidelines published between 2007 and 201	What are the AGREE II assessment findings of quality of methodological rigor and transparency of the four different WHO guideline published between 2007 and 2011?	Tool assessment, committee report	Higher scores to the most recent developed guidelines suggesting higher quality. Lower scores were noted to guidelines developed prior to 2007, although not much lower.	Studies from 2010 and 2011 received the highest AGREE II score compared to guidelines developed earlier in 2007 and 2009.	Level VII

Toronto, C. E., & Larocco, S. A. (2018). Family perception of and experience with family presence during cardiopulmonary resuscitation: An integrative review. *Journal of Clinical Nursing, 28*(1-2), 2-46. http://doi:10.1111/jocn.14649	Family Presence during resuscitation	Considers family presence during resuscitation (FPDR) from the perspective of the family member.	Integrative Review	Integrated Review from 1994-2017. Twelve studies suggest that family members view family presence as a fundamental right, benefitted the patient and healthcare team.	Findings support that family members' desire for FPDR; however, the literature reflects that HCPs do not always embrace the practice of FPDR. Stronger educational preparation of nurses and other HCPs related to FPDR is warranted.	Level V

Note. Evidence graded using the hierarchy of evidence model from "Evidence-based Practice Step by Step: Critical appraisal of the evidence: Part I," by E. Fineout-Overholt , B. M. Melnyk, S. B Stillwell, and K. M Williamson, 2010, *American Journal of Nursing, 110*(7), p.47-52.

Appendix B: Melynk & Fineout-Overholt Levels of Evidence

Levels of Evidence	Description of the Evidence
Level 1	Evidence obtained from systematic reviews or meta-analyses of randomized controlled trials
Level 2	Randomized controlled trials
Level 3	Evidence obtained from well-designed controlled trials without randomization, quasi-experimental
Level 4	Evidence from well-designed case-control or cohort studies
Level 5	Systematic reviews of descriptive or qualitative studies
Level 6	Evidence obtained from a single descriptive or qualitative study
Level 7	Evidence obtained from the opinions of authorities and/or reports of expert committees

Evidence-Based Practice in Nursing and Health Care: A Guide to Best Practice (Melynk & Fineout-Overholt, 2011, p. 12.).

Appendix C: AGREE II Tool

Domain 1. Scope and Purpose

1. The overall objective(s) of the guideline is (are) specifically described.
2. The health question(s) covered by the guideline is (are) specifically described.
3. The population (patients, public, etc.) to whom the guideline is meant to apply is specifically described.

Domain 2. Stakeholder Involvement

4. The guideline development group includes individuals from all the relevant professional groups.
5. The views and preferences of the target population (patients, public, etc.) have been sought
6. The target users of the guideline are clearly defined.

Domain 3. Rigor of Development

7. Systematic methods were used to search for evidence.
8. The criteria for selecting the evidence are clearly described.
9. The strengths and limitations of the body of evidence are clearly described.
10. The methods for formulating the recommendations are clearly described.
11. The health benefits, side effects, and risks have been considered in formulating the recommendations.

12. There is an explicit link between the recommendations and the supporting evidence.

13. The guideline has been externally reviewed by experts prior to its publication.

14. A procedure for updating the guideline is provided.

Domain 4. Clarity of Presentation

15. The recommendations are specific and unambiguous.

16. The different options for management of the condition or health issue are clearly presented.

17. Key recommendations are easily identifiable.

Domain 5. Applicability

18. The guideline describes facilitators and barriers to its application.

19. The guideline provides advice or tools on how the recommendations can be put into practice.

20. The potential resource implications of applying the recommendations have been considered.

21. The guideline presents monitoring or auditing criteria.

Domain 6. Editorial Independence

22. The views of the funding body have not influenced the content of

the guideline.

23. Competing interests of guideline development group members have been recorded and addressed.

Appendix D: CPG

Clinical Practice Guidelines for Family Presence During Resuscitation (FPDR)

Purpose

To better provide the option for family to be present during resuscitation.

Procedure

- When a patient arrives in the ED and is being resuscitated, the physician or the primary nurse for the patient will invite family to be present during the resuscitation.
- The physician running the code will be speaking with the family and explaining step by step on what interventions are per performed to save their loved one's life. After the resuscitation is complete, a moment of silence will be observed for the deceased patient.
- The primary nurse will be responsible for contacting the coroner and One Legacy after the nurse has spoken to the family and taken a detailed medical history for the patient.
- A social worker will always be available during the resuscitation and after to provide family with emotional/ financial support and burial resources.
- For patients who had a successful resuscitation, the physician will discuss code status if patient codes again.
- The physician will also discuss the next step in the plan of care for the patient with family.

Question

What information does the healthcare team need to make an evidence-based decision on allowing family members to be present at the bedside during resuscitation and providing the family members with a positive experience?

Target population

- Family members of the patient undergoing resuscitation
- All healthcare team members (physicians, residents, nursing staff, social workers) involved in providing care for patients requiring resuscitation

Recommendations

There is a lack of a standardized guideline to follow in making the decision to allow FPDR in acute care settings, though literature shows both that family and professional bodies favor the concept of family being present (Dwyer & Friel, 2016).

- In the 2009 ENA released a position statement supporting families having the option to be present during resuscitative measures to meet the emotional needs of the family (AACN, 2018).
- Most healthcare teams have reservations of themselves underperforming or anxiety about family members' emotional responses to witnessing a loved one's resuscitation (Bradley et al., 2017; Niemczyk & Ozga, 2019).
- Clinical practice guidelines (CPG) allow healthcare professionals to provide patient-family centered, evidence-based care by meeting the needs of the family in a time of crisis (Goldberger et al., 2015).

- Having set guidelines in making the decision to allow family at the beside during critical situations will provide guidance for the healthcare staff to base this decision on, no longer leaving the choice to the discretion of the physician.

Key Evidence

- Physicians who practice patient-family centered care encompass dignity, respect, information-sharing, participation, and collaboration during difficult decision-making which supports FPDR (Bradley et al., 2017; Niemczyk & Ozga, 2019).
- FPDR exemplifies patient and family-centered care, displaying dignity, respect, information-sharing, participation, and collaboration demonstrating improvement in healthcare (Niemczyk & Ozga, 2019).
- Family members who support being at the bedside reported the need to witness the efforts of the healthcare providers to understand what was going on and being present helped their grieving process, aided in closure, and provided a positive presence and comfort to the patient (Bradley et al., 2017; Niemczyk & Ozga, 2019).
- FPDR will have a positive impact on the family by allowing them to witness the efforts of the healthcare team and have a better understanding and sense of satisfaction towards the care provided to their loved one (De Stefano et al., 2016; Goldberger et al., 2015).
- FPDR will have a positive impact on physicians, residents, and nurses by encouraging professional behavior among the medical staff during resuscitation and providing a time to develop a rapport with the family, as well as building

confidence in including the family during the care of the patient and considering them as part of the care team (De Stefano et al., 2016; Goldberger et al., 2015).

Guideline monitoring

- The guideline should be reevaluated every 3 years or when new recommendations arise on the process of FPDR.
- Barriers to applying this guideline should be addressed as they arise by physicians, nursing staff, residents, and social workers and before implementation.

No funding was requested or received throughout the FPDR project as I developed this CPPEG.

Clinical Practice Guideline: Family Presence During Resuscitation

This guideline is intended as a standardized procedure to direct the healthcare team who decide if family will be given the option to be present during resuscitation and how to provide the best experience possible.

- Why should family be given the option to be present during resuscitation?
    - Family has expressed the need to witness the efforts of the healthcare team (Bradley et al., 2017)
        - Family wants to understand what was going on during the resuscitation period (Bradley et al., 2017)
        - Being present can help with their grieving process, aid in closure, and provide a positive presence and comfort to the patient (Derosa et al., 2019)
    - Family presence will have a positive impact on physicians, residents, and nursing staff (De Stefano et al., 2016; Goldberger et al., 2015)
        - By encouraging professional behavior among the healthcare team during resuscitation
            - By developing a rapport with the family
    - FPDR exemplifies patient and family-centered care, displaying
            - Dignity
            - Respect
            - Information sharing
            - Participation

      - Collaboration
        - Demonstrating improvement in healthcare (Goldberger et al., 2015)

- When should family be allowed at bedside?
  - Patients have strong preferences about family presence during cardiopulmonary resuscitation
    - Should have the opportunity to make the decision about having present (Bradley et al., 2017)
      - Honor the patient's preferences when possible
      - Review advanced directive on hospital admission
  - During resuscitation
    - Following being invited by physician or primary nurse
  - During invasive procedures
    - Intubation, chest tube placement, central line placement, arterial line placement
- When is family **not** allowed at beside?
  - When patient being resuscitated is under possible investigation for homicide or suicide
  - Police department or Sheriff is at the bedside requesting family not be allowed to witness resuscitation
    - Potential that evidence may be tampered with (family member touching the patient)

- Who are the key persons to be present during resuscitation?
    - Patient’s family members
        - According to known express patient preference or as determined in advanced directives
    - Physician/ surgeon running the code
    - Residents
    - Nursing staff
        - Primary nurse
        - Other nurses involved in the resuscitation phase
    - Social worker
    - Respiratory therapist
    - Pastoral staff
    - Security
- Who is responsible to invite family to the bedside?
    - The physician or the primary nurse give approval
        - The social worker after deemed ok with physician or nurse
- What are the responsibilities of the healthcare team?
    - Physician/surgeon/ resident
        - Explain the resuscitation process to family step by step
        - Answer questions the family may have during and after the code
        - Actively participate in the resuscitation process by stating orders for the healthcare team to carry out during the code

- Social worker
    - Always stay with family members during the resuscitation measures
        - Provide support for family during and after resuscitation measures
        - Provide resources for emotional, financial, and social concerns

- What should happen when resuscitation is completed
    - For patients who have expired
        - Identify any cultural norms or practices that would guide activities at time of or shortly after death to follow (speak with family to determine what their cultural preferences may be)
        - A moment of silence should be observed for the patient and their family members by everyone involved in the resuscitation process
        - Offer Chaplin services to the family
        - The physician/ surgeon/ resident answers all questions the family may have
    - For patients with successful resuscitation
        - The physician should answer all questions the family may have
        - Discuss code status with next of kin or DPOA should the patient code again
        - Discuss the next step in the plan of care

- General guidance for healthcare providers
    - Do not use vague language.
        - Do not use terms like “full code”, “DNR”, or “DNI”.
            - Define these terms so the family understand the meaning.
        - Instead of saying “full code or DNR” reframe this to say,
            - “Would your family member want their chest pressed on?”
            - “Would they want us to give them life-saving medications?”
            - “Would they want us to put a tube down to help them breathe?”
    - Avoid the use of medical jargon
        - Instead of saying “The patient had a cardiac arrest”- say, “The patient’s heart stopped.”
        - Instead of saying the patient had respiratory failure- say, “The patient stopped breathing or was having a hard time breathing.”
    - Avoid delays in delivering bad news, if possible
    - Do not delegate end-of-life tasks to those without sufficient experience
        - The physician
            - Delivers the news that the patient has died
        - The primary nurse:
            - Speak with family and gather information about the patients’ medical history

        - Make phones calls to the coroner and One Legacy
      - The social worker:
        - Provide family with grieving resources
        - Provide family with burial information if family requests
  - Avoid abrupt ends or premature ends to discussions when possible
    - Allow family time for questions or comments
    - Let family end the discussion, if possible
  - Consider having a social worker accompany the family member during the code to provide support, and escort family to the family room if family needs to leave the code
- Procedures for family who were invited to be present during the resuscitation and declined
    - Escorted to the family room by the social worker
    - Met by the physician/ surgeon/ resident and primary nurse taking care of their family member after the resuscitation is complete
      - Review resuscitation measures delivered to the family member discussing step by step
      - Answer all questions addressed by the healthcare team
      - Provide the opportunity to see their family member if requested

- Debriefing after the code
    - The healthcare team involved in the code should have a debriefing after the code
        - Discuss the resuscitation event process and outcomes
            - Break down the positive and negative events during the code
            - Create strategies to move forward
    - Discuss the emotional and psychological components of the event

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Appendix E: Expert Panel Summative Evaluation Questionnaire

Questions	Expert #1	Expert #2	Expert #3	Expert #4
1a. Please describe the effectiveness (or not) of this project as a team approach related to meetings, communication, and desired outcomes etc.	The team approach was very effective. It allowed for several different perspectives and various levels of experience to input their thoughts and objectives.	The team approach allowed different perspectives which is needed especially in a healthcare setting. Everyone plays a different role in caring for patients.	The team approach is excellent when trying to get different opinions for a subject matter. All team members bring different approach.	A team approach is great when it comes to creating a new policy or process, this way different experiences can add to a greater cause.
b. How do you feel about your involvement as a stakeholder/committee member?	I was pleased to be involved and felt my feedback was well taken.	I felt that my involvement was greatly appreciated by the student, and I felt honored to have apart in this project to improve patient and family care.	My involvement in this project I felt was helpful to the student because of my experience in education and being a hospital educator.	My involvement in this project was greatly appreciated especially as a resident. I am in training and can do my best to implement new changes into my practice to improve patient care.
c. What aspects of the committee process would you like to see improved?	No issues with the committee process	There were no committee process issues just the AGREE II tool website configuration issues which had nothing to do with the student's leadership.	I did not have issues with the committee process.	I did not have issues with the committee process. Had some issues with the AGREE II tool website.
2a. Describe your involvement in participating in the	I was given adequate involvement in the development of the	My Involvement in this project was well received. I work closely with the	I was able to involve myself into this project by providing personal	I was involved in this project to help develop CPG but gained more by

development/approval of the products.	educational curriculum and feel that my direction was well received.	student daily as professional colleagues. I was able to provide input on this project as we saw the needs arise in our work. If COVID had allowed, we would have loved to implement this project for every trauma patient coming in being resuscitated.	experiences and responses from staff in the past.	understanding why the need exists. I will be using the CPG if allowed at my facility. My involvement was appropriate.
b. Share how you might have liked to have participated in another way in developing the products.	My involvement was appropriate for the need of the project.		My involvement was appropriate.	

3a. As a team leader how did the student direct the team to meet the project goals?	Poonam was an excellent team leader and directed each individual to obtain her goals.	Poonam displayed great leadership skills when it came to knowing the project, why was it necessary, who should have input and developing the CPG.	Poonam has excellent leadership skills, she displayed them when she worked in the ED for so many years, and it was great to see her evolve into education and wanting to create change to better clinical practice.	I have had the pleasure of working alongside Poonam as a resident and she has great leadership skills not only in the clinical setting but now on an educational and policy development platform.
b. How did the leader support the team members in meeting the project goals?	She was great at communicating and addressing the needs of the project as they came up.	She was able to receive critique and make appropriate changes to her project. It was a pleasure to help her with this project.	She was able to take new recommendations and asked for help when she reached barriers.	Poonam is great at taking new direction and critique.
IV. Please offer suggestions for improvement.	NA	I do not have new suggestions currently.	No suggestions	Possibly improve AGREE II tool website to make it user friendly.